PAYMENT ARRANGEMENT OPTIONS FOR COMMUNITY-BASED PALLIATIVE CARE

The following payment options table provides a continuum of possible arrangements between payers and/or upstream providers and community-based palliative care service providers. The rows are organized from top to bottom to reflect progressively increasing financial risk. The table focuses on pros and cons with regard to fiscal impact, administrative burden for contracting and operations, and additional factors such as partnering organizations. Also, the greater the degree of risk (especially with regards to the professional services of third parties), the more important it is for the provider to have access to high quality data related to services provided by others to the patient population.

The table reflects a number of basic assumptions about the potential audience. In particular, this tool is intended for providers of non-hospice community-based palliative care. Non-hospice, community-based palliative care may be defined as the provision of palliative care through established delivery systems, such as home care, as well as collaborative partnerships with service agencies and individual clinicians with the goal of maintaining a person's life at home or place of residence by maximizing quality of life, optimizing function and providing care that supports their goals and preferences. Except where indicated, the assumption is that the payment arrangement is between a payer and palliative care provider directly, but some payment options are more likely to be with another provider entity that is in their own payment arrangement with a health.

	DESCRIPTION	Illustrative Ranges	PALLIATIVE CARE EXAMPLES	PROs FOR PROVIDER	CONs FOR PROVIDER
SPECIALIZED FEE SCHEDULE UNDER FEE-FOR-SERVICE FEE	The provider and the health plan negotiate fee-for-service payments from the typical fee schedule, but agree to higher payment rates to account for non-clinical services or extended times. Because the provider can only be paid for services for which there is a code to bill, in some cases, the payer creates a special code to accommodate the unique services of the palliative care team.	Specialized fees are often in proportion to the Medicare rates, such as 125 - 250% of Medicare.	***Health Plan – Palliative Care Program (TX):*** The health plan created a special "S" code to enable fee-for-service billing by the Palliative Care Social Worker. ***Health Plan – Home-based Palliative Care Program***: The program negotiated a payment of 140% of the Medicare rates, to capture their value and cover the additional costs of home visits.	Allow for compensation for important non-clinical services. Limited additional administrative burdens. No downside risk. Simple contract negotiations.	Limited, if any, opportunity for upside risk. No additional flexibility in delivery of services. No additional access to information or partnership with acute or post-acute care providers.

FFS WITH SHARED SAVINGS	Provider is assigned (or attributed) a specific population, then delivers services and bills fee-for-service for the billable services, as usual, along with any other providers involved in those patients' care. At the end of a period (typically six months or one year), the payer reviews ALL spending for the provider's patient population, and if the population's spending is less than target, the provider receives a share of the savings.	Often 25% to 75% of savings to provider. Some shared savings only start after a guaranteed threshold to the payer. Commonly, quality measure thresholds must also be met.	***Independence at Home Demonstration (US).*** Home-visiting team bills Medicare for the MD and NP visits, and at the end of the year, Medicare calculates their patient population's total spending vs. targets. If spending is less than target, Medicare and the provider share the savings (after a guaranteed 5-10% savings to Medicare)	Potential for shared savings in addition to FFS revenue. Access to additional information and referrals from acute and post-acute care providers. No downside risk	Potentially complex shared savings agreement negotiation. When downstream, shared savings diluted by split among broad range of providers. May not have access to data for negotiations and operations.
FFS WITH SHARED SAVINGS /LOSSES	Identical to the shared savings arrangement above but, if the population's spending is more than the target, the provider must pay its share of those losses.	Often 25% to 75%. Some shared savings only start after a guaranteed threshold to the payer, and shared losses often have upper limits. Commonly, quality measure thresholds must also be met.	***Oncology Practice – Palliative Care Program (MN) (in discussion phase)***: An oncology practice with a risk-based contract has agreed to share any savings achieved under the contract at year-end with a palliative care team that will share space in the practice; in the meantime, the palliative care team will bill fee-for-service.	Potential for a greater percentage of shared savings in addition to FFS revenue. Access to additional information and referrals from acute and post-acute care providers. Opportunities to participate with limited down-side risk.	Potentially complex shared savings agreement negotiation. When downstream, shared savings diluted by split among broad range of providers. Potential for liability of shared losses arising from unrelated providers. May not have access to data for negotiations and operations.

