Payment Primer

What to Know about Payment for Palliative Care Delivery

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Payment Primer

What to Know about Payment for Palliative Care Delivery

The **Center to Advance Palliative Care (CAPC)** is pleased to offer this resource covering the basics of Medicare, Medicaid, health plans and the alternative payment models that are taking hold in the U.S. health care system. The intent is to provide a solid introduction to health plans, payment concepts and key considerations as a foundation to support sustainable relationships with payers and other risk-bearing entities.

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FOREWORD

A Letter From Diane E. Meier, MD, FACP, FAAHPM

The future of health care payment is here. Value-based payments—methods of paying for health care which reward quality and cost-effectiveness—had reached 38% of all US health care payment by the end of 2015. In 2016, health plans changed their payment arrangements with providers at an even more rapid pace.

Value-based payments are a prime opportunity to assure access to quality palliative care for our sickest and most vulnerable patients. Fee-for-service historically has not adequately supported home-based care or time-consuming patient interactions; but as payment models change, the business case supports giving the right services at the right time to the right population in the right setting.

> Value-based payment provides the best opportunity to match care provided to the actual needs of patients with serious illness.

This is an opportunity for palliative care to be integrated as part of standard care for those with serious illness. Shifting from volume-based payment models to alternative payment models creates an environment where improving quality and patient experience while ensuring appropriate utilization of costly health care services is not only desired but required—and palliative care has a strong track record on all three counts. By providing expert pain and symptom management, psychosocial support and skilled communication with patients and families, palliative care can help ensure avoidance of unnecessary

emergency department visits, hospital admissions and unwanted procedures. Not only is unnecessary cost reduced, but palliative care also improves the patient experience and facilitates patient informed choice.

Challenging as it is to move from the familiar system of fee-for-service, value-based payment provides the best opportunity to match care provided to the actual needs of patients with serious illness. For example, there are now a number of palliative care organizations that contract directly with Medicare Advantage plans for fixed monthly payments and shared savings in return for the care and management of the health plans' sickest and most complex members. Without these contracts, these palliative care programs would not be financially viable.

So how can palliative care leaders make the most of this opportunity? In order to be effective messengers for the integration of palliative care into population management and alternative payment models, palliative care providers first require a basic understanding of health insurance, value-based payment and the new incentives at play in health care delivery.

This document provides basic background information on payers and alternative payment models. It works with its companion piece, the Center to Advance Palliative Care **Payment Glossary of Terms**, to introduce both concepts and vocabulary. Members of CAPC can gather more detailed information on business planning and problem solving through the tools and technical assistance available at **capc.org**.

PART 1

About Health Insurance

About Health Insurance

The Traditional Payment Model

THIRD-PARTY PAYMENT

Early in United States history, health care was paid for as any other professional transaction: a private exchange between a client and a professional. Health insurance came about in the 1920s and 1930s (originally in an effort to protect people financially from catastrophic health events). With the postwar failure of efforts to develop a National Health Plan, employer-funded payments to third-party insurers became standard, and with the addition of Medicare and Medicaid legislation in the 1960s, third-party payments became the dominant mechanism to financially support health care delivery (see Figure 1).

FIGURE 1: U.S. Health Care Has Evolved to Rely on Payment by a Third Party

SOURCE: Bodenheimer TS, Grumbach K: *Understanding Health Policy, 5th Edition*: http://accessmedicine.com

THE FEE-FOR-SERVICE PAYMENT MODEL AND ITS INCENTIVES

The majority of third-party payment historically relied on "fee-for-service," meaning that a payment is made for each service delivered. Onto this construct, fee schedules and rules about what's covered or not were grafted, but **reimbursing for each unit of service has been the prevalent model**. Now both payers and policy-makers recognize that fee-for-service payments inherently incentivize volume and complex procedures[1], as illustrated in Table 1.

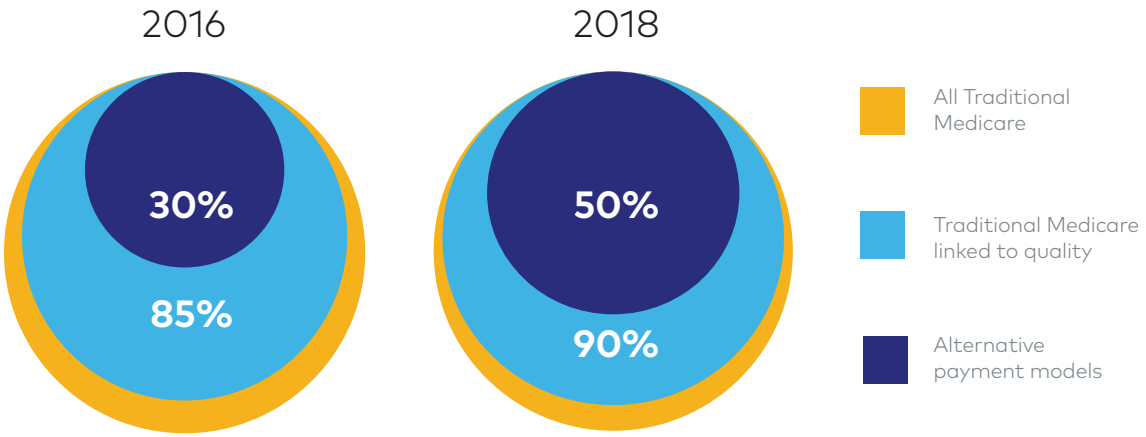
TABLE 1: Fee-For-Service Payment May Incentivize Volume and Complex Procedures

	How the Third-Party Calculates Payment	What Then are the Possible Financial Incentives[2]
Professional Services	For each service delivered and coded with a CPT code, the physician or advanced practitioner gets a payment based on the payer's fee schedule	• Deliver more services • Deliver the services with the highest relative value ("RVU") and payment • Don't deliver services without a code
Hospitals	For each stay, hospital bills a DRG-code for a lump sum payment, and for some health plans, hospital bills a *daily rate*	• Maximize the number of admissions • Maximize the DRG assignment with higher reimbursement
Home Care Agencies	For each "episode" of service (up to 60 days), agency gets lump payment based on what was provided during the episode	• Maximize the number of episodes • Minimize length of service • Deliver more physical therapy services because the episode is paid more
Skilled Nursing Facilities	For each day in the facility, SNF receives a daily payment	• Maximize the number of admissions • Maximize length-of-stay to the number of days covered or approved • For sub-acute rehab, deliver more physical therapy services for higher daily rate

Today, payers and policy-makers are **seeking to correct for the unintended incentives created under fee-for-service by changing to new payment models**. Under the Obama administration, Medicare had set an ambitious goal of tying 90% of its payments to quality, with at least half being in alternative payment models where the ultimate payment is not dependent on volume at all (see Figure 2).

FIGURE 2: Medicare Had Been Moving Quickly Away from Traditional Fee-for-Service

Target percentage of Traditional Medicare payments linked to quality and alternative payment models in 2016 and 2018



While there is some uncertainty about whether this Medicare momentum will continue under a new Administration, many political analysts believe that any restructuring of Medicare will take some time, and that the drive to value will continue in the meantime[3].

The second part of this document describes value, value-based payment and alternative payment models in greater detail.

KEY TAKEAWAYS

- The Fee-for-Service payment model can encourage a high volume of service delivery, especially highly paid services.
- Fee-for-Service is a challenging payment model for palliative care, given the often unbillable interdisciplinary team services and the significant time spent with patients and caregivers.
- Payers and policymakers are rapidly moving away from fee-for-service.

RISK, MANAGING RISK AND SHIFTING RISK TO PROVIDERS

WHAT IS RISK AND HOW DO HEALTH INSURERS MANAGE RISK?

Risk is involved in anything that is likely to entail unpredictable costs. This includes acts of nature, gambling, traffic accidents, lawsuits and illness. Insurance exists to better manage such risks across a population. As noted, health insurance originally came about to protect people from the risk of significant financial losses associated with catastrophic accidents or serious illness.

> Predictability of cost is what is important here, rather than reducing costs to as low as possible.

Health insurers must then ***manage*** that risk to keep total spending in line with what they have collected in revenue based on their predicted costs. Predictability of cost is what is important here, rather than reducing costs to as low as possible. A health insurer that withholds spending on needed care will not be appealing to purchasers, such as employers, in the long run. Health plans expect to spend the bulk of their revenue on patient care, but do seek to ensure that this spending stays below their revenue, which was priced at predicted costs.

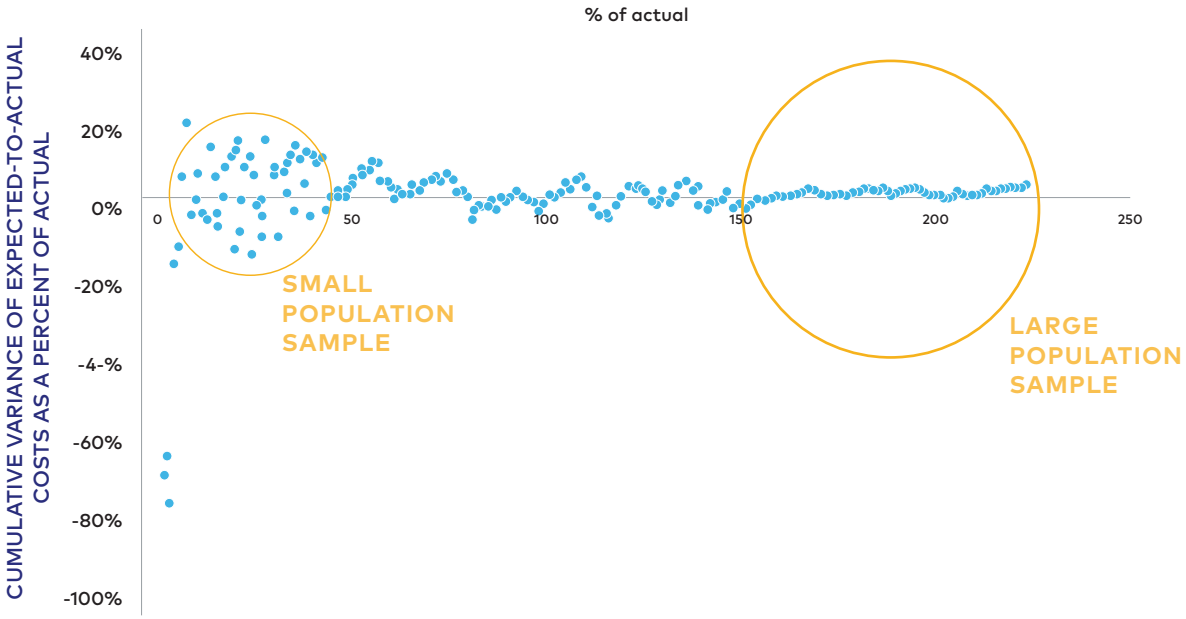
Health plans manage the risk in line with predictions in three ways:

1. Pooling Individual Risk

The health insurer consolidates individual risk across a ***large*** number of individuals, which reduces total variability and ensures that the costs of a relatively few high utilizers of health care are offset by the lower costs associated with the more numerous low utilizers of health care. This is all about predicting and spreading financial risk: if the pool of people insured is too small, just a small handful of complex, costly cases results in significant financial losses.

This is illustrated in Figure 3—the variability of costs from the average (or target) is simply too high when the numbers in the pool are small.

FIGURE 3: As Sample Size Increases, Variability Decreases



Source: HCI3, New York State Value-based Payment Bootcamp, August 2016

2. Reducing Demand by Encouraging Healthy Behaviors

The health insurer intervenes across the individuals in an insured population to reduce their need for expensive services. Examples of this include: supports that result in better adherence with medications and other treatment instructions; disease management programs that help individuals to better understand their disease and thereby improve medical follow-up; efforts targeting better completion of immunizations; and providing assistance with smoking cessation.

3. Ensuring Cost-Effective Care

A necessary component of managing financial risk is managing total cost of care. A range of mechanisms is typically used to ensure health care services are priced fairly and are medically necessary. Mechanisms include:

- contracting for market competitive rates for each service
- contracting with a narrow network of providers

- establishing annual limits on numbers of visits or days
- limiting coverage for interventions that are not judged effective or cost-effective compared to alternatives
- determining medical necessity prior to authorization

While payers work to ground these mechanisms in sound medical practice and published research, in a fee-for-service environment, payer efforts to restrain payments often put them at odds with health providers**.** Providers perceive these restrictions as an attempt to override the clinician's professional judgment or as evidence that the plan's utilization review staff are essentially practicing medicine on patients they have never met. These mechanisms also put health insurers at odds with their members, because patients want freedom of choice in providers and access to the services or treatments these providers recommend.

In a fee-for-service environment, payer efforts to restrain payments often put them at odds with health providers.

RISK SHARING WITH PROVIDERS

While health care professionals are in the best position to communicate treatment options and ensure appropriate utilization for the individuals they care for, in the past they have not had responsibility for the cost of that care, or even knowledge of what their recommended treatments actually cost. This is changing as payment models evolve to hold providers accountable for the quality and cost of the care they deliver via risk sharing.

Risk sharing means that a provider, or group of providers, is at least partly responsible for managing a population's health care spending, and is at risk to lose money if cost is higher than the predicted target. **The goal is not to simply cut costs; the quality of the care delivered, as well as the outcomes of that care, should have equal consideration in the cost calculations.** Thus, the sharing of risk and its management are about the "triple aim": better care, smarter spending and healthier people across the whole population.

POPULATION HEALTH MANAGEMENT COMPETENCIES

Effectively managing a population with diverse health and social needs is a complex undertaking, requiring capabilities in:

- **Stakeholder engagement, such as with community leaders or employers**
- **Data collection and sharing**
- **Data analysis**
- **Risk assessment and stratification**
- **Care coordination**
- **Patient engagement**
- **Provider alerts**
- **Expanded hours for provider access**
- **Evidence-based protocol dissemination**
- **Quality management and improvement**

For a comprehensive list of required competencies, please see the Accountable Care Learning Collaborative's list of accountable care competencies: accountablecarelc.org

When providers manage risk, two skill sets become essential.

