Designing Effective Payer Models to Improve Serious Illness Care

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Improving care for patients with serious illness requires building reliable supports across settings and over time. Consistency of approach by payers can simplify and accelerate provider-based solutions. Early attention to predictable challenges and shared principles can help guide design to more sustainable solutions.

Examples and Characteristics of Innovative Payer-led Programs

Significant innovative work is underway in North Carolina and nationally to improve care for seriously ill patients. This reflects a convergence of factors: the increase in value- or risk-based payment; the emergence of effective models for community-based palliative care; and recognition of the high cost of a small subset of patients. Several North Carolina pilots are designed to test concepts and prep the market for change.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) launched Care 360 – Specialized Support Services and Palliative Care in 2018; it was designed to increase access to home-based palliative care services and supported comprehensive needs assessments, care plan development, telephone support, caregiver support, assistance with transitions across care settings, and other services [1]. The pilot closed to new patients in October 2019. One of the challenges included a lack of understanding about palliative care among providers and patients, resulting in late referrals (email communication, Lori Taylor, Blue Cross NC, April 7, 2020). Late referrals have been found to show reduced opportunity for impact and measurement of results [2, 3]. Future initiatives in North Carolina will also need to plan for significant variation in care delivery structures and capabilities across palliative care organizations. This initiative encountered the common dilemma of introducing innovative approaches without sufficient readiness and alignment across the state.

The North Carolina Department of Health and Human Services (NC DHHS) Healthy Opportunities Pilots (planned for service delivery launch in 2021) include a strong emphasis on provision of health-related social services with a clearly defined portfolio of community services and specific payment terms, contracting with local organizations, and a five-year testing period [4-6]. This initiative recognizes the huge role that stable and safe housing, transportation, food, and caregiver support play in supporting better care. Learning from the successes and failures of the pilots and then replicating successful practices across payers and statewide could significantly transform our approach to reliable support for seriously ill patients.

Many examples of innovators outside the state have features and lessons learned that can be helpful in North Carolina, and which inform our observations; additionally, the Center to Advance Palliative Care has a series of case studies available on its website [7].

Common Design Features

Common care delivery design features include team-based care with new or expanded roles for lay health workers [8]; predictive analytics to identify appropriate patients and/or stratify them by intensity of service needs; formal assessment and intake processes; longitudinal relationships with a mix of home-based and telephonic services [9]; recognition of the key role and needs of family caregivers; and payment that more appropriately covers costs for coordination, time, and community service needs. Successful models include explicit training plans to build new skills in team members, outreach initiatives to integrate care in the community, and development of information technology systems that simplify documentation and communication.

Common design features of payer practices that support care delivery innovation include flexibility about roles for care team members, method of service delivery (telephonic, in-home, other), and covered services (often social supports beyond standard medical care). Payment methods include some combination of higher fee-for-service rates, bundled payments, per-enrollee per-month rates based on risk stratification, shared risk arrangements, and start-up funding or grants. Simply using modified fee schedules with sufficiently higher rates to cover costs can be effective in encouraging...
provider participation and investment; many regional markets or providers may not have the scale to effectively participate in risk-adjusted payments.

All of these approaches are intended to support expanded access to care through approved providers with enhanced services, and to recognize the time demands for effective work with serious illness patients and the need for a provider organization to have sufficient capacity and scale to succeed. Common challenges are variation across regional providers, difficulty scaling up, and difficulty with transitions for patients as they move across care settings.

Some of the more successful models have arisen in markets with high density of patients and high penetration of managed care payment, such as Sharp HealthCare in California [9], or in models focused on special populations (underserved, Medicaid) such as CareOregon [8]. Cambia Health Solutions in the Pacific Northwest has been the most comprehensive in building palliative care and support for serious illness populations into the design of its insurance products, provider contracts, funding for training and leadership initiatives, and start-up funding for local efforts [10].

Practical Challenges

Four challenges are well known to many working to improve care. These gaps increase direct costs of care for serious illness patients and/or reduce capacity of team members to care for more patients. Statewide efforts to create consistent approaches to these challenges will reduce uncertainty, risk, and costs.

Challenge One

Health care organizations are unlikely to make deep change in measures and incentives until a substantial percentage of revenue is derived from population-based payment. Discussion at executive levels may reflect a changing culture and approach. However, the budget norms and compensation methods are often still hardwired toward fee-for-service, volume, and procedure drivers. Changing practice perspective and habits requires alignment, effort, and reinforcement. Investment in community-based services to improve care options for seriously ill patients will be most effective when system-wide alignment is underway. Many current efforts focused on serious illness patients attempt to isolate a small volume of high-cost patients and create an alternative set of options for them, while leaving most of the traditional system norms unchanged.

