NHPCO Palliative Care Playbook for Hospices

Budget

This toolkit is part of NHPCO's comprehensive Palliative Care Playbook that is available to members as a benefit of membership. Learn more about Community-Based Palliative Care Resources at www.nhpco.org/palliativecare.

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You have completed your needs assessment, defined the model you want to deploy, in the care setting(s) identified, and are ready to develop a budget. Estimating financials for your palliative care program will likely be one of the most challenging activities you and your leadership team will do. Budgeting is a process that states future revenue and expenses to establish financial goals for your program within the organization. This chapter will not focus on the budgeting process; it will focus on various components important in determining what will be considered program revenue and expense.

Today there are a variety of methods for community-based palliative care programs to generate revenue from. It is important to include in your needs assessment how your program will utilize a diversified portfolio to ensure long-term sustainability. A resource to give you a quick overview of payment models is the California Healthcare Foundation's publication: Five Ways to Pay: Palliative Care Payment Options for Plans and Providers. Most programs start out utilizing a traditional fee-for-service reimbursement model. However, with growing understanding of what community-based palliative care is and can offer; and quality-based payment models it is important to plan for how your program can take advantage of opportunities such as shared savings, managed care and capitated based payment mechanisms.

Revenue Types

Your program can be supported through a variety of revenue sources (e.g. fee-for-service, payer per-member-per-month contracting, grant, etc.). Each of these revenue sources may alter the type of program you initially develop and will direct the type(s) of staff and other expenses necessary to provide services.

Fee-for-service.

Many hospice organizations utilize a fee-for-service revenue stream to support their program. This revenue model is relatively easy without assuming to much risk. Programs of this type will either hire a physician, nurse practitioner, or clinical nurse specialist who perform medical visits for medically necessary care. Typically, the medical care provided is billed through the patient's Medicare Part B benefits at a fee-for-service rate. Medicare, and other payers, pay the provider 80% of the billed services and the organization must bill the patient for the remaining 20%. The biggest risk to an organization using a fee-for-service revenue model is generating enough revenue to counter the expense of the provider(s) salary; and other costs associated with travel, supplies and any non-provider staff you may have supporting the program.

Fee-for-service models are limited. They only pay for services provided by a physician and non-physician providers at the fee-for-service fee rate. There are other aspects of a fee-for-service payment model that you should consider as outlined in other chapters. An advantage to employing a fee-for-service payment model is that it provides your program with an opportunity to demonstrate quality outcomes associated with potential savings. This information can then be used to negotiate payer contracts that could begin to diversify your payment portfolio.

Budgeting for fee-for-service payment model is pretty straight forward. You need to determine whether you are hiring a physician, or a non-physician provider. The individual staff, their mileage, and anticipated supplies are your direct cost and supporting infrastructure (e.g. office space, non-provider staff, and other ancillary support) are your indirect costs.

Through experience a fee-for-service payment model should be based on a cost neutral, or break-even budget. As a hospice and home health organization your business goal is to be able to provide increased levels of care to your patient population, increase referrals to your programs, identify patients who are appropriate for hospice services earlier in their disease trajectory, and transition them to hospice so that they can benefit from hospice services longer. This is your return on investment (ROI) and often considered your soft ROI. Soft ROI is the indirect benefit your organization receives through the activities listed above. In a fee-for-service revenue model it is difficult to achieve profitability for your palliative program without considering the soft ROI.

The following proforma is one example of how to budget your fee-for-service program. This proforma was developed for a hospice and home health free standing organization. Their palliative care program was a separate division within the organization. Within 18-months their palliative care ADC was 750 patients across 5 unique locations with 6 nurse practitioners, and 5 nurses supporting care.

