Center to Advance Palliative Care

INTEGRATING PALLIATIVE CARE INTO POPULATION MANAGEMENT:
A Toolkit for Health Plans and Accountable Care Organizations

PAYMENT AND INCENTIVES

"The future is here now. It's just not very evenly distributed." William Gibson, *The Economist,* 2003

What it is and Why it's Important

What doesn't get paid for doesn't get done. This truism of medical economics continues to apply despite the growth of value-based payment models. The high prevalence of palliative care in hospitals and in hospices in this country can be traced to the fact that there is a rational business model supporting both. In contrast, access to palliative care for the great majority of the seriously ill who are neither hospice-eligible nor hospitalized remains a matter of luck. In order to strengthen access to quality palliative care for high-need/high-cost patients, payment must provide a secure and sustainable basis for such care in patients' homes, doctors' offices, cancer centers, dialysis units, and long term care settings.

There are two parts to payment. The first is payment for specialty palliative care and interdisciplinary care teams in community settings. New payment models are needed because traditional fee-for-service payment does not adequately reimburse for specialty palliative care, comprising the time-intensity of skilled clinician conversations over time, the required access 24/7 for crisis management, the essential nature of the interdisciplinary care team for such a complex population, and the creation and sustainability of the reliable community partnerships necessary to address food, housing, transportation, and social needs.

The second part is financial incentives. Payment is a powerful mechanism for payers to accelerate the preparation of the healthcare workforce in care of people with serious illness. As noted in Section 4: Provider Network, the great majority of practicing clinicians have had little or no training in pain and symptom

management, expert communication skills, and coordinated care over time and across settings. Payers can expedite the adoption of core palliative care knowledge skills, along with the integration of palliative care specialists, through targeted financial incentives.

Best practices in Specialty Palliative Care Payment

In general, value-based payment models align well with specialty palliative care, as both seek to avert crises and unnecessary emergency department visits, hospitalizations, and low-value interventions like intubations in the ICU for end-stage dementia patients. Listed in the table below are a range of payment models that have been used by health plans or health systems to support high-quality palliative care teams:

Payment Models Currently in Use to Support Specialty Palliative Care Services	
Enhanced Fee-for-Service	• Enhanced fee-for-service, such as 200% of Medicare, to enable interdisciplinary team care. A national Medicare Advantage plan has piloted this for palliative care services in oncology practices. • Additional service codes to pay for the traditionally “non-billable” professionals such as social work, chaplaincy, and pharmacists. A health plan in Texas has created a code for social work advance care planning conversations. • Risk-adjusted payments for case management services, such as in the Medicare Comprehensive Primary Care Plus model. • It is possible to create tiered fee schedules, with higher fees paid for clinicians or programs holding certain palliative care certifications.
Lump Sum Payment	• Stipend or per-session payment for a specialty palliative care clinician or team. An ACO in Kentucky uses this to provide their patients access to specialty palliative care. • Salary and benefit support for the palliative care team, commonly used by risk-bearing health systems to enable access to palliative care services. • Start-up or implementation funding for program development and/or training. Blue Shield of California has used this to rapidly expand network capacity (see Case Studies).
Case Rate	• Payment on a per-enrolled-member-per-month basis for a set of palliative care services. o The rate typically encompasses the services of an interdisciplinary palliative care team, including physician, nursing, social work, and chaplaincy. o Specific additional services may be included such as medications, home nursing, personal care, and some durable medical equipment. o Specific outlier provisions, time limits, or risk adjustment payments are typically included. • Case rates are used by many health plans, typically to pay for palliative care services that include in-home visits and 24/7 response. See the Advanced Alternative Payment Model proposals in the Additional Resources Section for models under consideration by Medicare.
Episode Rate	• Payment of a single price for a defined set of palliative care services over a defined period of time. As with case rates, services typically include in-home visits and 24/7 response. Ongoing services and payment are possible either by re-authorizing the episode or moving to a lower case rate for ongoing support in the following months. o Episodes paid by HealthFirst in New York are for three months (see Case Studies). o Sharp Healthcare’s program includes six-weeks of in-home services, followed by ongoing telephonic support.

“Combination” Payment Model	Case rate or episode rate, combined with shared savings, shared risk, and/or quality incentive payments.

The payment model selection should consider the claim system’s capabilities to support alternative payments, as well as the accounts receivable capabilities of the providers in the network. If either party is unable to administer the preferred model, enhancements to fee-for-service should be considered while the systems are adjusted.

Best Practices in Incentive Payments that Promote Palliative Care Skills or Integration

The table below highlights best practices in financial incentives that have successfully encouraged the adoption and integration of palliative care.

Payment Incentives Currently In Use to Promote Palliative Care Skill Development and/or Integration of Palliative Care Services	
Practice-level Incentives	• Fee-for service with a periodic reconciliation for bonuses, based on: ○ Documentation of pain/symptoms and plans to address within targeted timeframes. ○ Measures related to occurrence and documentation of advance care planning conversations. ○ Improvement in accuracy and comprehensiveness of coding and documentation. ○ Reductions in end-of-life utilization, such as hospital days or ICU stays ○ Increases in end-of-life hospice utilization. ○ Member satisfaction scores above a certain threshold. • Two-sided payment adjustments, with bonuses for achievements such as those listed above, with penalties for less-than-targeted outcomes.
Hospital Incentives	• Higher payments for achievement of The Joint Commission Advanced Certification in Palliative Care or sufficient progress towards those standards. • Ongoing payment bonuses dependent upon the rate and timeliness of specialty palliative care consultations. • Increased annual rate increases based on TJC certification or proof of specific palliative care capabilities and processes. This is a strategy used by Anthem to promote network hospital palliative care capacity (see Case Studies).
Bundled or Episode of Care Payments	• Set a target price for certain episodes of care, requiring the inclusion of palliative care specialists and services. Examples of episodes appropriate for the bundled payment-with-palliative-care-requirement include: ○ Oncology care episode ○ CHF or COPD hospitalization ○ Skilled Nursing Facility episode • A national Oncology management vendor is using this strategy with all partnering practices.