Challenge Two

Prospective identification of high-need, high-risk patients is hard, and patients do not stay neatly in the same category over time. Kelley and Bolllens-Lund note that two of the most important indicators—functional decline and caregiver strain—are poorly documented [11]. They have very useful insights into available data and methods to identify high-need, potentially high-cost community-dwelling patients. Even with the best prospective data, some discretion and oversight will be needed to triage appropriate patients and to titrate the intensity of services.

Challenge Three

Electronic health records for patient care, documentation, billing, and practice support are not consistently available across settings. This results in significant burden for community-based clinicians providing services in patient homes and reduces likelihood that insightful information from community-based providers is available to specialists and hospital staff. This can further reduce reliable communication for continuity of care for serious illness patients and increases the direct cost of community-based services. Solutions often require scale and investment and may be controlled by health systems.

Challenge Four

Often there is misalignment between the entity that must absorb the direct budget impact of an investment (costs) and the entity most likely to see budget improvement (savings) (Figure 1). Evaluations of costs or benefits often omit inputs that are not in the direct line of sight of the evaluating entity. For example, a payer may measure what it pays for a hospital stay, the hospital may measure the cost it incurs for the services, and a patient may evaluate out-of-pocket costs of different care options. Being realistic about these differences will support better design and alignment and facilitate appropriate investment for sustainable change.

Principles for Improving Adoption and Results

It is well recognized that our current patchwork of community resources, health care resources, insurance options, medical centers, ancillary vendors, and provider networks is fragmented and can be difficult to navigate. Most pilots come from one perspective, often that of a payer, health system, or large practice. Efficient and sustainable change is much more feasible through systemic change. The recent work of the North Carolina Institute of Medicine Task Force on Serious Illness Care illustrated the importance of doing the hard work of convening across roles, entities, and locales to build a shared set of priorities and establish a base for future collaboration [12]. The following principles focus on often-overlooked barriers or enablers to encouraging more explicit inclusion in design.

Principle One

Consistency across payers enables faster and more sustainable change in the care delivery system. To achieve efficiency, reduced risk of adverse selection, and lower complexity or overhead, consistent approaches should be adopted. For example, if a primary care practice has numerous payers and one of them begins paying differently for certain services or allows flexibility in design, it is impractical to change care practices for one payer. The practice has to do things
at least two ways and/or provide unreimbursed services to all patients. If, in contrast, a statewide coordinated initiative rolls out, the practice can retool, retrain, and invest in successful changes. Consistency also should reduce perverse incentives and adverse selection.

**Principle Two**

Sustainable changes in patient care utilization patterns require a multiyear perspective for evaluating impact and savings. Often, investments in start-up expenses and in direct care costs occur in year one, and changes in care patterns occur in year two or three. This longer time horizon doesn’t fit operating budget cycles. Therefore, it is appropriate to track start-up expenses separately from operating expenses, and to develop a multiyear budget. This is true for both payers and providers. For payers, the higher costs may be for supplemental services or payments. For providers, they may be for costs related to start-up of new services, staff, or changes in existing systems such as electronic record modifications. In both cases, the impact or benefit lags the investment.

**Principle Three**

People with serious illness usually will move between primary care and community-based services and tertiary care/specialty services. Focus on primary care practices, community-based supports, and care manager overlays is necessary but not sufficient. When the serious illness patient is periodically enveloped in specialty and tertiary care settings, the longitudinal knowledge of the patient may be lost and well-intended care may undermine patient priorities. Having a care team member who can provide meaningful presence (attending visits, supplementing health care literacy, helping the patient and caregiver navigate) may help ensure effective care and return to home. Integration with tertiary care is more complicated, but also ensures more reliable and aligned care.

**Principle Four**

Tertiary care settings and academic medical centers often have limited knowledge of community resources, making it harder to effectively discharge patients. Building knowledge and relationships and creating simple pathways in and out of care settings can help expedite appropriate care and reliable transitions. Investment in building bidirectional communication and processes is essential for sustaining high-quality solutions. Relationships are local. However, incorporating this approach into statewide goals with consistent approaches and ways to share breakthroughs across markets can expedite change.

