California HealthCare Foundation

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Issue Brief

# **Five Ways to Pay:** Palliative Care Payment Options for Plans and Providers

Quality palliative care can be delivered in a variety of settings, and can be transitioned throughout the continuum of care as needed. To enable such services, payers and providers must have a structure and process for expanding the payment beyond the traditional definition often tied to hospice care. Payment for the extended use of palliative care services can be arranged in a number of ways. This issue brief describes five examples of payment models and how they impact health plans and providers.

## 1. Fee for Service

In the FFS model, specific codes and fee schedules must be developed to submit claims for palliative services. These become part of the contract with the purchaser (an employer or individual). The payer agrees on negotiated payments with palliative care providers, which could include pre-authorization requirements for palliative care. Beyond that it is a straightforward transaction; there are no retrospective determinations for shared savings or outcomes-based metrics.

### Examples

- Cambia Health Solutions in the Pacific Northwest provides comprehensive palliative care coverage across all of its insurance products, including FFS and PPO products.[1]
- Highmark, Inc., in Pittsburgh, provides FFS reimbursement for specific palliative care procedure codes. The program has also built in value-based reimbursements related to specific hospital-based metrics for the impacted population.[2]

### Payer Considerations

FFS allows easy-to-demonstrate savings attributed to inclusion of palliative care services. For example, the increased cost of offering palliative care can be compared to savings due to reductions in ER visits or hospital readmissions.

While FFS requires the establishment of claims codes, payment schedules, and benefit definitions upfront, it is often a fast way to initially reimburse the cost of palliative care services. Payers and providers may consider moving to approaches with more shared savings when they have data and experience with palliative care reimbursement.

### Provider Considerations

In straight FFS models providers are reimbursed for the care that is provided, not for how well they manage overall patient care or the outcomes. This means that providers have incentives to provide more services rather than to contain or manage care.

From a provider perspective, FFS limits their risk because they get paid for services provided. Because payment for palliative care is identified and easily measured, it is straightforward for providers because they don't have to administer or reserve funds for capitation, pay for performance, bundled care, or shared services, as some other payment models require.

It is a challenge to manage patient care across multiple treatment modalities for delivery systems that are not integrated. It is also difficult to coordinate capitation, bundled payments, and shared savings across treatment settings. As payer-provider relationships evolve, the ability to transition away from FFS will increase. Until both payers and providers are comfortable with the impact of adding palliative care services, an FFS approach provides a baseline for evaluation and the development of future payment options.

## 2. Outcomes-Based Reimbursement (Pay for Performance)

Outcomes-based reimbursement, also known as pay for performance (P4P), rewards doctors, hospitals, and other providers for attaining targeted service goals such as quality or efficiency standards. Similar to the shared savings model described below, a portion of the health care premium is placed in a separate fund and, based on the achievement of pre-determined metrics, additional payment flows to the providers on a retrospective basis.

### Examples

- Aetna's Compassionate Care Program provides value-based or P4P reimbursements. For members enrolled in the program, Aetna has demonstrated an 81% decrease in acute days, 86% decrease in ICU days, increased member and family satisfaction, and average cost reductions of $12,000/member.[3]
- Excellus BCBS in NY provides enhanced payments to providers who have completed a Physician Orders for Life-Sustaining Treatment (POLST) training program, and makes payments based on results related to the Excellus Hospital Performance Incentive Program (HPIP). Specific metrics are tied to the provision of palliative care services, not the reduction of other acute care services.[4]

### Payer Considerations

This approach can be easily measured once the metrics are defined and a baseline is established. However, gaining agreement on the metrics can be difficult. It can also be challenging to determine how to account for the funds that are withheld and used in the P4P payments.

### Provider Considerations

Payment is in large part based on attaining goals that are tied to improved outcomes, efficiency, and reductions in certain types of utilization; it is not necessarily driven by financial results. As with shared savings and capitated arrangements described below, providers may find it difficult to determine what services to offer at what cost.