Getting Started

Whatever the degree of penetration of value-based and alternative payment models in support of access to community-based palliative care, there are initial steps that all payer organizations can take to ensure sufficient financing for palliative care services, as follows:

1. Create incentives for appropriate referrals and goals of care conversations.
The best way to begin paying for palliative care is to begin incentivizing accountable providers for appropriate referrals to palliative care and/or documentation of a goals-of-care conversation for those patients identified as seriously ill (see Section 1: Identification). This could include adding an incentive payment to a contract with, say, an oncology practice that completes certain assessments on patients. Not only do these efforts incentivize timely and appropriate goals of care conversations with seriously ill patients, they also allow tracking of the effect advance care planning has on the member's subsequent care trajectory.

2. Assess whether existing payments and/or incentives may already promote access to palliative care.
Payment comes after other serious illness strategies are defined. Before tackling payment, a health plan should define who the target population is and what services they will be expected to utilize. Depending on the program, current payment models may be sufficient, or may need slight adjustments to align incentives. For example, if the serious illness program targets individuals undergoing cancer treatment and oncology bundled payment already exists, the bundled payment can be modified to require specialty palliative care consultations and/or elevate an incentive payment for documented goals of care conversations. In another example, primary care providers may already be receiving a higher tiered payment if they have certification as a Patient-Centered Medical Home, and the plan can highlight guidance on how palliative care capabilities meet the requisite standards.

3. **Consider starting with hospitals, building on existing hospital palliative care teams.**
As above, hospital stays are already paid for, but a health plan or ACO's members may not have access to any palliative care services under current conditions. To incentivize palliative care consultations for appropriate members, consider adding process measures, such as: timing (earlier is better) and occurrence of palliative care consultations for eligible hospitalized members; occurrence of advance care planning documentation in the electronic medical record or in physician claims; or rate of referral to, and timeliness of, hospice referral (again, earlier is better). Also, hospitals with an inpatient palliative care team that meet certain criteria, such as breadth of the interdisciplinary team or ratios of palliative care team FTEs to beds, might be contracted within a narrow network. These adjustments provide an opportunity to tier financial payouts based on the presence, utilization, and timeliness of palliative care services.

4. **Pilot payment for community-based palliative care with an existing provider**.
If you are aware of palliative care providers in your market area, consider beginning a small pilot to pay for outpatient or home-based palliative care services using a preferred starting payment model to support the time of the non-billable interdisciplinary team members. Use pre-existing data and published outcomes to determine patient eligibility and model out potential cost of pilot and savings. Start small and continue to evaluate; successful pilots can then incrementally add diagnoses, geographical areas, services, and quality requirements.

Note that you can process case rates for palliative care by creating an S-code for the pilot.

Practical considerations for implementation

1. Seek to align risk-adjustment methodologies and quality thresholds across providers.
Implementation is simplified and quality is more reliable if payers work towards consistency in the underlying structures, including risk-adjustment and quality thresholds, across all providers in the network, and not just the palliative care specialists. Otherwise, issues may arise when the palliative care providers are working towards outcomes that are not on the treating provider's "radar." For example, if palliative care providers are measured on the rate of advance care planning conversations, their colleagues in other specialties such as oncology and cardiology should be held to the same measures so that all efforts align to improve advance care planning, and no one works at cross-purposes. Developing a consistent set of risk-adjustment methodologies and

performance expectations will ensure both quality of care for those with serious illness and improve the ability to administer payment and provider network designs.

2. Carefully consider the metrics used in pay-for-performance.

Value based payment requires linking payment to outcomes. However, measure selection should incentivize services aligned with the patient and family's needs and priorities. For example, an excess focus on reducing 30 day readmissions or ED visits may create perverse incentives preventing some very sick and complex patients from receiving necessary and appropriate care in those settings. Similarly, driving towards adherence to HEDIS measures often incentivizes unnecessary and inappropriate preventive services, such as colonoscopy, that make no sense in patients with end stage dementia or progressive life threatening disease, and may even be dangerous. See more in Section 6: Measurement and Evaluation.

3. Consider using creative "bridge" or "investment" payments.

Making the transition from a fee-for-service to an alternative payment model often requires an upfront investment in infrastructure necessary for providers to deliver on value. For example, managing a population requires an investment in reliable after hours telephone responsiveness, health information technology, analytics, and sometimes case management. Investments may also be needed in telehealth/telemedicine, particularly to optimize access and cost appropriateness. Recognizing that the benefits of these provider investments often accrue to the health plan or ACO, some are partnering with palliative care providers to subsidize the initial financial investments required, including Blue Cross/Blue Shield of Massachusetts, ProHealth, Anthem, and others (see Case Studies across the sections).