

Payment for Community-Based Palliative Care in Oregon: Environmental Scan

March 2024

House Bill (HB) 2981 (2021) directs the Oregon Health Authority (OHA) to administer a program to provide palliative care services through coordinated care organizations (CCOs). OHA's Transformation Center staff interviewed CCO medical directors, palliative care providers, and members of the [Palliative Care and Quality of Life Advisory Council](#) (PCAC) between October and December 2023. These interviews aimed to better understand the current palliative care service delivery and payment structures, identify challenges in paying for palliative care in Oregon and assess CCOs' level of interest in collaboratively developing a payment model.

Although there was not enough interest from CCOs to convene a work group to develop a payment model, the Transformation Center is supporting CCOs by sharing the findings from the 2023 interviews. These findings are presented in this document, along with a set of web-based resources that support the delivery of and payment for community-based palliative care.

Environmental scan interview process

In interviews that were 15–60 minutes, Transformation Center staff asked CCOs, providers, PCAC members and other community partners the following general questions:

1. What is your perspective on the current payment and delivery system for palliative care services in Oregon? What is working well in this regard?
2. What obstacles do you face while trying to improve the delivery of palliative care services in Oregon? What challenges have you encountered in your work?

CCOs were asked the following questions:

1. What palliative care services do you currently cover? Which types of providers can be reimbursed for providing these services?
2. How do you currently reimburse providers for palliative care services?
3. What has been your experience of working and contracting with palliative care providers? Have you faced any workforce challenges?

4. What services described in HB 2981 are *not yet* covered by you? What are your plans for covering them in the future? Are you considering any other changes in how you provide palliative care services?
5. What are your ideas for improving the delivery of palliative care services?

Providers, PCAC members, and community partners were asked the following questions:

1. What is your experience providing palliative care in Oregon?
2. How are services currently being paid for? Are there any services that aren't being reimbursed appropriately?
3. Please share your experiences working with patients to provide palliative care. What have you observed about how our current system is operating? What patient needs are not being met?
4. What types of providers do you collaborate with to support palliative care delivery?
5. We are considering how workforce shortages might impact palliative care teams. How have provider availability and/or workforce shortages affected the way you operate? Have you used telehealth to deliver services?
6. We are considering how palliative care delivery may vary by geography (urban vs. rural service delivery), insurance type, and other demographic factors (race, age, language, etc.). What have you experienced or observed about how these differences impact patients?

Key findings from interviews

The following eight key themes emerged across the interviews:

- **Community-based palliative care is not available through all CCOs.** In many regions, palliative care services are only available through hospitals, with limited follow-up after discharge. When community-based care is available it is often only for a consult.
 - “Most hospitals have a palliative care program... but they have no mechanism for following up with the patient after discharge.” – CCO medical director
 - “There is a huge deficit in home-based services for those who are not in hospice care. Many hospitalizations could be prevented if services were available at home.” – Oregon Palliative Care and Quality of Life Interdisciplinary Advisory Council member, palliative care provider
- **The majority of CCOs are not providing all the services required by HB 2981.** The services most frequently excluded are spiritual care and 24/7 telephone support. The

CCOs that do provide coverage for these services often do so by providing access through existing hospice providers.