## 3. Pre-Paid/Capitated

With the capitated reimbursement approach, the payer offers the provider a fixed, or capitated, fee that is intended to cover all or a specific portion of care provided to a member. The provider assumes responsibility to pay for palliative care services according to the Division of Financial Responsibility (DOFR).[5] The provider organization, now the payer, can pay the palliative care provider in several ways: (1) a sub-capitation on a per member, per month (PMPM) basis; (2) via fee for service based on an established fee schedule; or (3) via a shared risk or outcomes-based methodology. In any of these approaches, the financial risk for providing palliative care services resides with the providers.

### Examples

- Kaiser Permanente established initial pilots in Kaiser of Colorado and the TriCentral Service Area in Southern California. Palliative care has now been incorporated across service areas in both Southern and Northern California regions.[6]
- CareMore, a Division of WellPoint, built a care model that extended covered benefits to include palliative care for its Medicare population. It has continually demonstrated increased patient satisfaction and reduction in key acute care services.[7]

### Payer Considerations

Including coverage for extended palliative care services in a pre-paid or capitated model is often desirable from a payer perspective for a number of reasons:

- Lack of experience in payment for these services outside of a traditional hospice environment makes it difficult to predict what the claims experience in a FFS arrangement would be.
- The payer does not have to set up the CPT codes for claims payment in its systems.
- It better supports the management of care on the part of the contracted provider organization across the continuum of care versus an incrementalized approach in a FFS claims model.

Based on a lack of experience in extended palliative care being included within the scope of services, the health plan may not be able to accurately determine the impact of extended palliative care on the overall capitation payment. Some capitation arrangements may include clauses to review reimbursement levels once the impact of palliative care on costs is experienced.

### Provider Considerations

The network is the beneficiary of savings that result from offering palliative care earlier in a patient's treatment plan, which may reduce the use of other acute care services such as ER visits. Capitated systems have the financial and organizational flexibility to integrate all elements of care — from physicians to financing — into a coherent whole. This model may facilitate care coordination across various provider specialties and programs. Any metrics that are developed and used for measurement are the property of the network, which allows the provider to determine the approach and setting of palliative care that is needed.

This model requires alignment of incentives within the provider network due to changes in compensation. The use of extended palliative care services can lower the overall cost of care for the capitated network in addition to providing more appropriate patient care. The risk for providing the care rests entirely with the delivery system, and there are few models from which to base the cost of palliative care in a capitated arrangement.

## 4. Bundled Payments

With this model, a bundled payment is made for patient care related to the diagnosis or condition as part of the fee schedule negotiation for specific diagnoses or conditions. The provider organization is given the flexibility to offer the appropriate levels of care, including extended palliative care services. By accepting a bundled payment, the provider assumes some financial risk for the specific condition or treatment.

### Examples

- Geisinger Health System has implemented a performance-based bundled payment system, ProvenCare, as a way to reimburse providers for coronary artery bypass graft (CABG) surgery. ProvenCare achieved notable results for CABGs, including a 10% reduction in readmissions, shorter average length of stay, and reduced hospital charges. Since the program's inception in 2006, Geisinger has added the following diagnoses to ProvenCare: elective coronary angioplasty (also known as PCI); bariatric surgery for obesity; perinatal care; and treatment for chronic conditions.[8]
- The Affordable Care Act (ACA), section 3023, allows for pilot tests to explore the impact a single "bundled" payment for all aspects of an episode of care would have on overall quality and cost. It encourages coordinated community care services and aligns incentives to reduce use of the most expensive setting for care. However, the ACA does not identify programs specific to palliative care.

### Payer Considerations

Bundled payment is a hybrid approach between fee for service and capitation in that it allows for the single payment for a treatment or condition versus a global capitation for a broader range of health care services. Bundled care payments better isolate the conditions and treatments where palliative care would be appropriate, beneficial to the patient, and apt to yield the greatest potential for cost savings.

Under the ACA, reimbursement models such as bundled payments and medical homes are likely to move forward. However, bundled payments are still in their early stages of development; as yet there are no standardized bundles for palliative care. Payers may also find bundled payments difficult to plan for and administer.

