

Alternative Payment for Palliative Care: Getting from Here to There

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July 11, 2018

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**Diane E. Meier, MD,
FACP**
Director, Center to
Advance Palliative Care



Edo Banach, JD
President and CEO,
National Hospice and
Palliative Care
Organization



**Elisabeth
Rosenthal, MD**
Author, *An American
Sickness* and
Editor-In-Chief,
Kaiser Health News



Jay D. Bhatt, DO
President, HRET and
Senior VP and CMO,
American Hospital
Association



**Christy Dempsey,
MSN, MBA, CNOR,
CENP, FAAN**
Author, *The Antidote to
Suffering* and CNO,
Press Ganey Associates

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Alternative Payment is the “Wind in Our Sails”

- Fee-for-Service, while getting better, always leaves a gap
- APMs reward quality and cost-appropriateness – exactly what palliative care delivers!
- Risk-bearing entities need feasible solutions for the high-need/high-cost population
- It's still up to us to make the case



2018 Fee-for-Service Can Form a Good Base

- Basic E&M visits
- Chronic care management
- Complex chronic care management
- Advance care planning
- Transitional care management
- Prolonged services: face-to-face, and non-face-to-face
- Cognitive and functional assessment
- Caregiver education and coordination

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Billing and Coding Resources for Palliative Care

1. Sign in to CAPC Central
2. Select *Program Development Tools by Topic*
3. Select *Billing, Financing & Making the Case for Palliative Care* (third option in the topic list)
4. Select *Billing and Coding*

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CAPC TOOLKIT: BILLING & CODING

Coding is critical to the financial stability of the palliative care program. Programs must bill for Part B Professional Services for direct patient care services. Revenue covers a substantial portion of direct costs (costs of staff time). This ratio of cost covered by:

- Quality of documentation by clinicians & billing process by billing staff
- Mix of team members – who is on the team, and who is counted in direct patient care
- Place of service (care setting)
- Contracts with payers and payer mix
- Proportion of team time spent on direct patient care vs. other activities (e.g., care but not be billable)

It is critical to understand the rules and regulations concerning scope of practice for your team. These include federal and state regulations and institutional bylaws regarding enrollment.

CAPC does not give specific advice about billing, and all examples in this toolkit are for illustration only. **Programs must seek specific interpretation and advice from federal and regional payer and CMS administrators.**

Foundational Principles of Palliative Care Billing

Prolonged Services Billing

Advance Care Planning

Palliative Care Programs Receive Payment Across a Broad Range of Models

See Payment Arrangements in Appendix

PAYMENT MODEL	Description
Specialized fee schedule	Paid a higher % of Medicare, in recognition of quality/cost contributions. Some commercial health plans develop codes for “non-billable” staff
FFS with shared savings/losses	Shared savings (or losses) based on meeting specific cost or quality targets
Add-on fee	Additional payment per patient for services such as case management
Case rate (PMPM)	Monthly fixed payment per “enrolled” member/patient per month
Lump sum payment	Contracted payment for specific clinical coverage period (e.g. \$X per 4 hour clinical block of time)

Who Has a Financial Interest in Ensuring Robust Access to High-Quality Palliative Care?

POTENTIAL PARTNER	COMMENTS ON OPPORTUNITY
Commercial Health Plans	Roughly 2% of their members can benefit
Medicare Advantage Plans	Common financial partner, especially to national vendors
Medicare Special Needs Plans	Greater need in these populations, and new SNPs continue to open (eg, I-SNPs)
Medicaid Managed Care Plans	Some states have large numbers of these plans (eg: TX 19; WI 19; FL 17; OR 16; AZ 12; IL 12; MI 11)
Risk-bearing Oncology Practices	Strong business case, but can be difficult “culturally”
Accountable Care Organizations	Emerging opportunity – many are still focused on infrastructure building
Risk-bearing Primary Care Practices	Finances may be tight, but joint partnership with a health plan has been used successfully
Palliative Care Vendors	Need local resources to deliver contracted services