Risk stratification, where providers:

- systematically collect information for the total population across all settings and services
- stratify each individual's level of need
- "dose" the type and amount of interventions they receive, depending upon each patient's level of need and evolving over time

Care coordination, where providers:

- assure that all providers who work with a patient have the same information about that patient, in a timely manner, regardless of setting
- assure that the patient and family and all of his/her providers are "on the same page" regarding care goals and understanding of treatment plans
- assure that gaps and barriers to needed care and services are addressed

Effective care coordination for at-risk populations can simultaneously improve quality of life and reduce hospital utilization[4]. Under fee-for-service, these "non-revenue-producing" services were financially impractical, but **when providers are responsible for both total cost and outcomes, investment in added layers of support is essential**.

Population health management also entails the provision of health education to at-risk patients in an effort to enhance their understanding of what to expect and what to do when concerns or crises arise, and their adherence to the care plan. Thus, population health management assumes accountability for areas formerly judged to be entirely the patients' responsibility.

> "Palliative care could expand the reach of population health interventions beyond prevention of illness by developing strategies to improve well-being after an illness has occurred."

Population health management needs palliative care in a number of ways, not only because it focuses specifically on care of the highest-risk, highest-need 5% of patients who drive over half of all health spending, but also because "palliative care could expand the reach of population health interventions beyond prevention of illness by developing strategies to improve well-being after an illness has occurred."[5]

KEY TAKEAWAYS

- Accepting risk means tolerating unpredictable costs. Health insurers manage this risk by pooling risk across a large population, incentivizing health behaviors, and managing utilization via narrow networks and utilization review. Insurers also contract with entities, whom they call "vendors," to better manage high-cost members, including palliative care programs.
- Risk-bearing providers invest significant resources in strategies to improve population health management and care coordination; palliative care fits well in these strategies.

Government Health Insurance: Medicare, Medicaid and Privatization

Palliative care providers commonly work with patients whose risk has been traditionally covered through government-funded health insurance: Medicare, Medicaid or both Medicare and Medicaid (dual-eligibles). A person who is entitled to such coverage is called a beneficiary.

WHAT ARE MEDICARE AND MEDICAID?[6]

Medicare	Medicaid
Federal Program	State-Federal Partnership
Eligibility: • Age 65+; or • End-stage renal disease; or • Disability income for more than 2 years	Eligibility: • 100–138% of the federal poverty level (depending on state)

Medicare is a federal program that covers anyone aged 65 or older (with at least a certain small amount of work history), along with anyone who has received Social Security Disability Income (SSDI) for more than 24 months and/or is on dialysis for a period of time or transplanted for end-stage renal disease. Medicare is broken into four parts: A, B, C and D, as illustrated in Table 2 below.

TABLE 2: Medicare Parts and What They Cover

	What It Covers
Part A	inpatient stays in hospitals, hospice care, eligible skilled days in a skilled nursing facility or Medicare-certified home health care
Part B	clinician and outpatient services, medical supplies and equipment and some therapy services
Part C	premiums in a Medicare Advantage Plan (see below)
Part D	prescription drug costs (which can also be covered by a Medicare Advantage Plan or a stand-alone prescription benefit plan)

Medicaid is a jointly-funded federal and state benefit program restricted to low-income individuals. Often, low-income people with disabilities under the age of 65 are covered by Medicaid, either until they have received 24 months of SSDI, or for a longer period if they are not eligible for SSDI.

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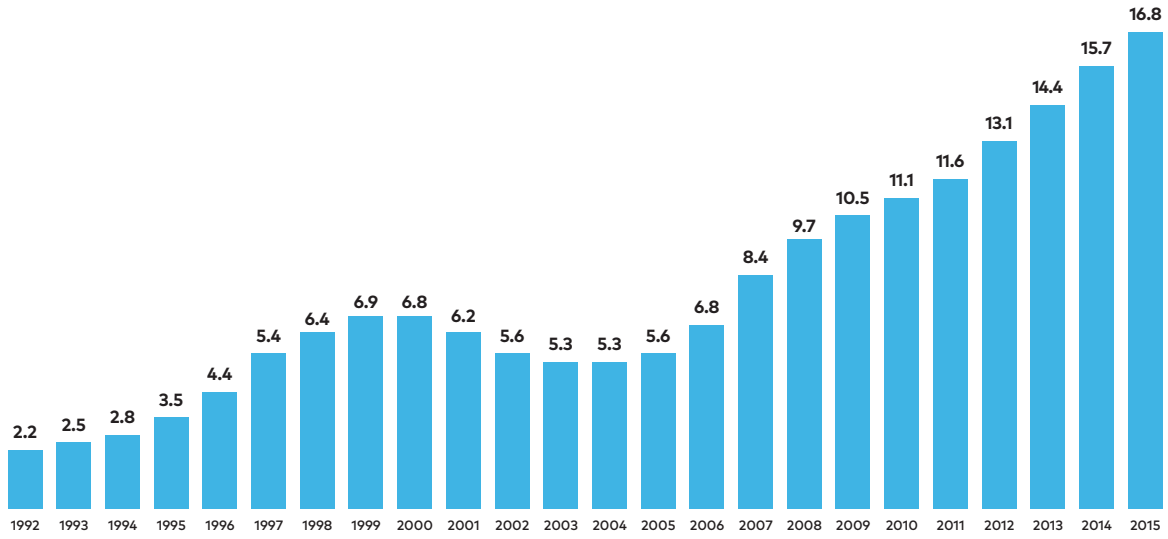
Because Medicaid is a federal-state partnership, rules of eligibility, coverage and other features are driven by each individual state, with certain variations requiring federal approval. For patients who are eligible for it, Medicaid fills in the gaps left by Medicare, especially for long-term care services and supports, such as care to help with activities of daily living. Medicare is restricted by law to covering only medical services that address a "skilled need," but most Medicaid programs include custodial care benefits. In fact, Medicaid is the majority payer for long-term care services in this country[7].

There are approximately 10 million individuals in the United States who are dually eligible for both Medicare and Medicaid (Kaiser Family Foundation State Health Facts). Dual-eligibles tend to be low-income seniors, and studies continue to show that dual-eligibles have a much higher incidence of serious chronic illness and functional impairment when compared to Medicare beneficiaries not eligible for Medicaid[8].

PRIVATIZATION OF MEDICARE: MEDICARE ADVANTAGE AND SPECIAL NEEDS PLANS (SNPS)

Since the 1970s, Medicare beneficiaries have had the option of receiving their benefits through private managed care plans administered by commercial health insurers, but there were few plans available for many years. However, revisions to the payment formula in the 1990s and 2000s led to growth both in the number of managed Medicare plans and the number of enrollees, so by 2015, more than 31% of total Medicare beneficiaries were enrolled in private Medicare Advantage plans (see Figure 4 below). Now, with a Republican president and congress, **many are expecting that enrollment in Medicare Advantage will accelerate**[9].

FIGURE 4: Total Medicare Advantage Enrollment, 1992–2015 in millions



SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008–2015, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2001–2007. Report of the Medicare Board of Trustees, 2002.

Medicare Advantage plans receive a monthly payment (which is called a premium in health insurance) from Medicare, and in return are responsible for covering all of the Part A and Part B benefits. If total costs exceed the total premiums, the losses are incurred by the health insurance plan. Medicare beneficiaries enrolled in a plan are called members or enrollees.

Because enrollment in a Medicare Advantage plan must be voluntary, plans typically attract enrollees by reducing out-of-pocket costs when compared with the original Medicare A and B benefits, by:

- reducing or eliminating premiums and co-payments
- enhancing benefits, such as adding dental and hearing aid coverage, providing over-the-counter drug discounts and even paying for gym memberships

In return for these enhancements, the enrolled beneficiaries have access to a narrower network of providers—only to the physicians, hospitals and facilities in their Medicare Advantage plan network, and only the prescription drugs that are covered on the plan's drug formulary, at least for the Medicare Advantage HMO-type of plans, which have the majority of enrollees. (There are Medicare Advantage PPOs which provide their enrollees

some out-of-network coverage, but typically PPOs have higher premiums and co-payments so they are not always affordable or as attractive as the HMO plans that more strongly limit enrollees' access.)

Enrolled beneficiaries have access to a narrower network of providers—only to the physicians, hospitals and facilities in their Medicare Advantage plan network.

Medicare Advantage Special Needs Plans (SNPs)

There are special Medicare Advantage plans that limit enrollment to specific sub-sets of Medicare beneficiaries, defined by demographics or diagnosis. There are three types of Medicare Special Needs Plans:

- **Institutional SNPs** (I-SNPs) are for beneficiaries who meet long-term nursing home eligibility; some I-SNPs limit enrollment to those residing in a nursing home, while others might include community-dwelling beneficiaries with the same level of need. It is common for I-SNPs to collaborate with a nursing home or an assisted living provider and work together to improve the population's health status and stability. OptumCare CarePlus, an I-SNP that originated out of the Evercare demonstration, is one of the largest I-SNPs in the United States.
- **Chronic SNPs** (C-SNPs) are for beneficiaries diagnosed with end-stage renal disease, congestive heart failure, diabetes, dementia or HIV/AIDS. Often these plans work with narrow networks of specialty providers with deep experience in the selected chronic illness.
- **Dual-Eligible SNPs** (D-SNPs) are for beneficiaries simultaneously eligible for Medicare and Medicaid. Note that while D-SNPs enroll persons who are entitled to Medicaid benefits, the health services covered by the D-SNP plan itself include only the Medicare benefits, such as hospitalizations and physician visits. D-SNPs do not cover the traditional Medicaid benefits such as dentistry or custodial nursing home care. The plans that cover the full Medicare and Medicaid benefits are called integrated plans (see Managed Care Plans for Dual-Eligibles, below.)

The potential advantages and disadvantages of Medicare Advantage enrollment are listed in Table 3.

TABLE 3: Original Medicare versus Medicare Advantage

	Original Medicare	Medicare Advantage
Pros	• Full choice of providers • No prior authorizations • Coverage of most medications	• Often added benefits such as dental or hearing aids • Often low or zero premiums • Often lower co-payments and deductibles • Sometimes includes gym memberships and other perks • Care management programs
Cons	• Premiums for Part B coverage • Significant co-payments (e.g., 20%) • No coverage for dental, hearing aids, eyewear	• Narrower choice of providers—care outside the network has less or no coverage • Medical management with prior authorizations and limited authorizations for some services • Medication access restricted to the terms of health plan's formulary

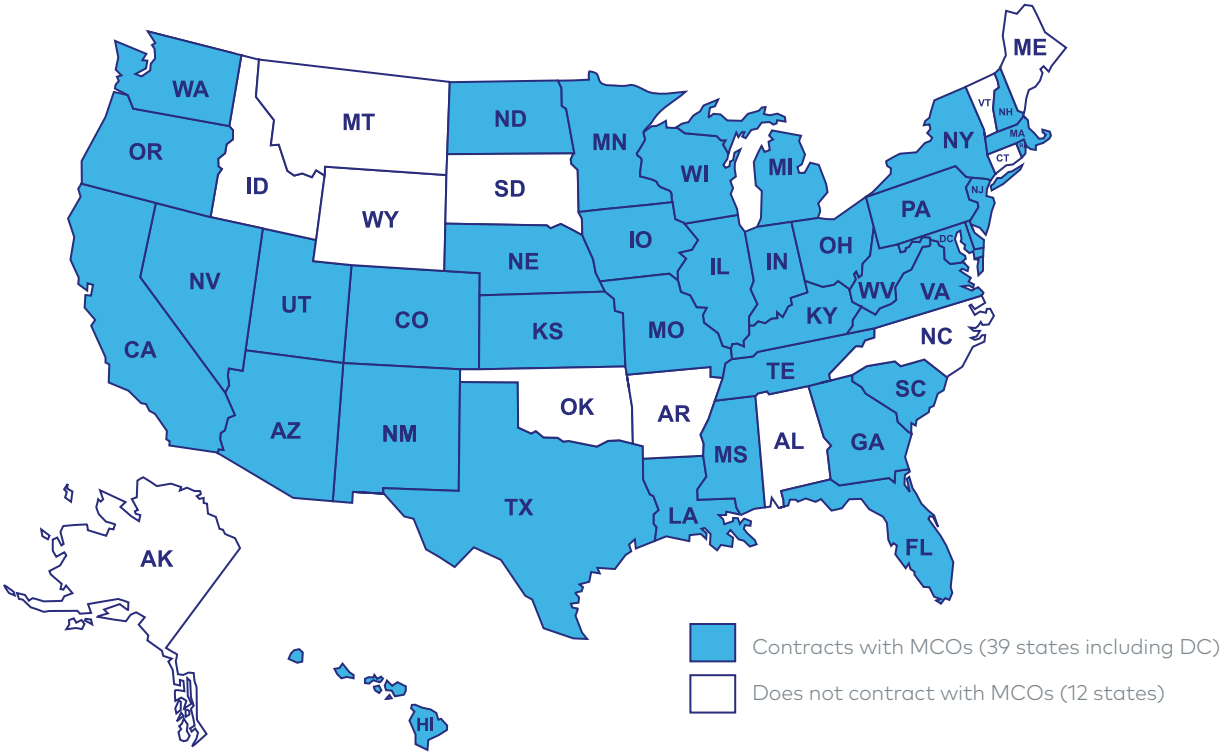
A growing number of Medicare Advantage plans are building innovative programs to integrate palliative care and support for those with serious illness. For more information on health plan programs for the seriously ill, please see CAPC's publication *Improving the Care of Serious Illness through Innovative Payer-Provider Partnerships: A Palliative Care Toolkit and Resource Guide*. Value-based payment arrangements under both Original Medicare and Medicare Advantage plans should incentivize further benefit customization to meet the needs of seriously ill individuals in either type of coverage.

