

Home-Based Palliative Care Payment and Delivery Models for Short-Term Interventions

With new flexibility in supplemental benefits, many health plans are adding home-based palliative care benefits for their members with serious illness. A prevailing model is a monthly case rate paid for each member enrolled in a home-based palliative care program. However, there are other, time-limited models, which have been used successfully. For example, some members may need only transitional support after a hospital stay, or the skills of a palliative care team to develop and implement a new care plan to be managed by others, or to create a “bridge” to hospice care. This tool summarizes health plan payment and delivery models for short-term palliative care supports in the home.

We found three basic models:

- (1) bundled payment for short-term palliative care co-management;
- (2) specialized fee-for-service payments for home visits by the palliative care team; and
- (3) a two-tiered approach.

Bundled Payment for Palliative Care Services

Health plans can pay a fixed amount for a bundle of in-home palliative care services to be provided within a set time period, to serve as a “wrap-around” to a member’s existing care team, or as a “wrap-around” to home health services.

Services can include: comprehensive assessment, pain and symptom management, goals of care conversations, advance care planning and documentation completion, member and family counseling, spiritual care, family and community resources assessment and linkage, after-hours telephonic support, and other services. Commonly, the contracted provider is required to conduct a comprehensive assessment, and the assessment then defines the services to be delivered. Minimum service requirements should be set by the health plan.

Time periods for the bundles can vary. Examples include 30 days, 60 days, and upwards to 180 days, and as noted, they can be created to coincide with home health episodes.

Example: Buckeye Health Plan’s Compassionate Connections Program

Buckeye Health Plan has developed an in-home palliative care benefit for the plan’s Medicaid aged, blind and disabled population and its dual-eligible beneficiaries. Buckeye, which covers 300,000 lives in Ohio, identifies members needing additional supportive services through a claims-based algorithm and care manager assessment.

Through a contract with the Visiting Physicians Association, Buckeye makes a single bundled payment for a series of in-home visits, during which nurse practitioners help patients identify and articulate their goals of care, implement strategies for quality of life and complete advance care plans. The contract requires that enrollees receive a minimum of six in-person visits from an NP with palliative care experience over the course of six months, with assessments conducted on the first and sixth visits. Under the fixed payment, the VPA is free to provide additional visits from NPs, social workers or chaplains, and to check in by telephone as needed.

The program launched in 2016 and achieved strong results during an initial pilot phase, with a 95% patient satisfaction rate, a more than 50% reduction in emergency room visits, and a \$1300 PMPM reduction in health care costs.

Specialized Fee-for-Service Payments

Health plans can use existing fee schedules to pay for palliative care visits in the home on a fee-for-service basis, ensuring scope of services through modifications, including: paying a much higher percent of Medicare to account for team-based services, and adding billing codes to cover palliative care nurse and/or social worker encounters.

Example: UPMC Health Plan's Advanced Illness Care Program

UPMC Health Plan has a home-based palliative care benefit available to members living with a wide range of serious illnesses. Member access to the benefit requires a referral from their doctor or home health agency. The health plan, which is part of an integrated delivery system, also uses claims-based algorithms and home health OASAS data to help identify patients that could benefit.

UPMC Health Plan authorizes up to six months of in-home palliative care visits at a time. The visits may be made by nurse practitioners or social workers, and telehealth visits may be billed as well. (The health plan also provides additional telemonitoring service for members to report medication adherence and problematic symptoms, which may then be communicated to the palliative care provider.) Commonly, members initially receive between three and four in-person visits during the first month, and a total of eight in-person visits over the course the first authorization period. A monthly complex case management fee is billed in addition to the visit encounters. These visits include zero cost-sharing for the members. The palliative care nurse practitioner may request an additional authorization period if the member has ongoing palliative care needs.

UPMC launched the benefit in 2014, and now receives around 20 referrals a week. The benefit has demonstrated promising results: on average, 75% of enrolled members experience no inpatient stay during the course of the program; 35-40% of enrolled members transition to hospice care; and patients that transition to hospice have a longer length of stay on hospice.

Two-Tiered Approach

For many individuals, a time-limited bundled episode may indeed lead to stabilization, but leaves them without an easy option to re-engage with palliative care services upon a change of condition. Health plans can use a two-step approach to address short-term needs while anticipating future needs and reducing gaps in care. This could take the form of a stepped-bundled payment, for example, consisting of an initial episode followed by a monthly care management payment. Health plans can use the following - example - currently in use by a health system under full risk - to consider how to structure appropriate benefits and provider contracts for a two-tiered approach.

Example: Sharp HealthCare's Transitions Program

Sharp HealthCare's Transitions program provides home-based palliative care for Medicare Advantage patients with advanced chronic illness. The program uses a co-management model - patients continue to see their primary care physicians and specialists. Patients are referred by

primary care providers, specialists, hospitalists, case managers, home health nurses or skilled nursing discharge planners using general and disease-specific criteria.

The program has an initial "active" phase, which then switches to a "maintenance" phase after patients have stabilized. During the active phase, lasting about six weeks on average, patients receive 4-6 weekly home visits from a registered nurse and 1-3 weekly visits from a social worker, as well as spiritual care as desired; all these staff are overseen by a palliative care certified physician.

Visits are structured to address pain and symptom management, medication reconciliation and advance care planning. Once the patient is stabilized, s/he enters the maintenance phase. During the maintenance phase, the patient receives scheduled telephone calls with the nurse or social worker approximately every 2 weeks, while home visits continue from the nurse, but the frequency drops to once every 4-6 weeks. Patients may also receive periodic visits from the social worker or chaplain as needed during this second phase.

In a recent study, Transitions patients had better outcomes than matched controls, and considerably lower health care costs. The average cost of the Transitions program was \$642 per participant per month (across both active and maintenance phases, with an average time from enrollment to death of 7 months), producing net savings per participant per month of between \$2,690 (for dementia patients) and \$4,258 (for cancer patients).ⁱ

ⁱ J. Brian Cassel et al., "Effect of a Home-Based Palliative Care Program on Healthcare Use and Costs," *Journal of the American Geriatrics Society* 64, no. 11 (2016): 2288-95, doi:10.1111/jgs.14354.