Prevalence is the “Case Rate” Payment

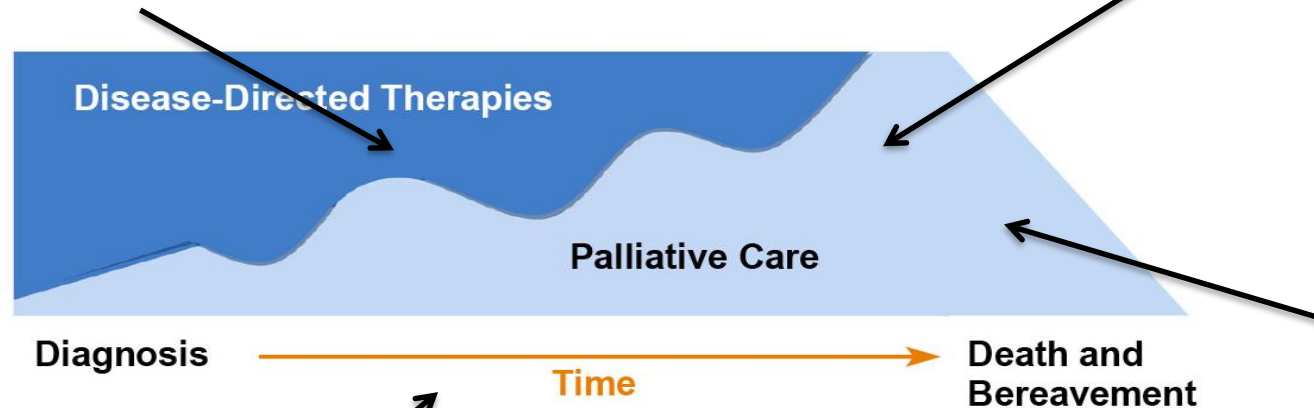
- Single monthly payment for a defined set of services
- Often requires 24/7 availability
- Onus on palliative care program to stratify their patient population to manage service delivery within fixed payments
- Often need to find operational efficiencies (e.g., telehealth, “outsourcing”)
- Does not necessarily require taking on additional risk



Payer-Provider Partnerships

Care requires coordination with all providers – **all clinicians** need the knowledge and skills to deliver quality palliative care

Complex conditions lead to variability in intensity over time – **payment** needs to reflect this variability



Need cannot always be predicted nor coded – **claims** **and clinical** data are required

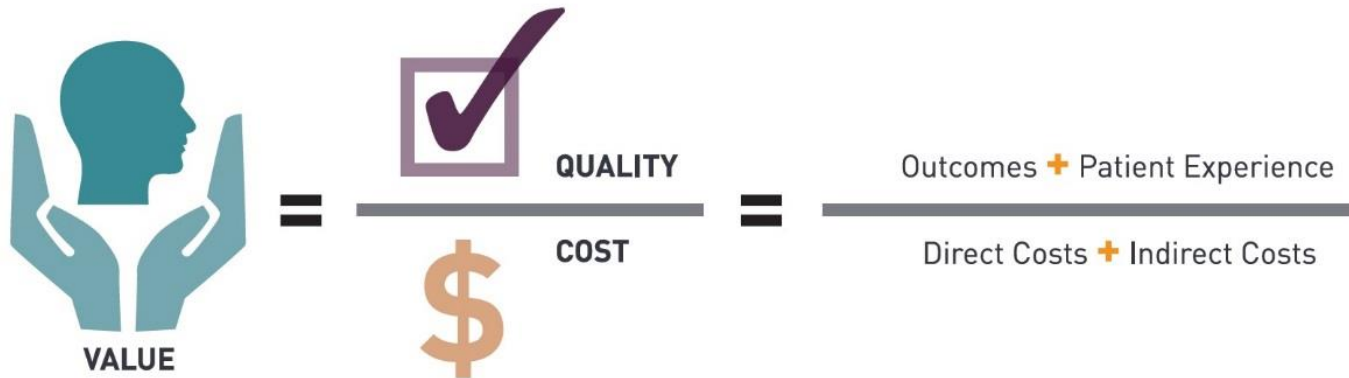
Serious illness is not one event - care needs to be available **across all settings**

- Functional decline
- Psychosocial needs
- Dementia

A Business Case for Palliative Care

→ Pilot Phase: Proving *estimated* savings and not *expected* savings

FIGURE 1: Value in Healthcare



Costs to Blue Shield: Claims expense, staffing to support, administrative impact, contracting time, analytic time, medical management and support, claims processing costs, external evaluation, initial implementation support and investment

Outcome: “Site of service shifts” (from inpatient to home), increased care coordination, decreased pharmacy and SNF, increase in revenue (risk scoring), quality score increases, decreased CM support