PRIVATIZATION OF MEDICAID: MEDICAID MANAGED CARE

Medicaid benefits are also increasingly delivered through private health plans, called Medicaid Managed Care Plans. **In some states, all or just some types of Medicaid beneficiaries are *mandated* to enroll in a managed care plan, while in other states, enrollment is voluntary**. There are more than 55 million Medicaid beneficiaries enrolled in Medicaid Managed Care (including about 3 million dual-eligibles), representing more than 75% of total U.S. Medicaid beneficiaries. Several states have 100% of their beneficiaries in privately managed Medicaid, while only twelve states do not have any managed care penetration.[10]

FIGURE 5: Most States Provide At Least Some Medicaid Coverage Through Private Plans

States Contracting with Comprehensive Medicaid Managed Care Organizations (MCOs) as of September 2014



SOURCE: KFF Medicaid Managed Care Market Tracker

Because the type of managed care coverage varies widely, the impact of Medicaid managed care on patients with serious illness is unknown. In some states, Medicaid managed care plans operate under special regulations or with a special focus on complex beneficiaries, and access to palliative care could theoretically be enhanced in these models.

MANAGED CARE PLANS FOR DUAL-ELIGIBLES

The Affordable Care Act launched the CMS Medicare-Medicaid Coordination Office (aka "the Office of the Duals"), which, among other efforts, has partnered with a handful of states to create health plan demonstrations that enroll dual-eligible beneficiaries. These integrated health plans provide the full scope of Medicare and Medicaid benefits, with an emphasis on coordinating care across primary, acute and long-term care.

The demonstrations will test whether a consolidated plan integrating the two streams of funding can improve quality and reduce costs, since there is now a single entity accountable for quality and cost for both sets of benefits, reducing the historical pattern of cost shifting between the two payment streams. Because of the high concentration of high-need, high-cost beneficiaries with both medical and social needs among dual-eligibles, integrated funding should improve beneficiary experience and reduce preventable utilization of emergency and hospital services.

Palliative care services offer significant opportunity to improve value for integrated plans for dual-eligibles, a population with a high concentration of complex and seriously ill individuals.

The Commonwealth Care Alliance (**commonwealthcarealliance.org**) in Massachusetts is a good example of an integrated health plan for dual-eligibles that seamlessly incorporates palliative care principles and practices into its care model.

KEY TAKEAWAYS

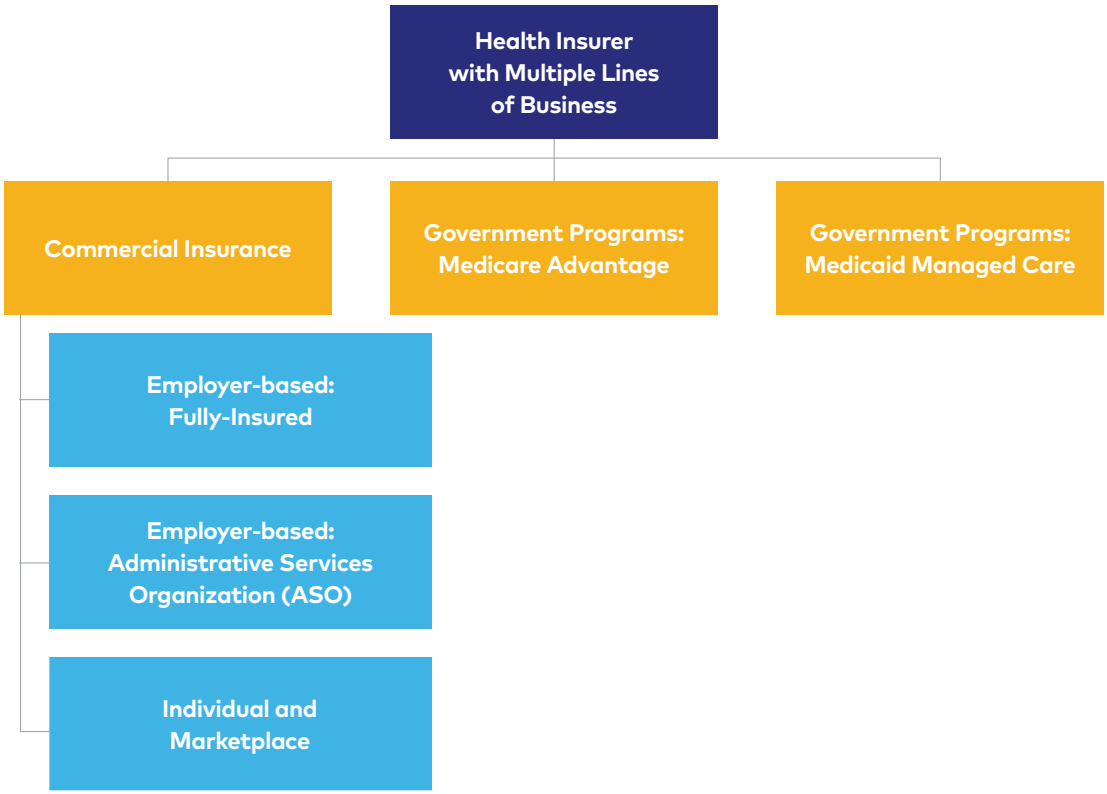
- Medicare is a federal health insurance program primarily for people 65 and older, and Medicaid is a state-federal partnership program for low-income citizens. Palliative care providers commonly treat Medicare and/or Medicaid beneficiaries who are disproportionately affected by serious illness, multiple chronic conditions and functional impairments.
- Increasingly, Medicare and Medicaid are being privatized, with Medicare beneficiaries moving into Medicare Advantage plans and states encouraging or mandating enrollment in Medicaid Managed Care.
- This privatization creates new opportunities for palliative care providers to partner with private payers to address the needs of high-cost, high-need populations.

Commercial Health Insurance

Many health plans offer products to a variety of buying customers to cover a variety of populations—each called a line of business. For example, lines of business can include not only employer-purchased insurance but also Medicare Advantage and Medicaid Managed Care as described above. For commercial insurance (i.e., paid for privately), there are three common lines of business: a) fully-insured employer-purchased plans, in which the insurance company assumes full financial risk; b) administrative services organizations (ASO) in which a health plan provides administrative services only for a large employer or union which self-funds the insurance and assumes the risk; and c) individual ("retail") coverage.

The complexity of health insurer lines of business is illustrated in Figure 6 below.

FIGURE 6: Lines of Business in a Health Insurance Plan



As with the Government programs, each line of the commercial insurance business comes with its own regulations and restraints. Coverage decisions are rarely under the full control of the health insurer.

FULLY INSURED, EMPLOYER-BASED

- **Employers or unions pay premiums to the health plan to take full risk** for the health expenditures of their employees and their families.
- The health plan presents a proposal defining benefits offered and terms of coverage, what the member will co-pay for what services and the cost of the premium. Once the proposal is accepted by the employer, the plan is contracted for a period of time.
- The benefits covered, member co-payments and often the premium price itself must also be **approved by the individual state's department of insurance**. Health plans cannot vary from these parameters once they are approved.

ADMINISTRATIVE SERVICES ORGANIZATION (ASO), EMPLOYER-BASED (SELF-INSURED PLANS)

- Employers pay the health plan to provide *administrative services only*, and the employer bears the full risk of the health costs (with provision for reinsurance as appropriate). Under an ASO, the health plan does not assume the risk, so that the employer retains the incentive to manage medical costs.
- The employer frequently distributes a request for proposals from health plans seeking information on plan rules and benefits. Employers may retain the ability to approve final network and coverage decisions.
- Administrative services provided by the health plan include:
    - enrollee record keeping
    - claims processing
    - utilization management (i.e., prior authorization processes and appeals)
- Typically, an employer or group that uses a health plan as an ASO also uses the health plan's network (contracts with the in-network providers), which stipulates payment arrangements and fee schedules. However, **there are growing numbers of examples of direct contracting where the employer—not the health plan—is the one that negotiates and contracts with the health care providers**.
    - Direct contracting can involve all types of health care providers (such as Boeing's direct contract with the University of Washington Medicine Accountable Care Network), or arrangements with particular health providers for certain bundles of care (such as Lowe's direct contract with the Cleveland Clinic for their employees' cardiac surgeries nationwide)[11].

Under an ASO, the health plan does not assume the risk, so that the *employer* retains the incentive to manage medical costs.

INDIVIDUAL INSURANCE (AKA RETAIL MARKET)

- **Individuals purchase insurance directly from the health plan** for themselves or their family—no employer is involved.
- State insurance regulators define the benefits that are available, but the plans can vary how much the individual must pay out-of-pocket for specific services.
- Medicare Supplemental (MediGap) insurance is sold individually, and covers Medicare co-payments, deductibles and some other items not covered by Medicare (such as hearing aids, eyeglasses). Medigap policies are regulated by the Federal Government, which defines types of policies and coverage available.

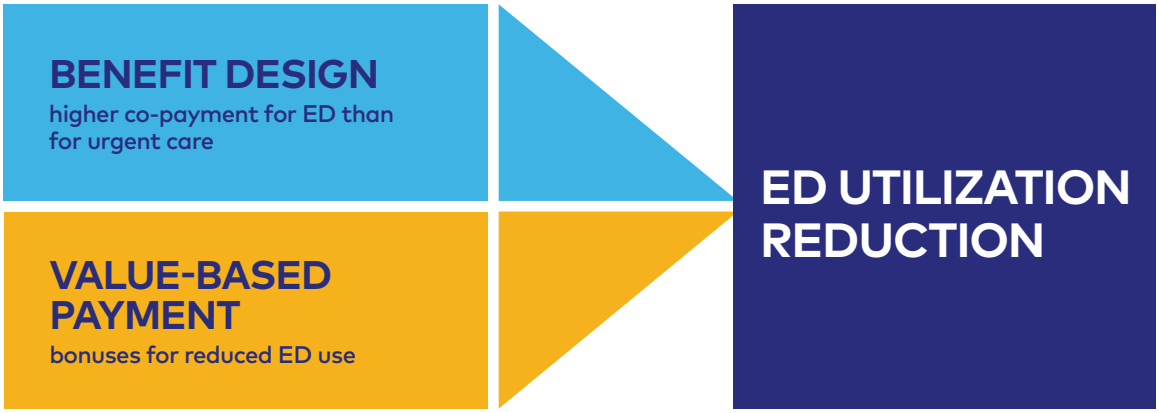
BENEFIT DESIGN AND VALUE-BASED INSURANCE DESIGN

What is covered and how much patients/members are responsible for via deductibles and co-payments are decisions known as *benefit design*. Value-based insurance design means that **benefits are designed to incentivize certain health behaviors (e.g., zero co-pays for primary or preventive care or drugs for hypertension and diabetes) or to disincentivize other health behaviors (e.g., requiring higher co-payments for high-cost services such as emergency department visits).** Similarly, a health plan could offer benefit designs specifically for complex and seriously ill populations that eliminate co-pays for palliative care consultations or home medical visits. A commercial health plan might also design its benefits to cover additional services, such as hospice services concurrent with treatment.

Ideally, benefit design goes hand in hand with value-based payment, with benefit design encouraging adherence to healthy behaviors and the targeted use of health care services matched to a patient's needs, while value-based payments encourage the providers to deliver care that is known to improve quality and/or to reduce unnecessary health care

spending. For example, a health plan may want members to rely on office visits, urgent care or even house calls instead of an emergency department under certain conditions. By setting a $0 co-pay for a primary care visit or house call and a 20% cost-share for an ED visit, and by setting a target threshold to reduce ED utilization for providers, both member and provider are then encouraged to seek alternatives to the emergency department. Thus, benefit design and value-based payment together advance care delivery transformation, as per Figure 7, below.

FIGURE 7: Benefit Design and Value-Based Payment Go Hand-in-Hand to Achieve Goals



Benefit design that supports access to high-quality palliative care services on both an inpatient and outpatient basis is especially appealing to health insurers because the advantages to both patient and plan accrue in the short term (as compared to a benefit design that encourages exercise or changes in eating habits, for which the results, if any, will be seen many years into the future). Medicare Advantage plans have been required to offer a standard and consistent benefit design regardless of individual member needs, but a 2016 Medicare Advantage Value-Based Insurance Design program[12] allows plans in certain states to design benefits available only to sub-populations who meet specific diagnostic criteria. This creates an opportunity to design palliative care benefit options for eligible members, such as eliminating co-payments on advance care planning discussions for Medicare beneficiaries with progressive dementia.

KEY TAKEAWAYS

- Commercial insurance is largely purchased by employers for their employees. Sometimes the health insurance plan is providing only administrative services, which means the employer bears the risk and takes an active role in determining coverage and benefits. In this situation the health plan must seek approval from the employer for non-standard or new coverage or programs.
- Health insurance plans use benefit design to encourage or discourage the use of particular services and providers, by reducing or increasing the individual patient's co-payment responsibility. Benefit designs could be deployed to improve access to palliative care services. For example, lower or no patient co-pay responsibility removes a barrier to access to quality palliative care.

Payer Cost Structure and Why It Matters

MEDICAL LOSS RATIO VS. ADMINISTRATIVE COSTS

Health plan expenses fall into one of two buckets: administrative costs or medical costs. Medical costs primarily consist of money paid out in claims—reimbursement to health care providers for the medical services that the patient/member received. Pharmacy, care management and some other expenditures also fall into the medical cost bucket.

$$\text{medical loss ratio} = \frac{\text{medical cost}}{\text{premium}}$$

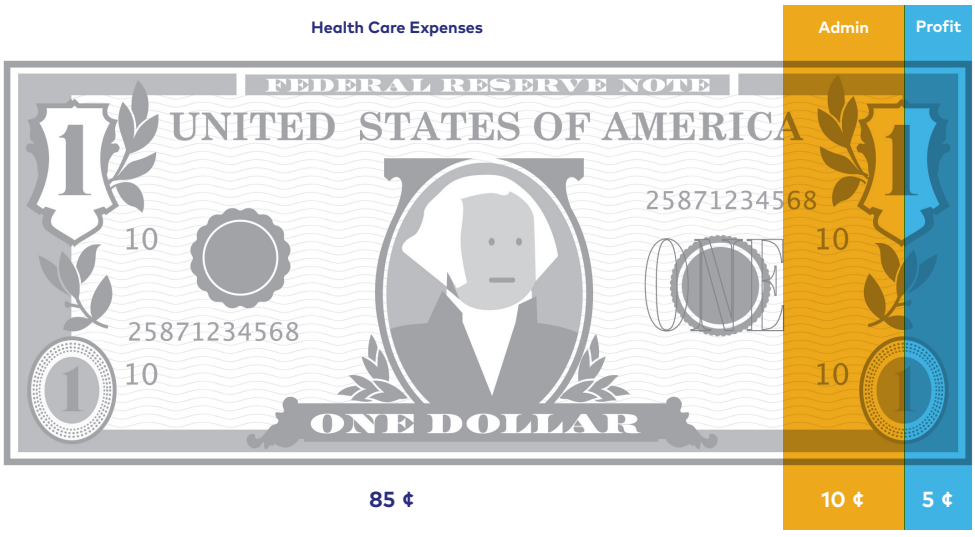
Health plans monitor their medical costs against the premium revenue they receive for each population. The ratio of medical cost to premium income is sometimes called the medical loss ratio or MLR, as well as the medical expense ratio or MER. The ratio comprises medical cost payouts in the numerator and total premium income in the denominator. For example, if a health plan receives $10 million in premiums, and spends $8.5 million in medical claims, its MLR is 85%.