- “Implementing the 2021 legislation will be a real challenge. There’s not enough demand, not enough interest or funding, and hospitals would need to see that it would be economical for them.” – CCO medical director
- “Palliative care patients benefit from 24-hour clinical telephone support and spiritual care services already available for hospice patients.” – CCO medical director
- **Fee-for-service billing does not adequately support community-based palliative care to provide the services required in HB 2981.** Fee-for-service cannot support non-billable services or providers, such as 24/7 telephone support, nurse visits and spiritual care. Value-based payment arrangements may provide more flexibility to support team-based care inclusive of a full range of necessary services, including those that are not currently billable.
 - “Fee-for-service doesn’t support holistic care.” – CCO medical director
 - “Demand exceeds the ability to serve people under the current reimbursement system. People are turned away who could benefit because they cannot afford to pay privately.” – Palliative care provider
 - “The challenge has been funding and reimbursement.” – CCO medical director
 - “Registered nurses are not able to bill for their services.” – Oregon Palliative Care and Quality of Life Interdisciplinary Advisory Council member, health care researcher
- **Workforce challenges are a significant barrier for rural CCOs.** A lack of trained providers in rural and urban areas makes it difficult to provide team-based palliative care and workforce development programs are needed. There is interest in exploring creative ways to provide palliative care services in rural areas, including using telehealth, community health workers and existing home health and hospice providers.
 - “Workforce shortages will be our largest challenge.” – CCO medical director
 - “The primary barrier is a lack of trained providers in rural areas. In rural Oregon, this will fall to primary care. There’s no one else who does this, and no one else to contract with.” – CCO medical director
- **Providers and CCOs do not have the data needed to deliver and measure quality care.** Providers need actionable utilization data to assess the needs of their population and identify patients who may need additional supports. To assess quality and cost savings, CCOs need to know what non-billable services are being provided, the cost of

those services, and whether the visits help reduce hospitalizations. It is not easy to capture and report out this data in many electronic health records.

- “The data doesn’t exist yet. The electronic health record isn’t currently set up to capture non-billable procedures.” – Oregon Palliative Care and Quality of Life Interdisciplinary Advisory Council member, health care researcher
- “There has to be communication between folks looking at utilization data and folks making population decisions. Getting this data can be challenging. CCOs have to be comfortable sharing data with providers.” – Oregon Palliative Care and Quality of Life Interdisciplinary Advisory Council member, palliative care provider
- **Palliative care services tailored specifically for children are limited throughout the state.** Children receiving palliative care services have unique needs. Without providers who have expertise in caring for children, pediatric patients may not receive the best possible care. Due to the differences in the care required, it may be necessary to consider alternative payment mechanisms for children’s palliative care.
 - “Palliative care is not the same for everybody...kids are unique and have unique needs...unless there is a pediatric-specific emphasis...we’re going to default to the greatest need (adults) and kids are potentially going to be left out of the mix...There is an innovative program in upstate New York in a similar population area and geographic catchment area where providers receive an assured monthly payment based on prognosis. They are able to staff up pediatric programs that cover a wide swath of not just conditions but geographic areas...We need to consider possibilities ...that might lead to a specific payment model based on children and prognosis specifically not expecting to live to age 21 which is commonly used in other jurisdictions.” – Oregon Palliative Care and Quality of Life Interdisciplinary Advisory Council member, pediatric palliative care provider
- **Value-based payment models may be challenging for providers to implement.** Providers expressed concern about the possible administrative burden of new payment models, particularly when fee-for-service payments are combined with value-based payments. Participants felt that such hybrid models could be excessively complicated to administer and may not do enough to reduce emergency department utilization.
 - “This sounds very complicated to have a hybrid model — very high maintenance, very labor intensive on both sides, for the CCO and for someone at the palliative care program to figure out what goes on this claim, or when to submit a claim. So, I would not advocate for that.” – Oregon Palliative Care and Quality of Life Interdisciplinary Advisory Council member, palliative care provider
 - “I don’t think the hybrid model is going to deliver the kinds of outcomes that the CCOs would want, which is preventing unnecessary ER visits and unnecessary hospitalizations.” – Oregon Palliative Care and Quality of Life Interdisciplinary Advisory Council member, palliative care provider

- **Building successful community-based services requires thoughtful planning and close collaboration with community partners.** In certain regions, the community may lack familiarity with referring patients to palliative care programs. To improve patient experience and impact utilization, programs must be thoughtfully designed and developed with the involvement of community partners.
 - “No one in this community is used to making palliative care referrals.” – CCO medical director
 - “Planning requires a significant investment in time with community partners. Make sure there is a mutual understanding of what palliative care is and what you hope to achieve. Get specific about program design, patient eligibility, and payment process but build in flexibility to new contracts up front to allow for evolution of the work.” – palliative care provider

CCO success case: CareOregon’s support for palliative care through Housecall Providers

CareOregon has provided a community-based palliative care benefit for 14 years. Since 2017, CareOregon has partnered with Housecall Providers to deliver this care to metro-area members. Through the Advanced Illness Care (AIC) program, Housecall Providers supports patients diagnosed with a serious illness. They provide ongoing symptom management, care coordination, medication management, advance care planning, social and spiritual support, housing and social determinants support, and more. As it exists today, the AIC program is delivered by a team of nurses, social workers, a chaplain, a pharmacist, and community health workers. The program is growing, with the average monthly census increasing from 40 to 140 patients per month since 2017.