Team was challenged in 2016 to develop a home-based palliative care rate model



Alternative Payment model

- NOT fee-for-service
- Preferably bundled case rate



Actuarially Sound

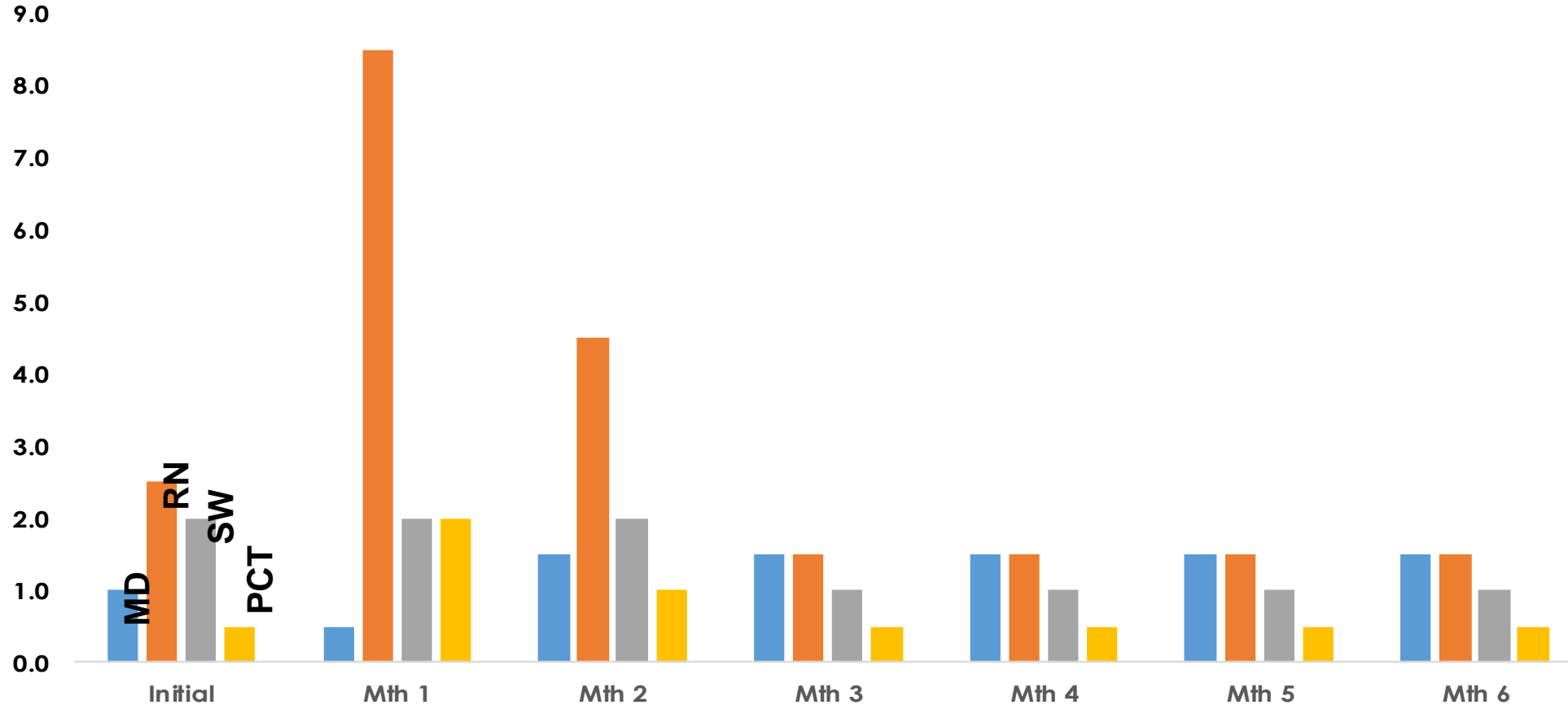
- Caregivers
- Services
- Typical protocol