The second bucket of expense is the administrative costs of the insurance plan. Examples of administrative costs include:

- premium billing and collection
- claims processing
- provider network development and relations
- member services
- benefit design and actuarial analyses
- marketing
- enrollment and disenrollment processing
- utilization management
- some care management activities
- some quality assurance activities

Profit is a third bucket. **Profit is not included in either the Medical Loss Ratio or the administrative costs.** Premium costs minus (medical expenses and administrative costs) result in either a net profit or loss for the payer. Continuing the example above, if a plan receives $10 million in premiums, spends $8.5 million in medical claims, and then spends $1 million in administrative costs, the plan will have a profit of $0.5 million (See Figure 8 below).

FIGURE 8: Medical Loss and Administrative Costs as a Percent of Premium



MINIMUM MLR UNDER THE AFFORDABLE CARE ACT

In an effort to ensure that the preponderance of the premium went to support health care, as opposed to administrative costs or profit, all employer fully-insured, individual, Medicare Advantage and Medicaid Managed Care products had to submit data on their Medical Loss Ratio (MLR). Plans had to adhere to a MLR (80% for individual and small group plans), or else pay back the difference to their members (commercial insurance) or the government (Medicare and Medicaid). MLR mandates will be re-visited under the new Administration.

PAYER LIMITATIONS ON SHARING ADMINISTRATIVE RESPONSIBILITY

When a provider assumes responsibility for care management or utilization management, this is considered delegation of responsibility by the health plan to the provider. In many states, **health plans are limited in terms of how much responsibility, what kind of responsibility and the type of entity to whom they can delegate**. (Similar limits exist on a health plan's ability to share financial risk.) For example, in New York State, the delegation agreement must be reviewed and pre-approved by the state insurance department. Further, plans can delegate either quality assurance or utilization management, but not both, and utilization management responsibility is allowable only for registered utilization review agents. In short, what, to whom and how much is delegated are often highly regulated.

These regulations exist to ensure that consumers are adequately protected. For example, if financial risk shifts to an entity that does not have adequate financial reserves to cover it, the costs may become the responsibility of the individual; since protection from excessive costs for the individual is the whole reason for health insurance in the first place, such exposure defeats the purpose of purchasing insurance. Similarly, if the utilization management function shifts to a provider entity ill-equipped for this responsibility, the consumer is at risk for inappropriate under-treatment.

KEY TAKEAWAYS

- Health plans are interested in working with providers to identify solutions that improve the *predictability* of their Medical Loss Ratio. Palliative care can help stabilize medical costs by supporting the sickest and most complex members to remain stable in their homes and communities and avoiding preventable and costly crises and unnecessary or even counterproductive medical intervention.
- Solutions that can be included as a health care cost in the MLR—as opposed to an administrative cost—will be more attractive to the plans, because the administrative "slice" needs to be very small in order to keep the MLR at target, and provide for some profit.
- Delegating key functions (such as quality assurance and utilization/case management) can involve state regulatory bodies, and can get complicated for health plans.

PART 2

2

Value-Based Payment and Alternative Payment Models

Value-Based Payment and Alternative Payment Models

What Is Value and What Is Value-Based Payment?

What is meant by value? It is the ratio of quality (in the numerator) to cost (in the denominator), so that maximizing value means achieving the best possible patient outcomes at the lowest possible cost. **Value-based payment means that quality and/or cost are variables in the payment calculation**.

- An example of a *high-value* intervention is the provision of cardiac medications for a patient with heart failure. For a small cost, pulmonary edema, hospitalization in the intensive care unit and possible death are averted.
- An example of a *low-value* intervention is the use of intensive care units and ventilator therapy for persons dying of pneumonia in the context of end-stage dementia. Such care contributes to suffering, does not reverse the underlying terminal illness and costs tens of thousands of dollars per patient per episode.

$$\text{value} = \frac{\text{quality}}{\text{cost}}$$

Under a value-based payment model, **health care that simultaneously maximizes quality and controls cost becomes the goal—and that is, often, exactly what palliative care delivers**. Numerous studies have demonstrated better quality of life, better quality of care, increased survival, greater satisfaction, fewer emergency department visits, fewer hospital days, fewer intensive care days and overall lower costs for patients receiving timely palliative care supports (see Part Three: How Palliative Care Adds Value). Thus, the rise of value-based payment presents an unprecedented opportunity for financing palliative care services.

Alternative Payment Models

ALTERNATIVE PAYMENT VS. RISK-BASED PAYMENT

Alternative payment models (or APMs) are an alternative to the fee-for-service payment model and its inherent volume incentives. Because almost all APMs consider quality and/or cost, most APMs are also value-based payment models. However, because there are also value-based payment models that pay small supplements (or penalties) on top of the fee-for-service foundation, APMs are really a subset of value-based payment models.

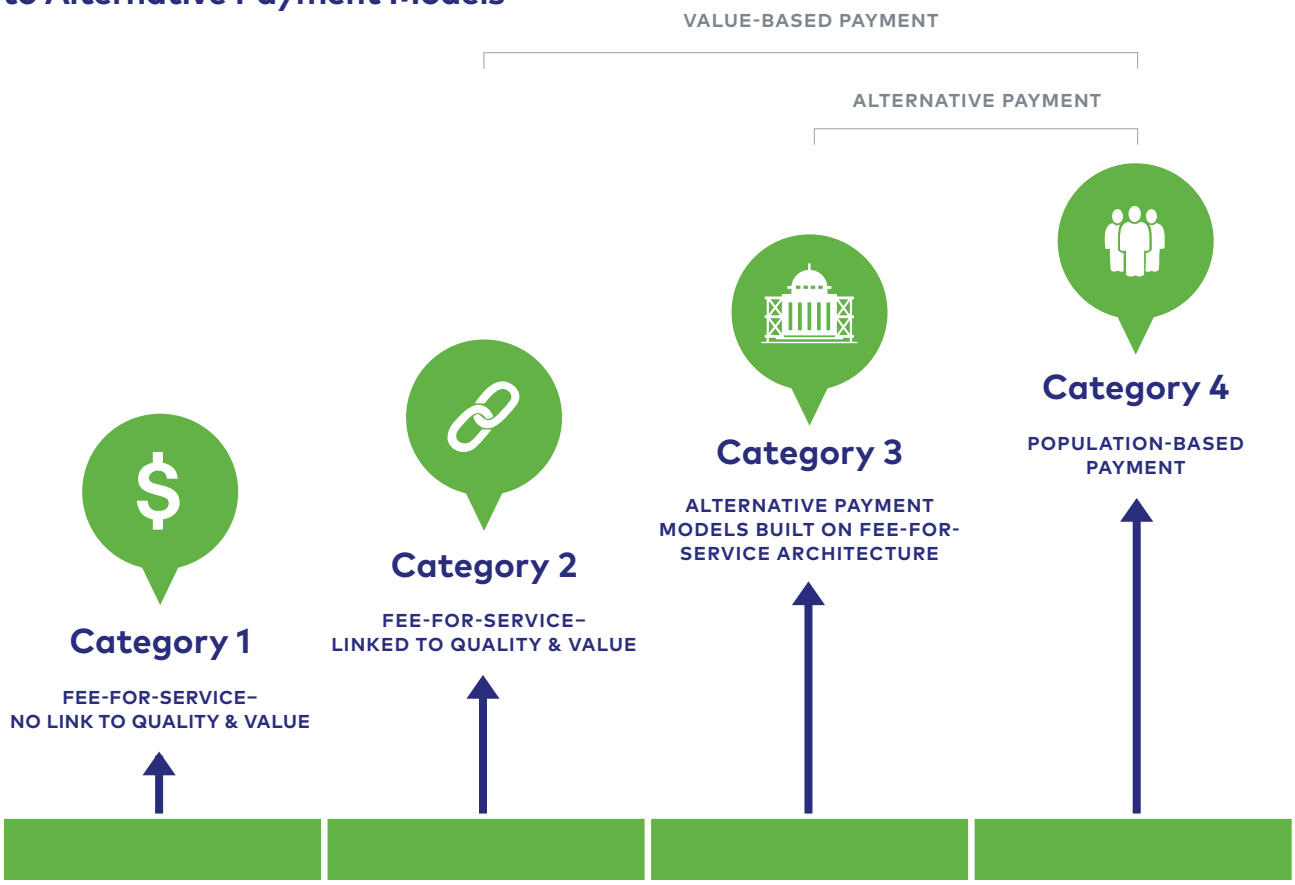
Alternative payment models do not necessarily mean that a provider assumes downside financial risk. There are many different alternative payment models and they vary in the degree of responsibility the provider(s) assumes for the cost of a population. There are also models that allow providers to be protected from cost overruns (downside risk), and instead focus on sharing savings generated (upside risk).

Alternative payment models do not necessarily mean that a provider assumes downside financial risk.

APM FRAMEWORK AND COMMON EXAMPLES

The Center for Medicare and Medicaid Services (CMS) had launched a public-private partnership to advance alternative payment models, called the Health Care Payment Learning and Action Network, or HCP-LAN. In an effort to provide a lexicon for all interested parties, they have created a four-category APM framework, progressively differing from fee-for-service. See Figure 9 below.

FIGURE 9: Four Categories of Value-Based Payment Moving to Alternative Payment Models



This graphic was adapted from the *Health Care Payment Learning and Action Network* (HCP-LAN) 2016 paper Alternative Payment Model (APM) Framework.

CMS considers APMs as those falling in categories 3 and 4, while value-based payment spans categories 2, 3 and 4. Currently, health plans prefer category 3 over category 4 because it uses existing claims infrastructure and enables needed data capture, but preferences are changing rapidly. Some common APMs are described in Table 4 below.

Keep in mind that alternative payment models are a means of compensating health care professionals and organizations, and do not, in and of themselves, change health care delivery. The onus is on the providers to determine how best to deliver measurably high-quality care within the spending targets.

TABLE 4: Common Alternative Payment Arrangements

Payment Arrangement	Description	Potential Advantages	Downside Risks and Risk Mitigation Strategies
Fee-for-Service with Shared Savings (and Losses) CATEGORY 3	Provider is paid under traditional FFS rules. If actual costs are lower than targets, provider receives a share of the savings. EXAMPLE: Medicare Shared Savings Program Track 1 is upside risk only; Tracks 2 and 3 include downside risk (see ACO section below).	In pure Shared Savings, there is no downside risk to the provider. Shared savings can help to cover the costs of non-billable services, such as care coordination.	Provider may not achieve the shared savings and will be unable to cover expenses that are non-billable. To reduce risk, the provider may minimize or triage non-billable services until savings are more certain. To protect against large losses, the contract can exclude outliers in the calculations.
Care Management or Care Coordination Fee CATEGORY 3	Provider is paid a per-patient fee (either monthly or via fee-for-service) for activities that support information-sharing and patient decision making. EXAMPLE: Primary care practices may receive additional fixed fees to create and coordinate care plans.	Funds are available to support the time and effort involved in assessment and conversations with patients and family.	Provider may be unable to cover all non-billable expenses involved in patient and family communications.

Payment Arrangement	Description	Potential Advantages	Downside Risks and Risk Mitigation Strategies
Bundled Payments for Defined Episodes CATEGORY 3	Provider bears almost full financial responsibility for costs of specifically defined patients over a limited period of time. EXAMPLE: A provider is held to a fixed price for joint replacement through 90-days post-surgery.	Bundled payments enable great flexibility to meet patients' needs. High-value supportive services can support quality and lower cost.	Provider may not be able to control all costs in the bundle. Risk mitigation is possible through narrowing how much upside and downside risk is taken (risk corridors) and clearly defining what is excluded from the bundle price.
Case Rate (Fixed Payment for Defined Services Partial Capitation) CATEGORY 4	Provider agrees to deliver a defined set of services to a defined population for a fixed price. A case rate may also be referred to as partial capitation, since the price is fixed for only a defined set of services. EXAMPLE: A physician office receives a fixed per-member-per-month payment to cover all primary care and ancillary services, but other costs, such as hospital care, are excluded.	By defining the set of services and the population, provider can better control care decisions and reduce its degree of downside financial risk.	Provider may not be able to control many factors, including patient demand for low-value services. Risk mitigation is possible with a narrower definition of the set of services included in the capitation amount.

Payment Arrangement	Description	Potential Advantages	Downside Risks and Risk Mitigation Strategies
Full or Global Capitation CATEGORY 4	Provider is paid prospectively and bears near-full financial responsibility for the health care needs of a population. Strong population management infrastructures, operations and skills are required. EXAMPLE: In the Program of All-Inclusive Care for the Elderly, all services needed must be paid for from the PACE fixed payments.	Provider has maximum freedom to direct services, whether billable or not. Savings accrue to the provider when utilization of high-ticket services is reduced.	Provider accepts both upside and downside risk, and uses population health management strategies to mitigate losses. Providers can mitigate risk by defining risk corridors. Protection against large losses may be possible through stop-loss provisions or re-insurance. Significant infrastructure and investment are required before assuming significant financial risk. This may not be feasible for small provider groups which might otherwise be well positioned to accomplish quality and savings initiatives.