**Perspective and Closing Comments**

The two months preceding this writing have been dominated by COVID-19’s disruption to lives, health care systems, community support networks, and our economy. The sudden shift of focus has highlighted amazing strengths within our communities, and also put the flaws of our systems into stark relief. In the serious illness realm, among many other things, we see the limitations of our advance care planning systems as we navigate access, signatures, legality, and intent. Staff whose roles shifted overnight need new skills and training. We struggle with access and new uses of telemedicine and video conferencing. We are jumping over traditional processes to put solutions in place. We can only guess at the disruption to health care budgets as normal services are cancelled and ICU triage expanded. Economic disruption and unemployment will have dramatic effects on insurance coverage and costs, and on state and local budgets.
How can we use this disruption to expedite change and build the systems we need to serve the serious illness population? Can we use the intense relationships and sense of shared purpose across organizational lines to build forward and tear down barriers? Consider these reflections from Don Berwick, former administrator of the Centers for Medicare and Medicaid Services, in 2004: “Year after year I can find only three messages at the core: focus on the suffering, build and use knowledge, and cooperate . . . Why do we continue trying to make great health care out of disconnected, separately perfected fragments instead of weaving the fabric of experience that our patients need from us?” [13]. Our current systems have evolved over the past 30 years, adjusting to incremental changes and creating layers of complexity and workarounds. What can we do to reconfigure care to add value, use people’s talents more effectively, and reduce costs, while improving care for patients with serious illness?

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**References**

1. BlueCross BlueShield of North Carolina. Care 360 – Specialized Support Services and Palliative Care. Blue Cross NC website. https://www.bluecrossnc.com/provider-news/care-360-specialized-support-services-and-palliative-care#search=palliative%20care%20Palliative%20Care. Updated October 31, 2019. Accessed April 15, 2020.

2. Chen CY, Thorsteinssott B, Cha SS, et al. Health care outcomes and advance care planning in older adults who receive home-based palliative care: a pilot cohort study. J Palliat Med. 2015;18(1):38-44. doi: 10.1089/jpm.2014.0150

3. Davis MP, Temel JS, Balboni T, Glare P. A review of the trials which examine early integration of outpatient and home palliative care for patients with serious illnesses. Ann Palliat Med. 2015;4(3):99-121. doi: 10.3978/j.issn.2224-5820.2015.04.04

4. North Carolina Department of Health and Human Services. Healthy Opportunities Pilot Service Fee Schedule. New York, NY: Manatt, Phelps & Phillips, LLP; 2019. https://www.manatt.com/Manatt/media/Documents/Articles/NC-Pilot-Service-Fee-Schedule_Final-for-Webpage.pdf. Accessed April 14, 2020.

5. North Carolina Department of Health and Human Services. Healthy Opportunities Pilots Overview. NC DHHS website. https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots/healthy-0. Accessed April 15, 2020.

6. Cohen M, Tilson EC, Dutton M, et al. Buying Health, Not Just Health Care: North Carolina’s Pilot Effort. The Commonwealth Fund website. https://www.commonwealthfund.org/blog/2020/putting-price-social-services-north-carolinas-pilot-effort. Published January 27, 2020. Accessed April 14, 2020.

7. Center to Advance Palliative Care. Population Management and Palliative Care. CAPC website. https://www.capc.org/toolkits/population-management-and-palliative-care/. Updated March 4, 2019. Accessed April 14, 2020.

8. Kennedy W, Hardin L, Kinderman A, Meier DE, Loughnane J, Volandes A. Five strategies to expand palliative care in safety-net populations. NEJM Catalyst Innovations in Care Delivery. 2020;1(2). doi: https://doi.org/10.1056/CAT.20.0004

9. Accountable Care Learning Collaborative. Providing Early Palliative Care Interventions for Patients with Serious Illness: Sharp HealthCare’s Approach. San Diego, CA: Accountable Care Learning Collaborative; 2017. https://www.accountablecarec.org/sites/default/files/ACLC_CS_B_Sharp_Final.pdf. Accessed April 15, 2020.

10. Cambia Health Solutions. Palliative Care and Caregiving. Cambia Health Solutions website. https://www.cambiahealth.com/about-us/palliative-care-and-caregiving. Accessed April 14, 2020.

11. Kelley AS, Bollens-Lund E. Identifying the population with serious illness: the “denominator” challenge. J Palliat Med. 2018;21(S2):S7-S16. doi: 10.1089/jpm.2017.0548

12. North Carolina Institute of Medicine. Improving Serious Illness Care in North Carolina. Morrisville, NC: North Carolina Institute of Medicine; 2020. http://nciom.org/wp-content/uploads/2020/06/NCIOM_Improving-Serious-Illness-Care-in-North-Carolina_Full-Report_April-2020.pdf. Published July 2020.

13. Berwick DM. Escape Fire: Designs for the Future of Health Care. San Francisco, CA: Jossey-Bass; 2004.