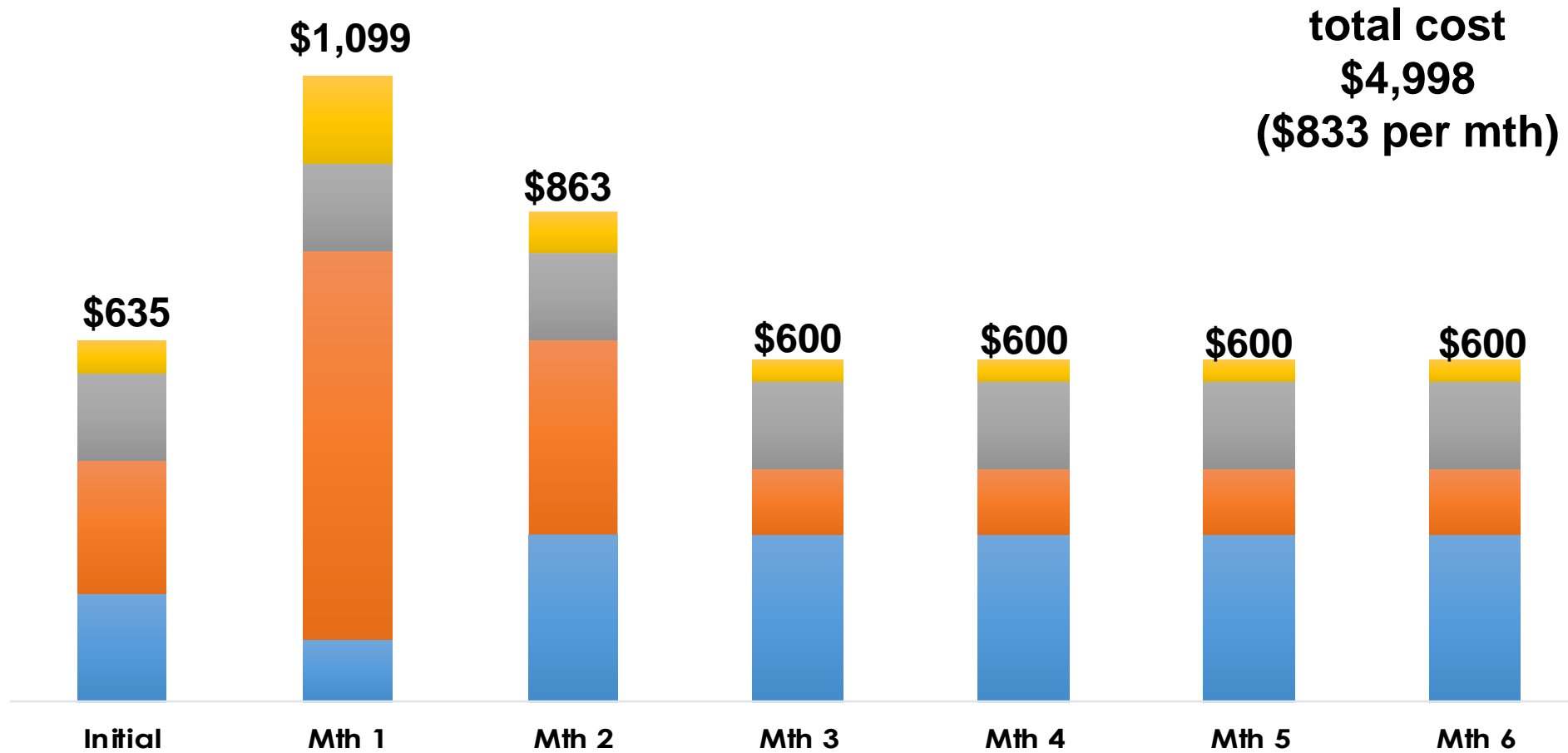
Marketable

- Contracting
- Flexible
- Regional

Typical home-based palliative protocol is 6 months, with most resources in the first 2 months



Total 6 month resource base costs



Note: CMS RBRVS 2016 Sacramento, CA fees used in model

Palliative per month case rate

\$833

**Per month resource
based costs**

+

\$125

15% for additional costs
(chaplain, 24 hour nurse line, etc.)

=

\$958

**TOTAL PER MONTH
BUNDLED CASE
RATE**

Note: CMS RBRVS 2016 Sacramento, CA fees used in model

Palliative Care—Payment & Services

Services include but are not limited to...