ALTERNATIVE PAYMENT: DIRECT OR INDIRECT (DOWNSTREAM) RELATIONSHIPS

For providers, sources of reimbursement from alternative payment models can come from two sources:

- **DIRECT FROM THE HEALTH INSURANCE PLAN** A palliative care program may contract directly with a health plan—either Medicare Advantage, Medicaid Managed Care, Commercial Insurance or some combination. In this scenario, it is not likely that the palliative care program will be able to assume significant downside risk because the program will be targeting only the highest-cost subset of the health plan's overall population, without low-cost patients to offset the risk. However, there are several options to contract directly with health plans for alternative payment, including fee-for-service with shared savings or case rate capitation (fixed per-member-per-month payment) for home-based primary and palliative care services.

- **INDIRECT OR "DOWNSTREAM" FROM AT-RISK PROVIDERS** Other palliative care programs might be in a downstream position, where their reimbursement will flow from their relationship with a health system, large provider group or accountable care organization. In many cases, the downstream relationship is within the program's own health system. For example, a group of cardiac surgeons accepting bundled payment for coronary artery bypass grafts might arrange a per-patient payment rate with a palliative care team in return for symptom and co-morbid disease management during the peri- and post-operative period.

  Such downstream **payment mechanisms may include per-member-per-month case rate, shared savings or full program support, where the at-risk entity simply pays the salaries and expenses for the program.** For example, many palliative care consultation teams are supported by the hospital which is at risk for the hospital length of stay, the cost per stay, and 30 day readmissions. The hospital values the impact of palliative care on these outcomes.

In many cases, the downstream relationship is within the program's own health system.

Providers who are interested in relationships with at-risk entities (whether providers or health plans) should become more familiar with three common types of provider organizations where the providers are incentivized to improve quality and reduce spending in their respective populations: Accountable Care Organizations, Patient-Centered Medical Homes and the Oncology Care Model. More information on these three models is presented below.

ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

ACCOUNTABLE CARE ORGANIZATIONS (ACOs) are groups of providers that come together to manage all the care of a defined population. The ACO assumes varying degrees of responsibility for the total cost, quality of care and outcomes for that population. An ACO is not a payment model, but an organizational and delivery structure; in fact, ACOs may function under a variety of payment models. Like health plans, ACOs may also have several lines of business, based on the different populations they are responsible for. These include Medicare, Commercial and Medicaid ACOs.

MEDICARE ACOs are responsible for the quality of care and cost of care for a population of Medicare beneficiaries. Medicare beneficiaries are assigned to an ACO through a retrospective attribution process calculated based on claims algorithms. **If the Medicare**

ACO meets the quality targets and holds the total cost of care below the expected target, the ACO receives a portion of the savings (shared savings). Most commonly, the savings are then shared across the participating providers, based on parameters defined in each ACO-provider contract. However, the ACO can vary its payment relationship with participating clinical programs in whatever way works for both parties.

Medicare has launched a variety of ACO options, each with different levels of upside and downside risk. See Table 5 below for a description of the most relevant models[13]. As with all Medicare initiatives, there is no certainty whether support for ACOs will continue or not.

TABLE 5: Key Medicare ACO Models

	Medicare Shared Savings Program (MSSP) ACOs	Pioneer ACOs	Next Generation ACOs
Description of Model	The MSSP is an ACO program in traditional Medicare that provides financial incentives for meeting or exceeding savings targets and quality goals. The MSSP allows ACOs to choose between sharing just savings (Track 1) or taking upside and downside risk by sharing in both savings and losses (Tracks 2 and 3). MSSPs must be accountable for at least 5,000 attributed Medicare beneficiaries.	Pioneer ACOs are required to take upside and downside risk and pay back CMS if spending exceeds their target. Pioneer ACOs must be accountable for at least 15,000 attributed Medicare beneficiaries, and must have experience accepting risk through contracts with other payers. Pioneer ACOs are eligible to waive the requirement for a 3-day hospital stay prior to SNF coverage.	The Next Generation ACO model builds on the MSSP and Pioneer experience. A key difference is the potential for greater possible financial risk and reward. NextGen ACOs are eligible to not only waive the requirement for a 3-day hospital stay prior to SNF coverage, but they have greater flexibility in using telehealth and can cover post-discharge home visits.

	Medicare Shared Savings Program (MSSP) ACOs	Pioneer ACOs	Next Generation ACOs
Payment Arrangements	Providers within MSSP ACOs continue to receive traditional Medicare fee-for-service payments for services rendered. Assessment of each ACO's overall spending and quality—for calculating shared savings eligibility and amount—is based on the collective quality and cost outcomes of all the ACO's attributed beneficiaries.	Like MSSPs, individual providers in Pioneer ACOs receive traditional Medicare fee-for-service payments and performance is based on the collective provider performance on spending and quality for attributed beneficiaries, using the same quality measures as MSSP ACOs. Beneficiary attribution to Pioneer ACOs is also usually based on primary care utilization, but Pioneer ACOs may submit beneficiary attestations regarding their desire to be attributed or not to the ACO if the beneficiary was attributed in the prior year.	Like the other two models, NextGen ACO payment relies on traditional Medicare fee-for-service payment, which is then reconciled based on quality and cost outcomes of all the ACO's attributed beneficiaries. However, whereas the other two models share up to 50% of the savings and losses, NextGen ACOs will share in either 80% or 100%, depending on the track chosen. In addition, NextGen ACOs share in first dollar savings and losses, while the other models first must meet minimum savings and loss rates for funds to flow.

COMMERCIAL ACOs receive some or all of their funding from private contracts with commercial health plans. Employers may also contract directly with an ACO (e.g., Boeing and University of Washington), without the involvement of a health plan. These arrangements function similarly to Medicare ACOs in terms of accountability for quality and cost for a specified patient population, but the **cost/quality targets and risk-sharing arrangements are negotiated between the private health plan (or employer) and the ACO**.

In addition to the negotiations contracted directly between the health plan and the ACO, state regulators may create an additional set of parameters, including what responsibilities a health plan is allowed to delegate to the ACO and how much total financial risk can be shared.

There are good examples of commercial ACOs that have been covered in both the medical and popular press. Blue Cross Blue Shield Massachusetts was one of the pioneers of accountable provider contracting, using what it calls the "Alternative Quality Contract."[14] The plan contracts with groups of providers using a target global budget and target quality measures to which the providers are held accountable; when actual spending is less than the target budget, the providers share in the savings, as long as the quality measures are met or exceeded.

Many of the country's large insurers seem to be converting their provider contracts into accountable-type agreements, and in the process, shifting some financial risk from themselves to provider entities. Indeed, a number of commercial ACO-like arrangements preceded the Medicare program, and have demonstrated beneficial impact on quality and cost[15]. Such commercial health plan-ACO contracts expand the range of experimentation that can be attempted, and allow participation by provider groups that may, by themselves, lack the scale or financial resources to participate in Medicare ACOs and other CMS innovations, but might also be in a position to achieve impressive results.

MEDICAID ACOs are also beginning to emerge in state Medicaid programs. The cost and quality targets and risk-sharing arrangements are defined by each state's Medicaid office.

PATIENT-CENTERED MEDICAL HOMES AND COMPREHENSIVE PRIMARY CARE

Like ACOs, medical homes are a delivery and not a payment model, but in return for their management of a population, a clinical practice can contract with various payers for a range of alternative payment arrangements. Patient-centered medical homes (PCMHs) are accountable for comprehensive management of the patients that use their services. PCMHs are recognized as such by Medicare, Medicaid and commercial health plans based upon **having received certification from an accrediting body** (NCQA most commonly, and also The Joint Commission, URAC or the Accreditation Association for Ambulatory Health Care). Key features of a medical home, according to the NCQA standards, include:

- expanded access to care through longer hours, walk-in capability and 24/7 responsiveness

- effective coordination of care with other providers by following up on referrals made and specific post-hospital discharge procedures
- documented population-based preventive care outreach, as well as proactive management of chronic illnesses
- shared decision making with patients, which includes expanded patient assessment and education efforts

For example, a medical home should have all the diabetic patients in the practice identified, and work to ensure that their hemoglobin A1c is measured every three to six months, in addition to holding group discussions (with teach-back) around an appropriate nutrition plan. Similarly, palliative care principles and practices in a PCMH can ensure that patients with serious illness, functional impairment and complicated pain and symptoms are identified proactively and their needs assessed, managed and monitored for improvement. In some primary care practices, for example, an embedded palliative care physician or advanced practice nurse carries his or her own panel of patients.

THE COMPREHENSIVE PRIMARY CARE MODEL (CPC) is a Medicare innovation program launched in 2012, built off the PCMH certification. The CPC program requires participating primary care practices to contract with commercial and state health insurance plans in addition to Medicare for **additional care management fees and shared savings opportunities in return for accountability for five key functions**:

1. risk-stratified care management
2. after-hours access and continuity
3. planned care for chronic conditions and preventive care
4. patient and caregiver engagement
5. coordination of care across providers[16]

Under 2016 regulations, strong CPC performers can participate in CPC-Plus, which offers both downside and upside financial risk opportunities through Medicare and the partnering payers. See **innovation.cms.gov/initiatives/comprehensive-primary-care-plus** for more information.

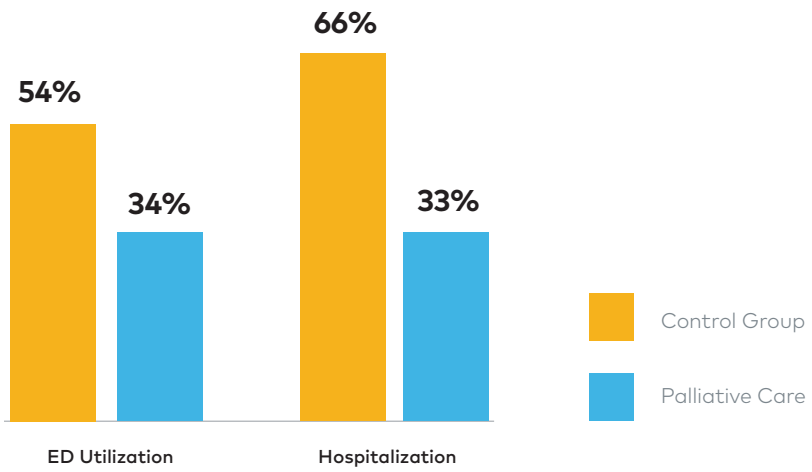
ONCOLOGY CARE MODEL

Another Medicare innovation program, the Oncology Care Model (OCM) seeks to reform payment and delivery of care for episodes of chemotherapy treatment. Built on a fee-for-service architecture (category 3), participating practices will continue to bill for their services as usual, with these added features:

- for each patient, the oncology practice will receive a Monthly Enhanced Oncology Services fee of $160 for the duration of the episode
- the practice can receive performance-based payments for improving quality and cost over targets

In 2017, Oncology Care Model practices can take two-sided risk, meaning that they are responsible for costs exceeding targets, but can share in savings beyond the performance-based payments if they are successful.

FIGURE 10: Utilization of Emergency Department and Hospital Among Oncology Patients with and without Palliative Care



Scibetta C, Kerr K, Mcguire J, Rabow MW. The costs of waiting: implications of the timing of palliative care consultation among a cohort of decedents at a comprehensive cancer center. Journal of Palliative Medicine, Nov 30, 2015

As illustrated in Figure 10, the Oncology Care Model represents a great opportunity for palliative care to partner with participating oncology practices. These practices need to minimize unnecessary emergency department and hospital utilization, and ensure high satisfaction through effective patient and family communications—outcomes that palliative care services can help achieve. OCM practices may seek to "buy" the added layer

of support from existing palliative care providers instead of "building" it themselves, either using the enhanced services fee, the performance-based payments or other mechanisms. See **https://innovation.cms.gov/initiatives/oncology-care/** for more information.

The Oncology Care Model represents a great opportunity for palliative care to partner with participating oncology practices.

KEY TAKEAWAYS

- Value is the ratio of quality to cost. Value-based payment means that both quality and cost are part of the equation in calculating payments to providers.
- Alternative payment models (APMs) are models that ultimately base payment on quality and/or cost outcomes rather than fee-for-service and volume. They are a subset of value-based payment models, categories 3 and 4 of the CMS payment framework. **Alternative payment does not always mean that a provider takes financial risk**.
- Common examples of APMs are: fee-for-service with shared savings (and losses); bundled payments for episodes of care; case rates, meaning a fixed monthly payment per patient that covers a small set of services; and global capitation, where the provider must cover all health care services within a fixed payment.
- Palliative care providers can receive alternative payment either directly from a health plan, or indirectly through an agreement with an at-risk provider such as Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs) or Oncology Care Model practices (OCMs).
- It is uncertain whether the current Medicare APMs will continue as planned. However, alternative payment for ACOs, PCMHs and OCMs is growing in Medicare Advantage and commercial health plans as well.