ADD-ON FEE (AKA "CARE MGT FEE")	A non-visit-based fee that is paid in return for a defined set of services that are typically not billable fee-for-service (such as non-billable-clinicians holding advance care planning conversations, or providing spiritual care). The provider is typically paid a monthly fee to deliver these services as needed or on a defined schedule. This fee is in addition to any other payment for clinical services.	$15 to $100 PMPM in the CPC+ $160 in the OCM. Fee depends on the scope of responsibilities for the additional services and, if risk-adjusted, the individual patient payment can vary based on patient characteristics.	***Vital Decisions (Multiple)***: Health Plans pay this organization a fixed monthly fee to engage selected patients telephonically and help them complete advance care plan documents. (There may also be bonuses for performance above targets.) ***Medicare Care Choices Demonstration (US)*:** Participating hospices are paid $400 PMPM by Medicare for the services of the hospice team, to cover services not otherwise covered. Medicare pays for other services and other providers separately.	Opportunity for additional revenue beyond traditional covered services. Straightforward contract negotiations. Predictable revenue. Opportunity for generating referrals to other service lines. No downside risk.	**Limited control over or coordination with services outside defined set.** **Risk of inadequate payment rates to cover needs of high-cost populations.** **Coverage may only include narrow set of services.**
CASE RATE (*PMPM*) (Partial Capitation) (Can also include shared savings and/or losses)	Provider delivers a defined set of services, and receives a fixed price for that set of services, typically paid monthly for each patient on the program (PMPM). The payment begins when the patient needs the services and continue for a predetermined period of time. The price does not cover any services that are not in the defined set, such as hospitalizations.	$100 to $900 depending on setting, and, if risk-adjusted, the individual patient payment can vary based on patient characteristics.	***Health Plan – Home-based Palliative Care Program (NY)***: A health plan pays the home-visiting program a fixed PMPM for the services of that team only. Any services outside of that are paid for separately. ***Advanced Illness Management (AIM) CMMI Payment Model Proposal (National):*** A fixed PMPM to cover care coordination, advance care planning, pain/symptom management and 24/7 response. Also includes shared savings ***Health Plan – Aspire Health (National)***: A fixed PMPM to cover the home-visiting team. Also includes shared savings.	Flexibility in the delivery of services within defined set. Predictable income with limited claims processing obligations. Opportunity to generate referrals for additional services outside defined set. Straightforward contract negotiations.	Limited control over or coordination with services outside defined set. Limited potential for savings/up-side risk. Risk of inadequate payment rates to cover needs of high-cost populations. Coverage may only include narrow set of services. Challenges in the ability of health plan or provider to administer this payment model.

LUMP SUM PAYMENT	Provider is paid to deliver services as needed for a period of time, rather than by the number of patients seen. This can include a "per session fee" for every four-hour block of time the provider is available in a clinic or office practice, as well as an annual contract to staff a service dedicated to specific patients. Often, these agreements specify service minimums and quality thresholds.	Per session fees are usually calculated from expected fee-for-service revenue, but are lately also accounting for savings potential. Unknown range, but an example is $600 per 4-hour session.	***Multi-Specialty Clinic – Palliative Care Program (KY):*** The clinic pays the palliative care program for a team to be available; originally, the arrangement was for ½ day per week, but the clinic has expanded their presence to now cover three full days per week. ***Health Plan – Palliative Care Program (CA)*:** The health plan pays the palliative care program a fixed annual stipend to cover the cost of a specialized nurse coordinator and social worker (non-billable staff) to be available to their members.	Greater flexibility in delivery of services with reduced claims submission obligations. Opportunity for increased revenue associated with increased efficiency and targeted services. Depending on terms, potential for more predictable revenue. Simple contract negotiations. Opportunity for increased referrals to other services.	Limited upside savings opportunities. Risk of high-cost patients exceeding budget of per-session rate. Limited access to or control over other providers in the continuum.
BUNDLED PAYMENT/ EPISODE-BASED	Provider is ultimately paid a fixed price for ALL services delivered to a patient in a defined period of time (such as 60 or 90 days). Typically, as with FFS with Shared Savings (above), all providers bill as usual, and at the end of a period, the payer reviews ALL spending by bundle against the target spending. When spending is less than the bundle target, the provider is given the savings, but if spending is above the target, the provider must pay the difference.	Target price is set by historical claims data. The average price of the mandatory 90-day joint replacement bundle under Medicare is $25,565. Some take account of quality measures and some do not.	***Health Plan – Home-based Palliative Care Program (NY)***: The health plans pays a fixed price for 90 days of total care; 90 days was selected to fairly compensate for the more intensive work in the first 30 days. ***At-Risk Health System – Time-Limited Transition Program (CA):*** The system pays the Transition Program a fixed price for a six week period of service, where patients receive pain/ symptom assessment and stabilization, prognostication, advance care planning and 24/7 response. There is also a potential subsequent "maintenance" program, covered under an additional price.	Potential for additional revenue in addition to FFS payments. Share savings based only on services related to episode (not all services) Strong incentive for acute and post-acute care providers to cooperate and provide information, referrals, and support.	Potential for losses resulting from poor quality of unrelated providers or unpredictably complex or costly patients. Complex contract negotiations requiring challenging legal and fiscal provisions. May not have access to data for negotiations and operations. Often subject to reporting and compliance burdens. Challenges in the ability of health plan or provider to administer this payment model.

FULL or GLOBAL CAPITATION	In this model, the provider assumes nearly all of the financial risk for a population – there are few or no limits on the services that the price includes, and responsibility extends beyond a time-limited episode. Provider is paid a fixed price for ALL services for the defined population. Although there are typically outlier or stop-loss provisions involved. The fixed price can be defined by either as a dollar amount or a percent-of-premium.	Provider is given a high dollar amount and as much as 95% of the premium dollar (or dollar equivalent)	***Please note: It is <u>not</u> recommended that palliative care programs pursue this option. There is extreme variability in the seriously ill population, which means a great deal of risk that often cannot be managed by a specialized program. Instead, a palliative care program can collaborate with other providers who are paid under global capitation, using one of the payment models above.***	Significant flexibility in delivery of covered services. Authority and opportunity to direct and coordinate services included in capitation. Opportunity for significant upside savings. Predictable revenue per patient.	Most complex contract negotiations and regulatory approvals including potential for solvency requirements. Absent risk-corridor or reinsurance arrangement, at full risk for services included within capitation. Potential lack of control over risk profile of patients and potential. Complex enrollment and assignment administrative obligations. Challenges in the ability of health plan or provider to administer this payment model.