- ☐ Comprehensive in-home, multi-domain assessment by interdisciplinary team
- ☐ Development of care plan aligned with patient's goals
- ☐ Assigned nurse case manager to coordinate medical care
- ☐ Home-based palliative care visits – in person and via video conferencing
- ☐ Medication management and reconciliation
- ☐ Psychosocial support for mental, emotional, social, and spiritual well-being
- ☐ 24/7 telephonic support
- ☐ Caregiver support
- ☐ Assistance with transitions across care settings

→ Bundled Payment

- Pre-Hospice/Palliative Care Revenue Codes (069x)
- Advance Care Planning Codes (99497 & 99498)
- Initial Preventive Physical Examination & Annual Wellness Visit (G0402, G0438, G0439)
- Palliative Care Visit, Per Month (S0311)

Policy Considerations & Trade-Offs

Scalability

- When a program is built sustainably, palliative care is treated as a standard service, monitored and evaluated in the same way
- Built in standard claims processing, pharmacy expedited approval, and supplies/DME prior authorization approval systems to reduce administrative overhead
- Removed prior authorization for enrollment; implemented audit process

Trade-offs

- Not as close to our palliative care programs and providers
- Increased up-front risk of inappropriate enrollment, duplication of services

AAHPM APM Task Force: Goals

- Ensure access to high-quality, interdisciplinary palliative care for patients and caregivers throughout their journey with serious illness
- Create a new payment model for palliative care teams (PCTs) that could qualify as an APM under MACRA
- Determine how PCTs can add value to other accountable providers in APMs, ACOs, and commercial health plans
- Provide flexibility in our models to maximize participation by a broad diversity of interdisciplinary palliative care teams, serving patients and caregivers in all settings and all geographies

Patient and Caregiver Support for Serious Illness (PACSSI)

- Focused on seriously ill patients with likelihood of unmet symptom, care coordination and support needs who are either not eligible or not ready for hospice care
- Provides new payment for interdisciplinary Palliative Care Teams (PCTs) to deliver high-value services across settings
- PCTs receive per-enrolled beneficiary per month (PMPM) payments which are adjusted for performance on quality and spending

PACSSI: Service Requirements

- Educate the patient and caregiver about anticipated serious illness trajectory;
- Comprehensive physical, psychosocial, emotional, and spiritual assessment;
- Identify threats to the safety of the patient or caregiver;
- Assist the patient in establishing clear goals for care and treatment;
- Develop a coordinated care plan consistent with the patient's care goals;
- Arrange for services from other providers in order to implement the care plan;
- Communicate with the patient's other physicians;
- Respond on a 24/7 basis to requests for information and assistance;
- Make visits to the patient in all sites of care (home, hospital, nursing home, etc.) as needed to respond appropriately to problems and concerns;
- Provide written care plan, approved by patient, by end of first service month;
- Maintain documentation of patient eligibility;
- At least one face-to-face visit monthly (may be provided virtually);
- Maintain documentation of PCT's interactions with patient/caregivers

Key Challenges in PACSSI Development

→ Eligibility

- Which patients need what types of serious illness services?
- How are patients identified, for both care delivery and control matching?

→ Quality Measures

- What structure, process and outcome measures of serious illness care are both viable and valuable?
- What measures are we willing to be accountable for?

→ Payment Methodology

- What level of payment is sustainable? What level of 'risk'?
- How are spending benchmarks for serious ill patients created?

PACSSI: Eligibility

	Serious Illness Diagnosis (one of the below)	Function (one of the below)	Health Care Utilization
Tier 1: Moderate Complexity	<p>OPTION 1: Serious illness</p> <p>OPTION 2: Three or more serious chronic conditions, as defined in the Dartmouth Atlas</p>	<p><i>Non-Cancer:</i> PPS of $\leq 60\%$ or ≥ 1 ADLs or DME order (oxygen, wheelchair, hospital bed)</p> <p><i>Cancer:</i> PPS of $\leq 70\%$ or ECOG ≥ 2 or ≥ 1 ADL or DME order (oxygen, wheelchair, hospital bed)</p>	<p>One significant health care utilization in the past 12 months, which may include:</p> <ul style="list-style-type: none"> - ED visit - Observation stay - Inpatient hospitalization <p><i>*May be waived if continuing PACSSI</i></p>
Tier 2: High Complexity	Same as above, excluding dementia as the primary illness	<p><i>Non-Cancer:</i> PPS of $\leq 50\%$ or ≥ 2 ADLs</p> <p><i>Cancer:</i> PPS of $\leq 60\%$ or ECOG ≥ 3 or ≥ 2 ADLs</p>	<p>Inpatient hospitalization in the past 12 months AND one of the following</p> <ul style="list-style-type: none"> - ED visit - Observation stay - Second Hospitalization <p><i>*May be waived if continuing PACSSI</i></p>