Value-Based Payment Under MACRA's Quality Payment Program

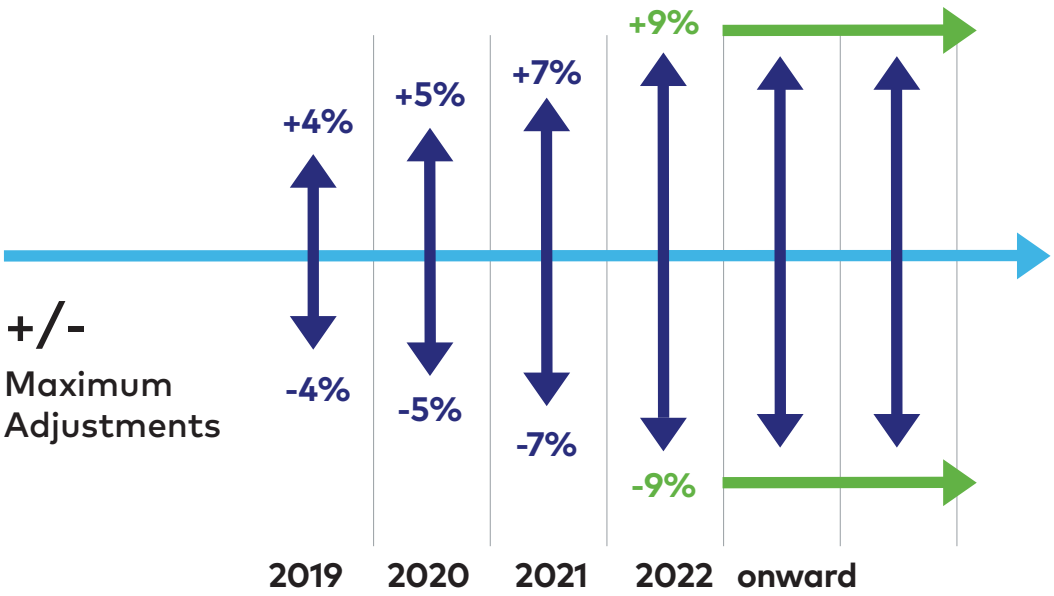
Medicare policy can play an important role in the drive towards value-based payment. First, with the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the introduction of the Quality Payment Program, all professionals paid by Medicare have strong incentives to participate in APMs in a significant way.

Any clinician who receives more than $30,000 from Medicare Part B and bills Part B for more than 100 Medicare beneficiaries annually must participate in the Quality Payment Program, which puts a portion of their Medicare payments at risk based upon performance. However, providers who participate in *any* Medicare APM receive automatic credit for parts of their payment calculations, and providers who participate in Advanced APMs– those that accept more than nominal downside financial risk—receive an automatic five percent bonus, and a higher fee schedule adjustment after that. A major incentive for participation in Advanced APMs, despite the requirement for providers to accept more-than-nominal downside financial risk, is exemption from the complexity of the Merit-based Incentive Payment System (MIPS), described below.

All professionals paid by Medicare have strong incentives to participate in APMs.

The alternative to participating in an advanced APM and accepting the required downside risk is the Merit-based Incentive Payment System (MIPS), a multi-domain reporting program aimed at improving quality and reducing costs through bonuses and penalties. It appears that Medicare hopes to use MIPS and its associated burdensome and complex reporting and performance requirements as a stick to drive providers away from fee-for-service. In brief, **MIPS will assess individual clinicians on the 4 domains of: quality metrics, spending, performance improvement activities and health IT use.** Provider performance relative to other clinicians will determine whether they receive a bonus payment or will be penalized, as depicted in Figure 11.

FIGURE 11: Increasing Rewards and Penalties Under MIPS



Because quality and cost are considered in the algorithm determining payment adjustment under MIPS, it is a value-based payment arrangement. Under MIPS, providers will be judged on these four components:

1. performance on six quality measures of their choosing, with a requirement to select at least one cross-cutting and one outcome measure when available
2. resource utilization, based on claims, which considers three calculations: total cost of care, per beneficiary spending and total costs of episodes, where relevant
3. documented participation in three to six quality improvement activities
4. use of certified electronic health records

The weighting of these four components will change over time, and will be based on the prevailing weights for that year, along with each clinician's performance compared to peers in each category. Together, the comparative scores and the weightings result in a composite performance score that determines the ultimate payment adjustment.

Because MIPS is both burdensome and exposes clinicians to more-than-nominal financial penalties, it may encourage clinicians to participate in advanced APMs in order both to collect the automatic bonuses and sidestep MIPS[17]. If, however, advanced APMs (such as a NextGen ACO) share financial penalties with their participating clinicians, significant losses are possible on that path as well. For this reason, Advanced APM participation requires careful analysis and preparation, which is discussed in the next section.

KEY TAKEAWAYS

- The Medicare Access and CHIP Re-Authorization Act (MACRA) introduces value-based payment for clinicians receiving Original Medicare Part B payments. Providers can participate either in an Advanced APM with more-than-nominal downside risk, or in the Merit-based Incentive Payment System (MIPS). MIPS uses an algorithm combining performance on quality measures, cost of care, quality improvement activities and use of electronic health records calculated to a score which, when compared to other clinicians, results in either a bonus or a penalty.
- MACRA is expected to encourage more participation in Advanced APMs with downside risk by giving an automatic 5% bonus.

LEARN MORE ABOUT THE QPP

The Quality Payment Program regulations lay out very specific processes and calculations to determine which providers will receive bonuses or penalties, and of what scale. For full information, please see the "MACRA Final Rule: What Should Palliative Care Teams Be Doing Now" webinar slides and audio at capc.org. You can also learn more at the Quality Payment Program website: qpp.cms.gov. *Note that this information does not reflect any changes made under a new Administration.*

Considerations for Taking Risk

Accepting risk is not to be taken lightly, and requires organizations to assess their goals and priorities, financial reserves and tolerance for accepting financial risk, readiness for population health management, ability to develop the necessary infrastructure and the likelihood of serving the requisite large numbers of patients.

POPULATION HEALTH MANAGEMENT READINESS

As discussed in the Risk section above, a provider entity that assumes even a portion of **financial risk for a population requires infrastructure and skills to proactively assess and manage the needs of that population**. This necessitates capital investment, strong information systems and high-quality staff development. Key population health management necessities are:

- as much data on each patient as possible, including at minimum: demographics; diagnoses; medications; laboratory values; past and current providers; past hospital, emergency department and nursing facility utilization; social circumstances; functional impairments; and results of assessments
- the ability to risk stratify the population to match the right patients to the right intensity or "dose" of services over time
- a well-trained and adequately staffed care management workforce skilled in patient and family assessment, engagement, care coordination, safe and effective pain and symptom management and expert communication about patient priorities and planning for the future
- strong partnerships with other providers (including specialists, post-acute care providers and social service organizations)

SCALE AND FINANCIAL RESERVES

Scale—the ability to spread or pool financial risk—is a key factor in assessing readiness for risk-bearing opportunities. As noted earlier, large numbers of patients help to cushion a risk-bearing entity from insolvency and also help to achieve predictability of costs. Therefore, **provider arrangements with downside risk must have a significant patient population size so that the highest risk/highest-cost patients account for only a small fraction of the total.** For example, Medicare ACOs require at least 5,000 patients, and some commercial health plan contracts also use that threshold[18]. The palliative care provider contracting with an ACO or other population health/risk-bearing entity should seek to participate in an arrangement where the population numbers are sufficient to sustain the model, and where the payment level is sufficient to provide reliable and consistent high-quality care for the high-need subset.

Perhaps the most important factor to consider is the organization's tolerance for financial risk.

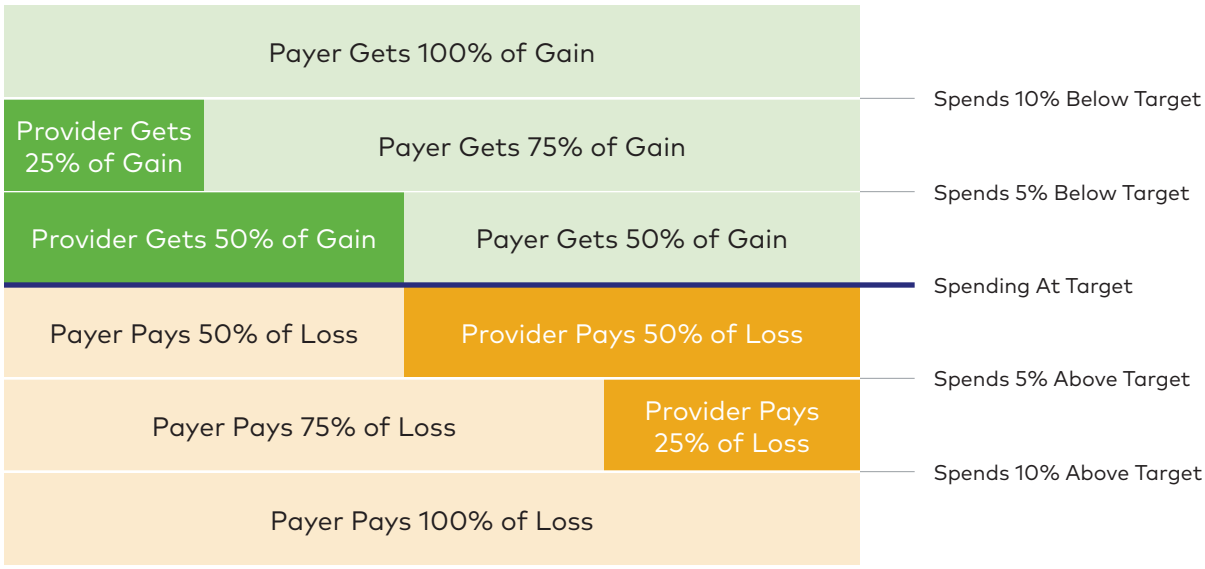
Even with a large scale, costs will remain variable and unpredictable. Therefore, it is wise to set aside funds (reserves) to protect against significant losses. Actuarial scientists are needed to help an organization estimate required reserve amounts.

RISK TOLERANCE AND LIMITING RISK

Beyond these objective considerations, perhaps the most important factor to consider is the organization's tolerance for financial risk. Leadership—particularly clinical leadership—must be willing to weather the inevitable early mixed financial and clinical results of these new contract arrangements.

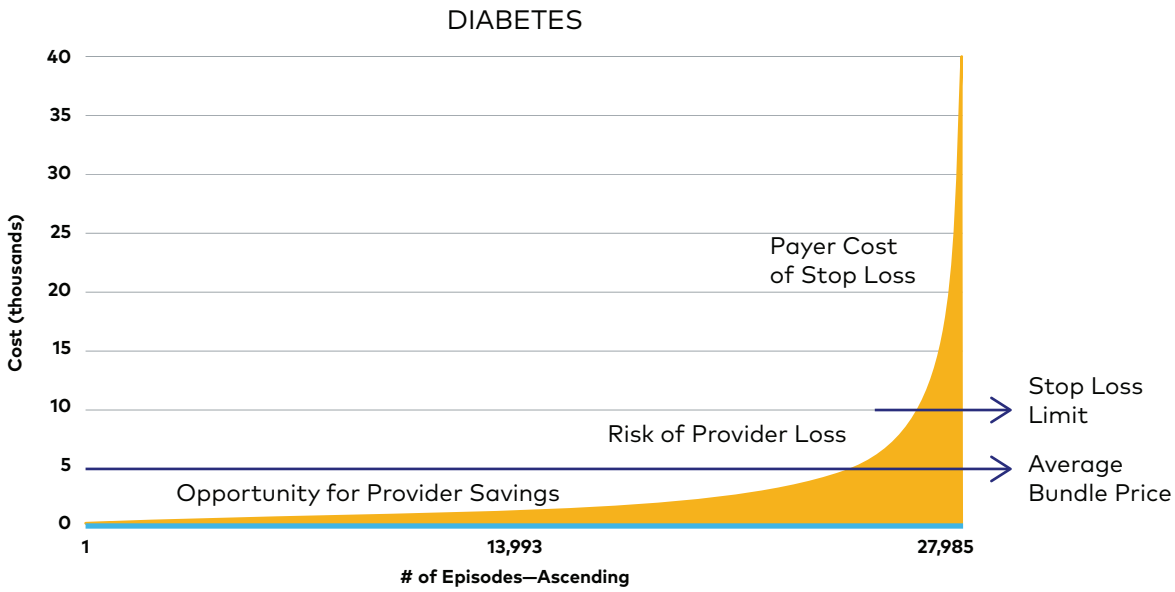
There are also ways to structure risk-bearing arrangements to limit exposure to losses. **First, a contract can define risk corridors (a limit on the percent or dollar amount of possible losses, usually in exchange for a limit on the possible gains) as illustrated in Figure 12.** For example, a program would be responsible for only 20% of any losses incurred, and conversely limited to share in only 20% of the savings gained.

FIGURE 12: Sample Arrangement in Which Provider is Protected from Significant Losses with Risk Corridors



Second, a contract can have stop-loss provisions, where an individual provider's or program's payment for losses can be limited at the upper end, such as to a certain percentage of the total losses, or up to a certain dollar amount. This is illustrated in Figure 13 below.

FIGURE 13: The Distribution of Health Care Financial Risk



Source: HCI3, New York State Value-based Payment Bootcamp, August 2016

Thirdly, the contract can include outlier exclusions, which exclude high-cost cases above a certain dollar amount (e.g., patients with annual costs above, say, $100,000) or certain services known to be high-cost (such as transplants).

APM PARTICIPATION WITHOUT RISK

A provider or organization lacking tolerance, scale or the ability to develop the population health management resources can participate in the alternative payment models that do not require assumption of downside risk (such as the Medicare Shared Savings Program ACO). There are many examples of palliative care providers and programs operating within ACOs, bundled payment programs and at-risk medical groups, where **the palliative care provider is paid a fixed rate (such as a per-member-per-month) by the larger entity,**

and that entity benefits from the value of its contributions. (For more about what those contributions can be, see the following section, How Palliative Care Adds Value). Some viable downstream alternative payment models for palliative care services can be:

- case rate capitation (e.g., per-member-per-month, PMPM) for the palliative care team's services
- per session payment for a palliative care provider to be available a certain number of hours per week
- direct payment/salary support for staffing
- negotiated fee-for-service rates that cover the full team's services, as well as travel time

Regardless of the risk assumed or the payment model used, **providers must know the cost of their services** in order to secure a sustainable level of reimbursement. For more information on accurate pricing from your program's costs, and business planning, please see CAPC Central, specifically Course 504, "Building the Business Plan for Your Community-Based Palliative Care Program," and the suite of tools under "Financing Your Palliative Care Services."

Finally, accurate and sustainable pricing, especially for episodes and populations, requires professional guidance, such as that provided by actuarial scientists. Legal counsel is, of course, required for any contractual arrangements. Relationships, even pilots, should not proceed without professional assistance.