### Provider Considerations

The difference between a broad capitation and a bundled payment approach is that the bundled payment focuses on specific patients with specific conditions or diagnoses, not the entire insured population. This strategy is easier to monitor and measure from an outcomes basis versus a full capitation arrangement. Similar to capitation, the overall

responsibility for managing patient care is in the hands of providers. This offers them greater discretion in determining the appropriate care needed, but bundled payments also increase the risk of managing complicated cases and could be difficult to administer.

## 5. Shared Savings

In the shared savings model, a percentage of the premium for a covered population is earmarked to be withheld in a pool to be paid out to the contracted provider organizations if certain pre-determined metrics are met that can be tied back to the extension of palliative care services.

This form of reimbursement is being incorporated into a number of ACO models. A portion of the premium is set aside — beyond the FFS payment — to be shared between the payer and the ACO. The amount is based on agreed-upon metrics for financial results, patient satisfaction, and overall quality measures. In an ACO model, the contribution of palliative care in improving patient satisfaction, achieving quality/utilization metrics, and reducing costs can contribute to the overall success of the ACO and increases its shared savings payments.

### Examples

- A *Wall Street Journal* article from February 2014 quoted Thomas J. Smith, director of the Johns Hopkins Palliative Care Program, saying that $5,000-$7,000 is the annual patient savings when palliative care is incorporated into a patient's care program.[9]
- Advocate Health ACO program with BCBS of Illinois is an example of an early successful ACO in the Metro Chicago market. It focuses on several efforts including strengthening and expanding palliative care medical leadership and practitioner education (nurses, doctors, care managers, chaplains, and social workers). It provides incentives to primary care physicians to have their patients' power of attorney for health care loaded into the electronic health record. It also educates its skilled nursing facility (SNF) partners, and is implementing a home-care-to-hospice program. These efforts have helped to reduce readmissions, avoidable admissions, ventilator days, and SNF length of stay, and increase hospice census and length of stay.[10]

### Payer Considerations

This model can be a transitional approach before the payer and provider move into a capitated arrangement. It allows the payer and the providers to isolate the extension of palliative care and measure the impact it has made on the pre-determined metrics.

The shared savings model requires establishing a "withhold pool" to be distributed between the payer and provider based on mutually agreed metrics. The withhold pool will need to be determined to be part of the percentage of premium that is allocated to health care expenditures as part of the medical loss ratio calculations. If the shared savings pool is not part of the 80% or 85% mandated medical loss ratio, it will create further challenges. Because extending palliative care benefits is relatively new, the ability to appropriately determine the division of financial responsibility can be difficult.

### Provider Considerations

Even though palliative care would be paid for on an FFS schedule, there would still be aligned incentives between the payer and providers based on outcomes. The patient overlap that palliative care providers have with providers in other specialties means that gaining the buy-in of specialists could be particularly challenging. It could be difficult for specialists to give up independence and be interdependent with other physicians and hospitals.

### Endnotes


1. Johnson, SR. "Palliative-care Medical Home Pilot Starting in West," *Modern Healthcare*, June 20, 2014.
2. Center to Advance Palliative Care. "Improving Care for People with Serious Illness Through Innovative Payer Provider Relationships." A Palliative Care Toolkit and Resource Guide, 2014.
3. Krakauer, R, et al. "Opportunities to Improve the Quality of Care for Advanced Illness," *Health Affairs*, Volume 28, Number 5, 2009.
4. Ibid.
5. A Division of Financial Responsibility (DOFR) is a tool used in the contracting process by health plans, physician organizations, and hospitals in capitated payment arrangements to define which party is financially responsible for services rendered.
6. Brumley, RD and Hillary, K. TriCentral Palliative Care Program Toolkit, 2002.
7. Beresford, L and Kerr, K. "Next Generation of Palliative Care: Community Models Offer Services Outside the Hospital," California HealthCare Foundation, November, 2012.
8. Delbanco, S. "Payment Reform Landscape: Bundled Payments," *Health Affairs* Blog, July 2, 2014.
9. Landro, L. "Patients Turn to Palliative Care for Relief from Serious Illness," *Wall Street Journal*, December 22, 2014.
10. Interview with William Santulli, chief operating officer, Advocate Health Care, December 18, 2014.

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## About the Foundation

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