Palliative Care													
Program Name					Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
	Palliative Care Admissions				10	15	20	20	20	20	20
	Palliative Care ADC				5	17.5	35	55	75	95	115
	Initial Assessment Visit			1.00	10.0	15.0	20.0	20.0	20.0	20.0	20.0
	Focused visit (1/2 per admission)			0.50	5.0	7.5	10.0	10.0	10.0	10.0	10.0
	Continued Focused Visits (1xmonth)			1.00	5.0	17.5	35.0	55.0	75.0	95.0	115.0
	Total Visits				20.0	40.0	65.0	85.0	105.0	125.0	145.0
Revenue	Per visit rate	Billed Rate									
Reimbursement / Initial assessment	$275	85%			$2,338	$3,506	$4,675	$4,675	$4,675	$4,675	$4,675
Reimbursement / focused visits	$100	85%			$850	$2,125	$3,825	$5,525	$7,225	$8,925	$10,625
Total Reimbursement					$3,188	$5,631	$8,500	$10,200	$11,900	$13,600	$15,300
	% Non-Billable	5.0%			$3,028	$5,350	$8,075	$9,690	$11,305	$12,920	$14,535
Costs											
Physician / Nurse Practitioner	$100,000	Shared Salary %		0%	$9,583	$9,583	$9,583	$9,583	$9,583	$9,583	$9,583
Nurse	$	Shared Salary %		%	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Add'l Nurse Practitioner(s)	$	Shared Salary %		%						#VALUE!	#VALUE!
Travel Costs	PPD	$	0.60		$183	$560	$961	$1,258	$1,373	$1,739	$2,105
Other Costs (supplies etc…)	PPD	$	0.20		$92	$267	$480	$671	$801	$869	$877
Total Costs					$9,858	$10,411	$11,024	$11,512	$11,756	$12,191	$12,565
Margin on Palliative Care Program					**-$6,830**	**-$5,061**	**-$2,949**	**-$1,822**	**-$451**	**$729**	**$1,970**
					-214%	**-90%**	**-35%**	**-18%**	**-4%**	**5%**	**13%**
Future Benefit to Hospice (Not part of Palliative Care Proforma)											
	Add'l Hospice ADC at 15% Conversion rate:				0.8	2.6	5.3	8.3	11.3	14.3	17.3
	Add'l Hospice ADC at 25% Conversion rate:				1.3	4.4	8.8	13.8	18.8	23.8	28.8
	Add'l Hospice ADC at 30% Conversion rate:				1.5	5.3	10.5	16.5	22.5	28.5	34.5
Hospice Revenue per month per converted patient				**$ 4,800**	**$ 3,600**	**$ 12,600**	**$ 25,200**	**$ 39,600**	**$ 54,000**	**$ 68,400**	**$ 82,800**
					$ (3,230)	**$ 7,539**	**$ 22,251**	**$ 37,778**	**$ 53,549**	**$ 69,129**	**$ 84,770**

For this example; considering all elements are met, the provider would meet their 100-encounter productivity target at month-5 and would provide a break-even return at month-6.

Assumptions:

- No infrastructure costs
  - This organization's hospice and home health divisions provided all infrastructure support as a 'cost of doing business' to their division for the soft ROI gains.
- Month over month increase in your palliative population
- Each provider to achieve 100 consults monthly
- Each provider to achieve 20% new patient and 80% established patient encounters monthly
- Reimbursement on an average of your potential billing
  - Currently set at 85% of 100% billing due to the provider being a nurse practitioner
  - New patient comprehensive encounter payment
  - Established patient encounter payment
  - A 5% non-billable line item
- Nurse practitioner salary
  - If you are sharing your provider with hospice to do face-to-face visits for ongoing eligibility you can adjust a given % out of your costs
- Travel costs/supplies variable

This budget template ends with a section labled 'Future Benefit to Hospice (Not part of Palliative Care Progorma) to show the potential soft ROI as the program achieves a 15, 25 and 30% converstion rate.

This program did realize approximately $3,000 a month profit. They increased their hospice ADC by 200 patients within 1-year with an average days on service of 91-days. Additionally, they increased the referrals to their home health by 33%, and increased their home health's ability to recertify patients by an additional certification period by 38% using palliative care interventions.

Per member per month (PMPM).