PACSSI: Quality Measurement

→ Patient Reported Outcomes

- Communication, responsiveness, pain/symptom treatment, likelihood to recommend
- Post-death survey, Hospice CAHPS

→ Completion of Care Processes

- Comprehensive assessment: physical, emotional, spiritual, caregiver symptoms and needs
- Phased in over the first three years of the model

→ Utilization of health care services

- Percentage of patients who died without ICU days in the last month of life
- Percentage of patients referred to hospice, and those with LOS > 7 days

PACSSI Track 1: Payment Incentives

- Tier 1 (Moderate Risk): \$400/PMPM
- Tier 2 (High Risk): \$650/PMPM
- Payments adjusted for performance on quality and spending compared to region- and risk-adjusted benchmarks

Performance on Quality	Performance on Spending	
	<i>Meets/Exceeds Benchmark</i>	<i>Misses Benchmark</i>
<i>Meets/Exceeds Benchmark</i>	+4%	0%
<i>Misses Benchmark</i>	-2%	-4%

PACSSI Track 2: Shared Savings & Shared Risk

- Tier 1 (Moderate Risk): \$400/PMPM
- Tier 2 (High Risk): \$650/PMPM
- Shared savings/loss based on total cost of care

Performance on Quality	Performance on Spending (relative to benchmark)			
	Shared Savings		Shared Losses	
	< 95%	Between 95% and 100%	Between 100% and 105%	> 105%
<i>Poor</i>	0% of savings	0% of savings	60% of losses	50% of losses
<i>Good</i>	60% of savings	70% of savings	50% of losses	40% of losses
<i>Excellent</i>	70% of savings	80% of savings	40% of losses	30% of losses

PACSSI Recommended for Testing, HHS States Interest

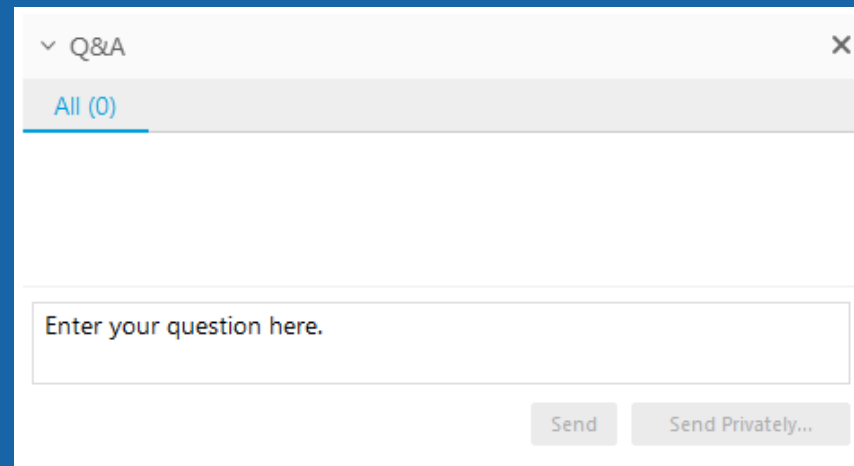
- March 2018: PACSSI and C-TAC's Advanced Care Model (ACM) are both recommended to CMMI for testing, with high priority
- June 2018: HHS Secretary Alex Azar expresses interest in testing a new payment model for serious illness care, names both PACSSI and ACM

CLOSING COMMENTS

QUESTION & ANSWER

Questions?

Please type your question into the questions pane on your WebEx control panel.

A screenshot of the WebEx Q&A interface. At the top, there is a header bar with a dropdown arrow and the text "Q&A" on the left, and a close button "X" on the right. Below the header, there is a tab labeled "All (0)". The main area is a large empty space. At the bottom, there is a text input field with the placeholder text "Enter your question here." and two buttons: "Send" and "Send Privately...".

Q&A

All (0)

Enter your question here.

Send Send Privately...

APPENDIX

PAYMENT ARRANGEMENT OPTIONS FOR COMMUNITY-BASED PALLIATIVE CARE

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

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

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

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



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

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