

Alternative Payment Supports Palliative Care Across the Continuum

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Introduction

The future of healthcare payment is here, presenting a great opportunity for palliative care. Alternative payment models (APMs) take many forms – shared savings, bundled payments, capitation and global payments – but they have one thing in common: they all increase provider responsibility for managing the quality of care and avoiding unnecessary utilization.

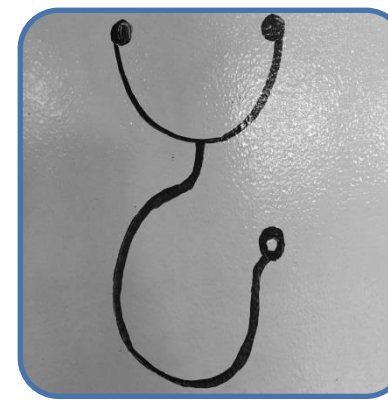
Palliative care has a strong track record on both quality and cost. By providing expert pain and symptom management, psychosocial support and skilled communication with patients and families, palliative care heightens shared decision-making and helps break the cycle of emergency room visits, hospital admissions, and unnecessary procedures. Not only does this reduce spending, but it vastly improves the patient experience.

What did we do?

We conducted exploratory research to learn how palliative care programs are integrating into models of alternative payment across the continuum of care; collecting best practices and lessons learned from program leaders. Informational interviews were conducted with more than 20 program leaders around the United States. Programs cared for seriously ill patients across multiple settings and using multiple delivery models. They also had varying degrees of integration in alternative payment models, from the planning stages to fully integrated and at risk.

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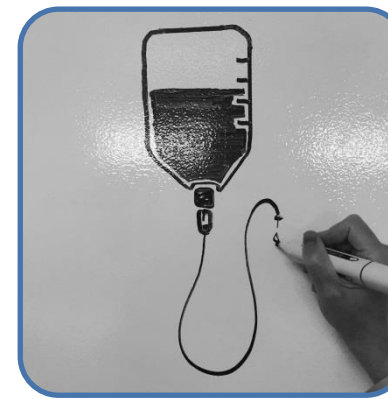
How APMs support Palliative Care in...



Primary Care

Per-Member-Per-Month, Shared Savings, Care Management

Some practices use the flexibility under capitated payment for high-quality generalist palliative care, including home visits. Others in shared savings models work with case managers to identify and connect patients to palliative care services.



Specialty Practices

Contracted Rate, Shared Savings, Care Management

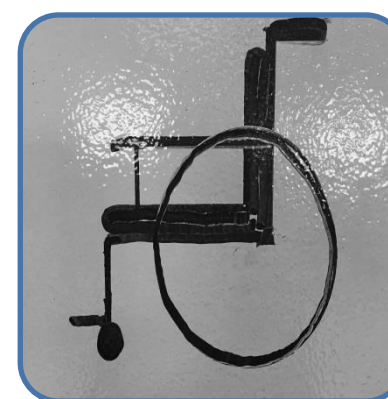
Palliative care programs either are paid by the practice or bill fee-for-service with possible shared savings bonuses. The oncology care model pays a care management fee, which could supplement a specialist palliative care team.



Acute Care

Accountable Care Shared Savings

Palliative care is well-established in many hospitals, where inpatient consultations and co-management of seriously ill patients has reduced readmissions and modified the care trajectory, contributing to shared savings.



Post-Acute Care

Episodes, Accountable Care Shared Savings

Palliative care consultations and co-management in skilled nursing improve care transitions, optimize pain and symptom management to reduce readmissions, modify the care plan to control rehabilitation costs, and improve hospice utilization.



Home-Based Care

Per-Member-Per-Month, Accountable Care Shared Savings

Home-based programs are integrated with ACOs, and paid either PMPM with shared savings or fee-for-service with shared savings; Independence at Home is the latter. Patients benefit, while programs support themselves on the costs they avoid

Keys Findings

➤ **Alternative payment does not mean your program has to take downside risk.**

There are many payment models to choose from and they vary in how much responsibility the provider assumes for the total cost. You could simply contract for a fixed PMPM fee for your program's services, or share in savings without taking the risk of covering excess costs.

➤ **Relationships are all-important.**

Nurture your relationships with ACO and system leadership to educate them on the benefits of palliative care, and how it can support their quality and cost goals. Collaborate closely with primary care providers and specialists to demonstrate concurrent care.

➤ **Relationship rely on data**

Data is central to making a compelling business case for supporting your program; data is needed to identify the right patients, as well as to “dose” your interventions according to their needs; and data is the only cast-iron way to track your impact.

➤ **Adapt to the business culture**

Some organizations demand rapid transformation with innovations brought quickly to scale, while others prefer to collect evidence with small-scale pilots before they commit. Ideally, palliative care sits at the table for payer discussions.