Through various payer contracts your program may be supported through PMPM revenue streams. This type of revenue (terms to be established by the payer) typically pays a capitated rate (fixed rate) per enrolled member that is paid to the provider. The amount paid is determined by the range of services that the organization is providing, the number of patients and the period of time services will be provided.

Typically the payer does not direct how care should be provided; however, they will likely determine a list or range of services the organization must provide to their members. These services could range from only requiring a physician or non-physician provider to support that requires an interdisciplinary team. They may direct that a physician or non-physician provider see an individual member at X intervals, or not as often as other resources.

For a PMPM capitated revenue model it is very important to manage your overall cost of care per enrolled patient. It is critical to monitor the utilization of the various services, which patient requires more or less, and how to manage the care needs utilizing the agreed on services to ensure efficiency. You will have some patients who utilize services at a lower margin than others; however you must ensure your overall services support your budgeted margin. Similarly to a fee-for-service revenue model, PMPM revenue models work well when the organization has a volume of patients.

Budgeting a PMPM revenue model simply establishes the per member per month rate to the number of lives serving against the associated costs.

Grants/Other:

Additional revenue sources can be realized through philenthopic grants, research funding, demonstration projects, and other sources. Typically these sources have an expiration date to them. Building a program solely on these types of reveues will not provide long-term sustainability – they are however great ways to diversify your revenue portfolio.

Similarly, to the PMPM discuss, these revenue sources will likely be specifically based on what type of services you will be required to provide against a set revenue over a specific timeframe. Using the Medicare Care Choices Model (MCCM), a Center for Medicare and Medicaid Innovation demonstration initiative; those awarded the opportunity to participate are being paid a set monthly fee for each patient enrolled who meets their criteria. This is very similar to the PMPM revenue model. The program directs the services that are required to participate – your fixed costs, and the payment per patient enrolled – your revenue. It is equally important to ensure you are managing your expenses against the revenue efficently.

For PMPM, grants and other types of revenue programs you may consider using a staffing calculator to determine budgeting parameters based on census or volume. A staffing calculator can help you scale resources as your volume increases or decreases.

Expenses

Throughout this chapter we have outlined some of the expenses to consider when budgeting for your palliative care program. Similarly, to your hospice budget, you will need to consider your direct and indirect costs, as well as, potential contracted services. Going back to the staffing chapter, we discussed the importance of incorporating National Consensus Project for Quality Palliative Care's 4th Edition of the Clinical Practice Guidelines for Quality Palliative Care into your program design as the gold standard. Again, these guidelines are not intended to be seen as an absolute structure of care that must be adopted and your program may never be able to fully implement all of its recommendations. Depending on the type of model your organization launches, and the financial parameters that govern your program you will need to make decisions on the best way to staff your program. It was suggested that you determine alternate ways to supplement members of the interdisciplinary team in a way that does not result in direct expense to your program.

Staffing costs will be your highest expense line. This is no different than how you budget for your hospice staffing. Depending on the model you choose and the way in which you choose to support your palliative care patients utilizing the interdisciplinary team will direct the various staff members you need to budget for. Other direct patient care expense will include travel

(mileage reimbursement), and any associated supplies that you may be required, or will provide (personal protective equipment, etc.) as shown in the example proforma.

Your indirect cost will come through the overhead, or infrastructure cost associated with your program. The costs associated with the administrator of your palliative care program, office space, phones, receptionist, billing department needs, etc. should all be considered indirect costs of your program. We have outlined one programs use of their hospice and home health division's infrastructure to reduce the program's indirect costs as an investment in towards the soft ROI your program will provide them through increased referrals, etc. Some will argue if you budget in this way you will not fully understand the costs associated with your palliative care program. There is certainly no one way to budget your program's revenue and expenses. The bottom line is that you and your organization must determine what is right for your organization, and your organization's structure.

Resource: Appendix A from Business Case chapter or under Tools for Planning & Evaluating Programs – Supportive Care Calculator Home at https://coalitionccc.org/tools-resources/palliative-care/

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