KEY TAKEAWAYS

- → Again, alternative payment and value-based payment do not always mean that a provider takes financial risk. Even under MACRA's definition of nominal risk in Advanced APMs, the risk taken is at the APM level and may not trickle down to all providers, or trickle down evenly.
- → Assuming financial risk for a population requires significant population management capabilities and infrastructure.
- → If a provider does accept downside risk, there are contract provisions to protect against undue losses. These include risk corridors, stop-loss and outlier exclusions.
- → **Lawyers and actuaries must be consulted** for any risk arrangements.

3

PART 3

How Palliative Care Adds Value

How Palliative Care Adds Value to Payers

Of key concern to payers are quality, satisfaction and cost, and the provision of high-quality palliative care to seriously ill patients can positively impact each of these domains.

Accountability for Quality and Palliative Care

QUALITY MEASURES AND RATINGS

All health plans and health provider organizations are held accountable by government and purchasers (such as employers) for demonstrating quality, and performance on quality metrics has financial implications. Some of the key quality mechanisms are listed in Table 6 below.

Table 6: Health Care Industry Quality Mechanisms Applicable to Payers and Selected Provider Entities*

	Mechanism	Domains Measured
Medicare Advantage Plans	Medicare Plan Compare Star Ratings (CMS)	A combination of information from other measures (see below): staying healthy, managing chronic conditions, member experience with health plans, member complaints and changes in health plans, medication adherence and health plan customer service. Since star ratings impact the payment rate an MA plan receives, there is strong incentive to be successful in quality measures.
	Health Care Effectiveness Data and Information Set (HEDIS)	Effectiveness of care, access/availability of care, experience of care, utilization and relative resource use, health plan descriptive information

	Mechanism	Domains Measured
Medicare Advantage Plans (continued)	Health Outcomes Survey (HOS)	Improving or maintaining physical health, improving or maintaining mental health, monitoring physical activity, improving bladder control, reducing risk of falling
	NCQA Plan Ratings	Consumer satisfaction, prevention, treatment
Commercial Health Plans	Healthcare Effectiveness Data and Information Set (HEDIS)	Effectiveness of care, access/availability of care, experience of care, utilization and relative resource use, health plan descriptive information *NB: Plans may adapt or enhance HEDIS for a more plan-specific quality mechanism.*
	NCQA Plan Ratings	Consumer satisfaction, prevention, treatment
Medicaid Managed Care Plans	Core Set of Adult Health Care Quality Measures, including HEDIS and CMS Measures	Preventive care, maternal/perinatal health, behavioral health, care of acute and chronic conditions, care coordination, experience of care
Accountable Care Organizations	ACO Quality Measures (Medicare)	Patient/caregiver experience, care coordination/patient safety, preventive care, at-risk population care
Medical Homes	Merit-Based Incentive Payment System (MIPS) (Medicare)	Quality measures, resource use, clinical practice improvement activities, meaningful use of EHR
	Comprehensive Primary Care Program (CPC and CPC+) (CMMI)	Clinical process/effectiveness, patient safety, population/public health, efficient use of health care resources, care coordination, patient and family engagement, utilization
Hospitals	Hospital Compare Star Ratings (CMS)	Patient experience, process measures, complication rate, readmission and death rates, use of medical imaging, payment and value of care
	Health Plan Provider Rankings for Hospitals (and Other Providers)	Many private health plans assess hospitals and other providers on their own criteria, and publish those results for their members' use.

	Mechanism	Domains Measured
Hospitals (continued)	Hospital Value-based Purchasing (Medicare)	Clinical process of care, patient experience of care, clinical outcomes, efficiency and resource use
	Hospital Re-admission Penalties (CMS)	Re-admission rates for specific diagnostic groups
Cancer Centers	Cancer Center Value-Based Purchasing (Medicare) and Oncology Care Model (CMMI)	Clinical quality of care, communication and care coordination, patient- and caregiver-centered experience and outcomes, population health, efficiency and cost reduction, patient safety

* For information on specific measures, please see:
- HEDIS Measures: **ncqa.org/hedis-quality-measurement/hedis-measures**
- HOS Survey: **hosonline.org**
- ACO Quality Measures: **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf**
- MIPS Quality Measures: **cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/measurescodes.html**
- Hospital Quality Reporting: **cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalrhqdapu.html**
- OCM: **innovation.cms.gov/Files/x/ocm-methodology.pdf**

For health insurance plans, the employers who purchase their coverage often comparison shop not only by price (premium), but also by comparing the quality scores and ratings that are publicly available. Because more than 90% of United States health insurance plans use HEDIS, and because the measures are specific, plans can be compared on the same things—on an "apples-to-apples" basis. HEDIS reporting is required for accreditation and Medicare Advantage contracts, and is also used for **NCQA health plan rankings**, used by Consumer Reports.

As you can see in Table 6 above, health insurance plans are not the only entities with publicly-reported quality metrics. Accountable care organizations, medical homes, hospitals, cancer centers, skilled nursing facilities, home care agencies, dialysis centers, hospices and other providers are all assessed on quality metrics. **By virtue of its focus on symptom management, rapid response and shared decision making, palliative care could positively impact scores on quite a number of quality measures,** as detailed in Table 7.

TABLE 7: Scorable Quality Measures Relevant to Palliative Care

	Health Plans	Medicare Advantage Plans	Medicaid Plans	Accountable Care Orgs	Comp. Primary Care	Cancer Centers (OCM)
All-Cause Readmissions (all, unplanned)	X	X	X	X		
SNF All-Cause Readmissions				X		
Emergency Department Utilization	X	X			X	X
Hospitalization for Potentially Preventable Complications	X	X				
All-Cause Unplanned Admissions (for specific diagnoses)				X		
Ambulatory Sensitive Admissions (for specific diagnoses)			X	X		
Inpatient Utilization—General Hospital/Acute Care	X	X			X	X
Older Adult Screenings (e.g., function, fall risk, dementia, pain)		X (and HOS)			X	
Medication Reconciliation Post-Discharge		X				
Potentially Harmful Drug-Disease Interactions in the Elderly		X				
Use of High-Risk Medications in the Elderly		X			X	
Fall Risk Management		X				
Depression Measures: Utilization of the PHQ-9 to Monitor Depression Symptoms/ Depression Screening and Follow-up/ Depression Remission at 12 months	X	X		X	X	X
Relative Resource Use (specific diagnoses)	X	X				

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)*

Patient experience figures into publicly-reported quality performance and payment through surveys called Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS measures consumers' satisfaction with provider access, provider communication ability and consumers' relationships with their providers. Unfortunately, members who die within six weeks of the survey start are excluded from the calculations, but palliative care providers working with a broad range of patients will have patients included in the CAHPS survey.

In addition to the commercial health insurance plan CAHPS surveys, most health care organizations are now assessed for the consumer perspective with their own specific CAHPS survey, detailed in Table 8 below.

TABLE 8: CAHPS Entity Surveys

Survey Title	Applicable Entity
CAHPS Health Plan Survey	Commercial plans, Medicare Advantage Plans
CAHPS Clinician and Group Survey	Physicians, PCMH
CAHPS Surgical Care Survey	Freestanding Surgery Centers
CAHPS Child Hospital Survey	Hospitals
CAHPS Adult Hospital Survey	Hospitals
CAHPS Dental Plan Survey	Dental Plans
Experience of Care and Health Outcomes Survey	Medicaid Managed Care
CAHPS American Indian Survey	American Indian National Health Services
CAHPS Nursing Home Survey	Nursing Homes
CAHPS Home Health Care Survey	Home Health Agencies
CAHPS Hospice Survey	Hospice Facilities

* For more information about **CAHPS**: **https://ahrq.gov/cahps/surveys-guidance/hp/instructions/version5.html**

Survey Title	Applicable Entity
CAHPS In-Center Hemodialysis Survey	Dialysis Facilities
CAHPS Outpatient and Ambulatory Surgery Survey	Hospital Outpatient Surgery Departments

Palliative care services influence many CAHPS domains, including:

- getting timely care, appointments and information
- how well your providers communicate—explaining and listening
- how much time your providers spend with you
- patients' rating of provider
- shared decision making
- stewardship of patient resources

MEDICARE STAR RATINGS: WHY THEY MATTER

Not only are quality measures and CAHPS results publicly reported, but they also have a direct impact on Medicare revenue. Medicare rates the following entities on a scale of one to five stars, calculated from relevant quality measures and CAHPS results. **Higher Medicare Star ratings mean higher payment** for:

- Medicare Advantage plans
- hospitals
- skilled nursing facilities/nursing homes
- home health care agencies
- dialysis centers

The number of stars also has a significant effect on a Medicare Advantage plan's ability to attract and retain members. Consumers consider the Medicare star ratings during the enrollment period for Medicare Advantage[19]; Five-Star plans have the added advantage of being able to enroll members switching from other Medicare Advantage plans at any time during the year*.

* Medicare beneficiaries can enroll in or switch their Medicare Advantage plan only during the open enrollment period, which is October 15 to December 7, unless switching to a 5-star plan.

KEY TAKEAWAYS

- Quality measures are important to health plans and many at-risk providers, not only to assure quality care delivery, but also for their link to payment.
- Health plans' quality scores are publicly available and can impact their market position. Medicare Advantage plans further benefit from high quality scores through an enhanced premium payment.
- Health plans and most types of providers are evaluated through the CAHPS survey, measuring the member/patient experience of care.
- High-quality palliative care should positively impact a number of the key quality metrics, making palliative care providers a valuable partner.

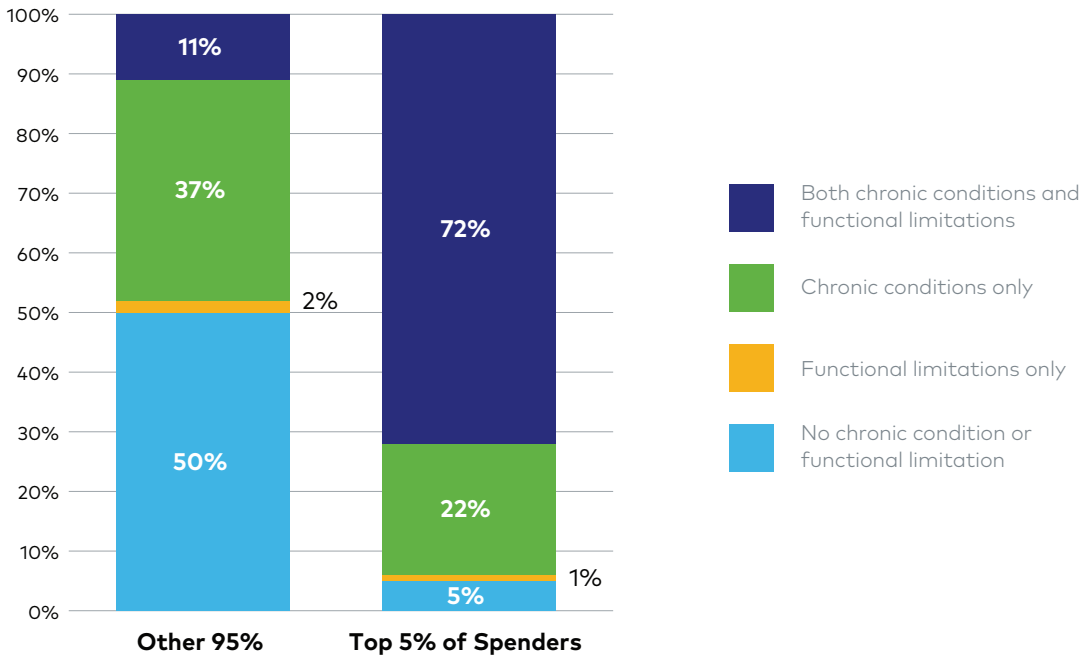
Financial Impact of Palliative Care

REDUCING COST BY PREVENTING CRISES, EXACERBATIONS AND UNNECESSARY ED AND HOSPITAL VISITS

While providers and payers are driven to ensure the best possible outcomes for patients and members, organizations are simply not sustainable if financial losses threaten long-term viability. Ensuring that spending stays within revenue projections is a major goal not only for payers but also for providers who are risk-bearing. Solutions that can help keep spending within predictable levels are critical to sustainability.

Executives and Medical Directors focus attention on solutions for the small fraction of their population that accounts for the majority of health care spending (see Figure 14 below): high-need/high-cost (aka high-claimant) members, the group most likely to benefit from palliative care.

FIGURE 14: Health Spending Is Highly Concentrated Among Those Who Can Benefit From Palliative Care



To a considerable extent, particularly in Medicare, these populations are characterized by multiple comorbid conditions, functional dependency and high use of hospitals and nursing homes.

Palliative care teams work to improve the management of pain and other symptoms, which can reduce emergency department visits and hospitalizations. Skilled palliative care teams can also help patients and families to weigh the pros and cons of realistic treatment options in the context of patient-centered goals and values. Fully-informed patients and families frequently (but not always) choose to receive further care in lower-intensity settings. This usually leads to higher-quality care, most often at lower expense.

Strong studies demonstrate statistically significant reductions in health services utilization and total cost for patients receiving palliative care services compared to their matched peers in usual care:

- Home-based palliative care has been shown to significantly reduce hospital utilization—both admissions and length of stay[20,21].
- A payer-led effort combining expert care management with early referral to palliative care has been shown to produce sizable savings in a Medicare population principally through reduced hospitalization[22], achieving savings of over $12,000 over the last several months of life.

- Per-member per-month (PMPM) savings of $3,000 to $4,500 in the last three months of life have been achieved with home-visiting palliative care, similarly saving $12,000 per case[23,24].
- Additional compelling evidence can be found in the Center for Medicare and Medicaid Innovation demonstration, *Independence at Home*, a home-based primary care model for frail, functionally impaired older adults with at least two chronic conditions and at least one hospitalization or nursing facility admission in the prior 12 months. In just the first year of the program, savings averaged $3,070 per member per year, with a number of programs saving over $6,000 per member per year[25].