Many of the patients who receive services through the AIC program have complex medical and social support needs. According to Kelly Ambrose, director of the AIC program, many patients are living in poverty, socially isolated, and lack support in navigating the healthcare system. Many are experiencing mental illness, substance use disorder, and/or lack of permanent housing, with “nearly half of our patients experiencing one of these, and 10-15% of our patients experiencing a combination of all three.” To address this level of complexity, Housecall Providers relies on a robust team model to provide supports for “the symptoms and stress of serious illness, including team members focused on addressing complex social needs.”

CareOregon pays for the program using a per-member-per-month rate that covers all the essential services provided through the AIC program, with an additional payment for housing navigation and support. When the program began in 2017, CareOregon also provided a bonus payment that was tied to performance on quality metrics. Because Housecall Providers met these performance targets for several consecutive years, that additional payment is no longer contingent upon measure performance, though measure performance is still tracked as part of the program. CareOregon uses process measures and quality measures, both designed to ensure high-quality care for patients receiving AIC services.

AIC process measures include:

- Patients enrolled in services
- Patients with individualized care plans
- Length of stay
- Utilization
- Percent of patients who transition to hospice or home-based primary care
- Documented goals of care conversations
- Identification of surrogate decision-maker
- Patients housed or eviction prevented

AIC quality measures include:

- Timely transitional care support
- Patient and caregiver satisfaction
- Provider satisfaction
- Utilization rates
- Goal concordant care
- Completion of advance care planning

According to Ambrose, this payment model makes it possible for Housecall Providers to “offer more robust services and individualize the care plan for each of our patients depending on what their care needs are” and also “flex services up or down as frequently as patients need.” Housecall Providers doesn’t believe it would be possible to provide this level of robust support around social determinants of health using fee-for-service billing. Because of the flexibility provided by the payment model, Ambrose says the AIC program is uniquely able to provide the full range of medical and social supports that patients with serious illnesses need. CareOregon and Housecall Providers are planning to expand the model to additional regions beginning in 2024.

Palliative care payment resources

Although these resources are not comprehensive, they represent a selection of materials designed to support health plans, providers, and other organizations in expanding access to high-quality community-based palliative care services for patients.

[Center to Advance Palliative Care](#)

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to increasing the availability of quality, equitable health care for people living with serious illness. As the nation’s leading resource in its field, CAPC provides health care professionals, health plans and other organizations with the training, tools, and technical assistance necessary to effectively meet this need.

[Patient and Caregiver Support for Serious Illness](#)

The American Academy of Hospice and Palliative Medicine (AAHPM) developed the Patient and Caregiver Support for Serious Illness (PACSSI) alternative payment model (APM) to address barriers in the payment system to allow for the delivery of community-based palliative care medical home services to high-need patients who are not eligible for or ready to elect hospice care. The PACSSI APM was developed by an AAHPM-convened panel of national palliative care leaders, who sought iterative input from numerous relevant stakeholders to meet the panel's goal of maximizing Medicare beneficiaries' access to high-value palliative care services.

[National Academy for State Health Policy \(NASHP\) Palliative Care Resource Center](#)

The NASHP Palliative Care Resource Center provides a variety of resources for state Medicaid programs to implement and expand community-based palliative care programs. An FAQ page provides basic information about palliative care and how it is typically paid for by state Medicaid health plans.

[NASHP report: "Palliative Care in Medicaid Costing Out the Benefit: Actuarial Analysis of Medicaid Experience"](#)

NASHP partnered with Optumas and Torrie Fields Analytics to analyze the impact of a palliative care benefit in Medicaid and provide an actuarial analysis. The report outlines a method for estimating the financial impact of offering palliative care to Medicaid enrollees and highlights the potential cost savings for those members utilizing the benefit, finding a potential return on investment ranging between \$0.80 and \$2.60 for every \$1 spent on palliative care.

[Clinical Practice Guidelines for Quality Palliative Care, 4th Edition](#)

This document provides nationally endorsed, best-practice guidance for providing palliative care services, including clinical and organizational strategies, screening and assessment tools, practice examples, and other resources. It is available as a free PDF download online or for hard copy purchase.

[MessageLab Evidence-Based Messaging for Serious Illness Care](#)

The MessageLab Toolkit provides resources for messaging around palliative care, developed by a group led by Tony Back at the University of Washington, with work funded by the Cambia Health Foundation and John A. Hartford Foundation. The toolkit is based on a review of palliative care literature, a stakeholder design process, focus groups and collaboration with other national research projects.

[Transforming Care Partners Toolkit](#)

The Transforming Care Partners Toolkit is part of an initiative funded by the California Health Care Foundation to advance palliative care within the state. The toolkit is designed to support health plans in expanding access to equitable and high-quality

outpatient and home-based palliative care services. It includes resources to help health plans advocate for, develop a business case for, and formulate plans to increase access to palliative care services for members.

[Designing and Implementing Community-Based Palliative Care: A Guide for Payers](#)

The focus of this toolkit is on the decisions, questions, and considerations that go into designing and implementing a community-based palliative care program from a payer's perspective. The information presented in this toolkit is based on the valuable insights and lessons learned from a health insurance company's experience, which ultimately led from a pilot to an operational state-wide program.

[Oregon Hospice and Palliative Care Association](#)

The Oregon Hospice and Palliative Care Association is a statewide public benefit organization that helps to ensure that Oregonians have access to high-quality hospice and palliative care services. The association's services include public and professional education, advocacy, research, consultation and leadership. The association also provides resources and education for patients receiving palliative care services and their families.

[Washington Palliative Care Payment Model](#)

The Oregon Health & Science University Center for Evidence-Based Policy produced a report for the Washington Health Care Authority in March 2023 that looks at reimbursement options for palliative care services. The report recommends adopting a hybrid payment model that consists of traditional fee-for-service components and alternative payment model structures based on the [Patient and Caregiver Support for Serious Illness](#) model published by the American Academy of Hospice and Palliative Medicine.

[The Washington Rural Palliative Care Initiative](#)

The Washington Rural Palliative Care Initiative (WRPCI) is an effort to provide better services to patients with serious illnesses in rural communities, led by the Washington State Office of Rural Health at the Washington State Department of Health. This initiative is a public-private partnership with more than 24 organizations to integrate palliative care into multiple settings, including emergency departments, inpatient settings, skilled rehabilitation, home health, hospice, primary care, and long-term care. The WRPCI website includes a 2018 report on the use of telehealth to provide palliative care in rural settings.

[California Palliative Care Payment Model](#)

California passed Senate Bill 1004 in 2014. The law required the state to “establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services” while remaining cost-neutral. While California's Medicaid program does not require managed care organizations (MCOs) to use a

specific payment model, it does monitor for quality of care and require MCOs to meet performance standards. According to a [survey](#) conducted by California Healthcare Foundation and the Coalition for Compassionate Care of California in 2021, MCOs most often used a per member per month payment to cover palliative care services.

[Palliative Care in Medi-Cal \(SB 1004\) Resource Center](#)

Senate Bill 1004 (SB 1004) is the California law that requires Medi-Cal managed care plans to provide access to palliative care. Explore the California Health Care Foundation’s collection of tools and resources aimed at helping organizations implement, sustain, and improve programs providing palliative care to Medi-Cal enrollees under SB 1004.

[Coalition for Compassionate Care of California: Palliative Care Tools and Resources](#)

The California Coalition for Compassionate Care provides a collection of palliative care resources for healthcare providers and consumers. Resources include an “Introducing Palliative Care” video series, decision aids for healthcare providers, and educational webinars on advance care planning and other topics related to serious illness.