IMPACT OF COMPREHENSIVE ASSESSMENT AND DOCUMENTATION ON PREMIUM INCOME

Medicare Advantage plans receive monthly payments (premiums) from Medicare that are risk-adjusted to cover the costs of care for their enrollees. The risk adjustment is intended to ensure that plans are willing to enroll even the sickest individuals, and therefore risk adjustment considers types, numbers and severity of diagnoses. Without accurate risk adjustment, the sickest members become significant financial liabilities to the plan. Risk adjustment depends critically on how accurately clinicians document patient conditions and diagnoses, and the care plan for each, in the medical record.

Risk adjustment depends critically on how accurately clinicians document patient conditions and diagnoses, and the care plan for each, in the medical record.

The **risk adjustment factor (RAF)** is done through a **hierarchical condition categories (HCC and HCC scores)** weighting algorithm. Palliative care providers, because of the complex nature of the patients they see, and because of the comprehensive assessments and treatments involved, are more likely to routinely collect detailed diagnosis information. Many of the diagnoses and disease interactions which increase the level of risk adjustment are the reasons palliative care becomes involved with a patient in the first place. For example, diagnoses that are highly-weighted in the HCC algorithm include:

- heart failure
- cancer

- COPD
- malnutrition
- pressure ulcers
- advanced kidney disease
- Alzheimer's disease

As illustrated in Table 9, accurate and complete diagnosis capture could improve the RAF and thus the revenue to the Medicare Advantage plan.

TABLE 9: Risk Adjustment Factor Variation and Impact on Plan Premium

Beneficiary 1		Beneficiary 2		Beneficiary 3	
	RAF		RAF		RAF
68 y/o, community-dwelling, non-dual, aged	0.300	80 y/o, community-dwelling, dual, aged	1.009	80 y/o, institutionalized, non-dual, aged	1.189
Medical Conditions:		Medical Conditions:		Medical Conditions:	
None	0.000	Prostate cancer	0.159	Colorectal cancer	0.293
		Morbid obesity	0.410	Protein-calorie malnutrition	0.260
		Diabetes with CC	0.346	Parkinson's Disease	0.145
				Major Depressive Disorder	0.271
				Congestive heart failure	0.191
				Vascular disease with CC	0.321
Total RAF:	0.300	Total RAF:	1.924	Total RAF:	2.670
Plan Premium that is risk-adjusted	X$800	Plan Premium that is risk-adjusted	X$800	Plan Premium that is risk-adjusted	X$800
	$240		$1,539		$2,136

Source: CAPC "Partnering with Medicare Advantage Plans" Webinar by Aspire Health, July 28, 2016

Provider ability to show high accuracy and reliability in identifying and documenting all diagnoses and their level of severity, including symptom distress, is an asset to Medicare Advantage plans. However, coding and documentation for RAF scoring are complicated, with important legal and Medicare certification implications—**all providers should work closely with a billing and coding specialist to ensure accuracy and completeness of documentation.**

Putting it All Together

> "Value is the new economy, and measurement is going to be the new currency."
>
> *Craig McKasson, chief financial officer of Premier*

Palliative care has been shown to improve quality measures, CAHPS scores, total spending and risk scores. These findings will help in partnership discussions, but the more data shared on the provider's specific program, the stronger the interest. In fact, there have been examples of established home-based palliative care services that have been unable to secure payment contracts because they had no data to back up their claims of quality and cost effectiveness. **The best approach is comparing the palliative care program's outcomes to available outcome measures that are important to payers** (see Table 10 below).

TABLE 10: Data to Illustrate Program Value

Program Data to Collect and Share	Value of that Data
Emergency department visits per 1,000 patients	Cost driver and addresses HEDIS and ACO quality measures
Overall hospital admissions per 1,000 patients (APK)	Primary cost driver
All-cause re-admissions rate	Cost driver and addresses HEDIS and ACO quality measures
Overall skilled nursing facility admissions per 1,000 patients	Cost driver
Patient satisfaction scores and shared decision making	Addresses health plan and ACO measures and creates good word of mouth for payer
Program length of stay	Speaks to program's effectiveness
Rate of advance care plan documentation completion	Speaks to program's effectiveness

Program Data to Collect and Share	Value of that Data
Hospice referrals and hospice length of stay (when applicable)	Speaks to program's effectiveness and to cost effectiveness under Medicare Advantage

While data are essential, they are insufficient alone. **Data presentations should be brought to life with a few case studies—real patient stories**—showing the impact that the program has had on the lives of individual patients and families.

KEY TAKEAWAYS

- Evidence shows that palliative care reduces avoidable emergency department and hospital utilization, resulting in cost savings.
- Palliative care's comprehensive assessment and documentation approach can also have a positive impact on a Medicare Advantage plan's risk adjustment factor (RAF) and level of premium.
- Assertion of value is not convincing. Data must be brought to the table to demonstrate the value and impact of palliative care programs.

CALCULATING RETURN ON INVESTMENT (ROI)

One of the most common metrics that health plans use to decide whether to move forward with a new service or approach is the **Return on Investment, or ROI.** A basic ROI is calculated by the cost savings generated by the program minus the payments to the program in the numerator, and the program payments (again) in the denominator. For example, if a home-based palliative care program costs $400 per member per month for its staff and transportation costs, and generates savings of $2,000 per member per month in avoided hospital days, the ROI = (2,000-400)/400) = 4:1.

It may be difficult to appeal to a payer with an ROI below a certain threshold. Larger health plans, for example, may require a minimum ROI of 3:1. Payers will not depend upon your numbers, but will run calculations of their own.

4

PART 4

Key Success Factors and Key Takeaways

Key Success Factors and Key Takeaways

Key Success Factors: Relationships, Data and Contracting Resources

There are three key success factors for long-term success in value-based payment models: **relationships, data and contracting resources**.

RELATIONSHIPS

Cultivating relationships with key stakeholders—the "C-Suite" of your organization, contracting experts, payer organization representatives and population health leaders—is essential to building trust, dialogue and a platform for ongoing communication and problem solving. Relationship building and the communication it requires take time, interpersonal skills and expertise in appreciative inquiry, meaning the ability to ask about and listen to the context, constraints and opportunities of your partners in this work so that effective identification of shared goals and mission alignment can occur. **These are not one-time-only conversations**—as in any relationship, the key is communication, communication, communication.

In general, relationship building should start with piloting to test expectations, gathering data on the actual population, planning and improving processes and building communication channels between the program, providers and the payer. Members of CAPC can learn more about developing proposals and pilots through the tools and technical assistance available at **capc.org**.

DATA

Data are essential. Data will make a compelling business case for supporting your program. Data are needed to identify the patients who will benefit from higher-intensity care models, and performance monitoring is the only cast-iron way to track operational reliability and impact. Data will help build those strong relationships with stakeholders and other providers by helping them all to understand how concurrent palliative care supports their own quality and cost goals. CAPC members can learn more about key measures of value to payers and risk-bearing entities at **capc.org**.

CONTRACTING RESOURCES

Palliative care programs must seek the assistance of contracting professionals to protect against taking undue risk, ensure analyses of the right data and to build win-win relationships. Actuarial and legal expertise is required before any serious discussions with health plans or partners begin. There are several means of finding the right team to assist:

- For programs within larger health systems or independent practice associations, the needed expertise is likely available within your own organization. Health System Medical Directors, Chief Medical Officers and Population Health Offices/Officers are often the best starting point. The most important and necessary allies are finance

MARKET FORCES CAN HELP

Palliative care programs within health systems often struggle with getting recognition for their impact on value from system leadership. One program, seeking to secure a capitated payment for home-based palliative care, did indeed collect and report its data demonstrating impact on both quality and costs, but could not gain support or interest from its organization's contracting team.

A short time later, a local health plan approached the health system, asking if that system could create a home-based palliative care program for the plan's seriously ill members. With payer interest prompting the conversation, the palliative care program and the health system's Population Health department worked together to prepare a strong proposal.

and managed care contracting officers. Finance teams have the actuarial and analytic expertise to evaluate the value of your program and the contracting team will be needed to create any new agreement. With medical leadership, highlight the quality, cost and satisfaction gains from palliative care, using data from your own program. For finance and contracting partners, highlight the financial return your program is creating for payers and encourage them to contract to recoup financial support for these services.

- For smaller or independent programs, seek out recommendations for lawyers and actuaries from colleagues. Research the health care legal firms in your area—provider associations are a good place to start—and look for attorneys with significant experience with contract negotiations between providers and health plans, as well as expertise in state and federal compliance. Request proposals with descriptions of the firm's qualifications, ask for references and compare firms before finalizing your legal and actuarial team.

Palliative care programs must seek the assistance of contracting professionals.

Key Takeaways

Patients that need palliative care are increasingly sitting in Medicare Advantage, Medicaid Managed Care and Accountable Care Organizations.

→ Palliative care providers primarily care for beneficiaries of Medicare and Medicaid. Increasingly, these programs are either being privatized and run by health insurance plans, or else delegated to at-risk providers (such as Accountable Care Organizations), or both. It is unlikely that this privatization trend will stop anytime soon. Privatization creates new opportunities for palliative care providers to partner with payers to assure sufficient funding—to supplement or replace traditional fee-for-service.

Quality drives revenue for health insurers and at-risk providers.

→ Quality measures are important to health insurance plans and at-risk providers for both care quality and financial reasons. Quality scores are publicly available and impact both revenue and market position. For Medicare Advantage plans, revenue

also depends on accurate risk adjustment. High-quality palliative care should positively impact a number of the key quality metrics as well as risk scoring, making palliative care providers valuable partners.

Cost-effectiveness is another key value of palliative care.

- Health insurance plans are interested in solutions that improve the *predictability* of their medical loss ratio (MLR = medical costs/total premium). Palliative care can help stabilize medical costs by supporting the sickest and most complex members to remain stable in their homes and communities and avoiding preventable and costly crises. A program lacking its own cost or utilization data can turn to the wealth of literature on palliative care's cost-effectiveness.

There are viable ways to be paid without fee-for-service.

- Alternative payment models (APMs) are models that base payment on quality and/or cost outcomes. Common examples of APMs include shared savings (and sometimes losses), bundled payments, and case rates (PMPMs).

Assuming downside risk is not for all.

- Alternative payment may or may not require that a provider take on financial risk. Assuming financial risk requires significant population management capabilities and infrastructure. Before considering, assess financial reserves, risk tolerance, the strength of other provider relationships and the strength of data management. Also rely upon lawyers and actuaries—"*don't try this at home*"—and ensure that protections such as risk corridors, stop-loss and outlier exclusions are well-defined.

Data are essential for any value-based payment relationship.

- Working with health insurance plans and at-risk providers requires a commitment to collecting data, and using that data to make the case and cultivate relationships.

Endnotes

1 MedPAC Report to the Congress: Medicare Payment Policy, March 2010

2 ibid

3 Is America ready for a major Medicare overhaul? *Modern Healthcare*, November 23, 2016

4 Eklund K. and Wilhelmson K. Outcomes of coordinated and integrated interventions targeting frail elderly people: a systematic review of randomized controlled trials, *Health and Social Care*, February 25, 2009

5 Casarett, D. and Teno, J. Why population health and palliative care need each other, *Viewpoint in the Journal of the American Medical Association*, July 5, 2016; 316 (1)

6 Information on this section is drawn from **Medicare.gov**, **Medicaid.gov** and Kaiser Family Foundation **kff.org**, all accessed in July, 2016

7 Reaves, EL. and Musumeci, M. Medicaid and Long-Term Services and Supports: A Primer, The Kaiser Commission on Medicaid and the Uninsured, Dec 15, 2015.

8 Coughlin, Teresa et al. "Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries." Kaiser Family Foundation. April 2009.

9 Rovner, J. Price's appointment boosts GOP plans to overhaul Medicare and Medicaid, *Kaiser Health News*, November 29, 2016

10 Kaiser State Health Facts, based on 2014 information, the most recent available at the time of publication

11 These direct purchasing examples were featured by the Health Care Payment Learning and Action Network webinar, "Accountable Care: The Purchaser's Perspective" recorded March 23, 2016

12 Center for Medicare and Medicaid Innovation, Medicare Advantage Value-Based Insurance Design Model Fact Sheet, released August 10, 2016

13 Adapted from: Baseman, Boccuti, Moon, Griffin and Dutta, *Payment and Delivery System Reform in Medicare: A Primer on Medical Homes, Accountable Care Organizations, and Bundled Payments*, Kaiser Family Foundation, May 20, 2016. The Next Generation ACO information has been added for this publication based on the CMMI website, accessed July, 2016.

14 Chernew, ME. et al., Private payer innovations in Massachusetts: The 'Alternative Quality Contract' *Health Affairs*, Jan 2011; 30 (5)

15 Claffey, T. et al. "Payer-Provider Collaboration in Accountable Care Reduced Use and Improved Quality in Maine Medicare Advantage Plan. Health Affairs; September, 2012; 31 (9)

16 Center for Medicare and Medicaid Innovation website, accessed July, 2016

17 "Docs face stark choices under new Medicare pay proposal," *Modern Healthcare*, April 30, 2016

18 Chernew, 2011

19 "Sixty percent of Medicare enrollees now in plans with four or more stars" Avalere Health Insights, March 18, 2015

20 Lukas, L. Foltz, C. and Paxton, H. Hospital outcomes for a home-based palliative medicine consulting service, *Journal of Palliative Medicine*, Vol 16, No 2, 2013

21 Lustbader D. et al. The impact of a home-based palliative care program on an accountable care organization, *Journal of Palliative Medicine*, 2016

22 Krakauer, et al. Opportunities to improve the Quality of Care for Advanced Illness, *Health Affairs* September/October 2009; 28(5)

23 Lustbader 2016

24 Brumley, R et al. 2007. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. *Journal of the American Geriatrics Society*; 2007; 55 (7)

25 "Affordable Care Act payment model saves more than $25 million in the first performance year" Centers for Medicare and Medicaid Services press release, June 18, 2015

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to increasing the availability of quality palliative care services for people facing serious illness. As the leading resource for palliative care development and growth, CAPC provides health care professionals with the training, tools and technical assistance necessary to start and sustain successful palliative care programs in hospitals and other health care settings.

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