Fundamentals of a Palliative Care Benefit for Public and Private Insurance Plans

OIC Palliative Care Benefit Workgroup
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Objectives

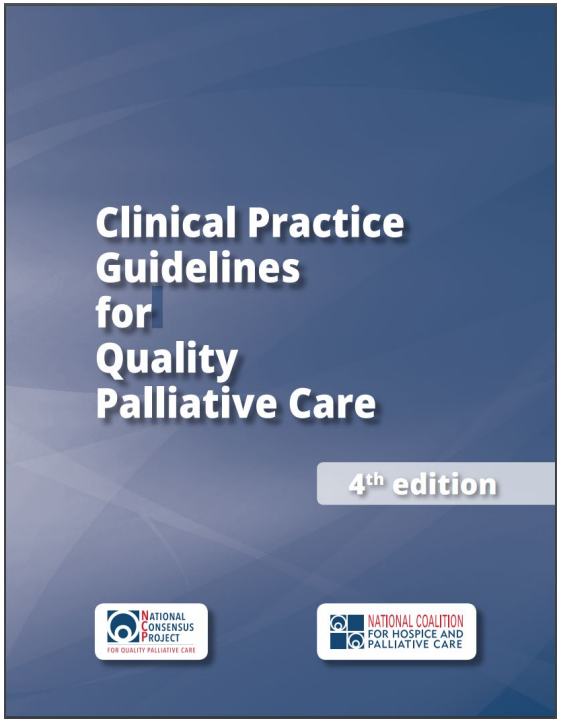
- Define clinical domains and services within both primary and specialized palliative care
- Review coverage and deficits in coverage for palliative care in historical payment structures
- Describe elements included in successful community-based palliative care models
- List essential elements for a comprehensive, cost-effective palliative care insurance benefit

Clinical Practice Guidelines: 8 Domains of Palliative Care

1. Structure and Process of Care
2. Physical
3. Psychological and Psychiatric
4. Social
5. Spiritual, Religious and Existential
6. Cultural
7. Care of the Patient Nearing the End of Life
8. Ethical and Legal Aspects of Care

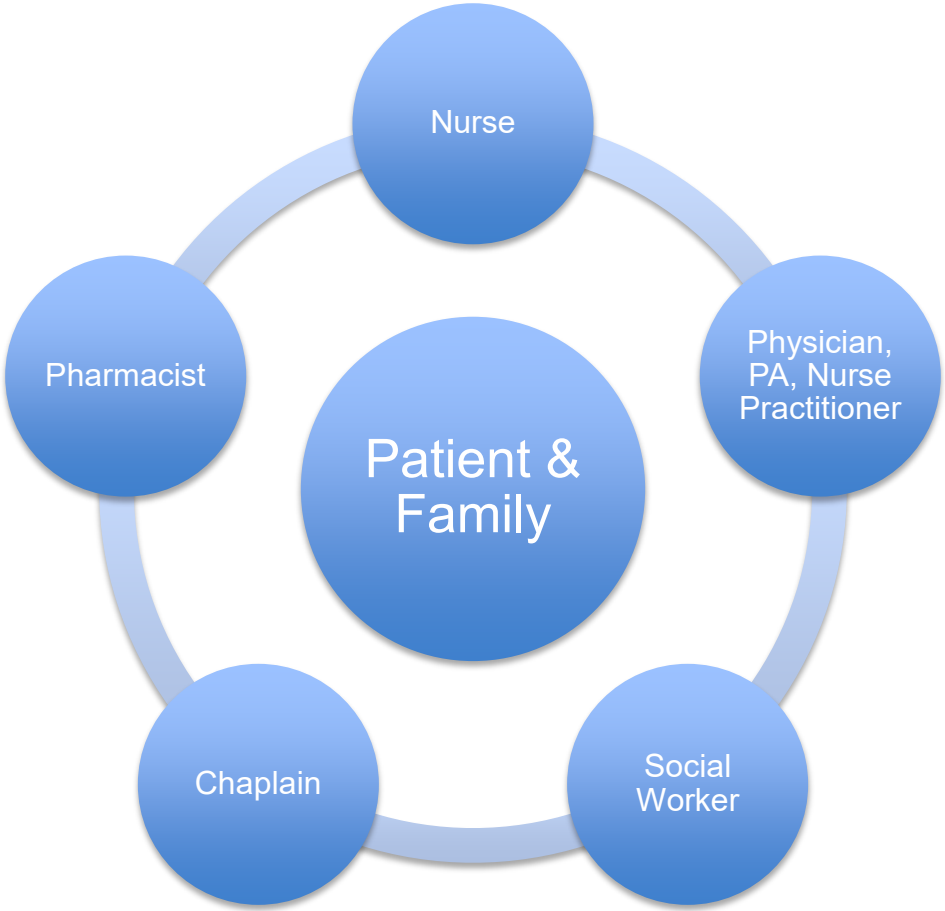
The National Consensus Project for Quality Palliative Care

- NCP Guidelines - National Coalition for Hospice and Palliative Care

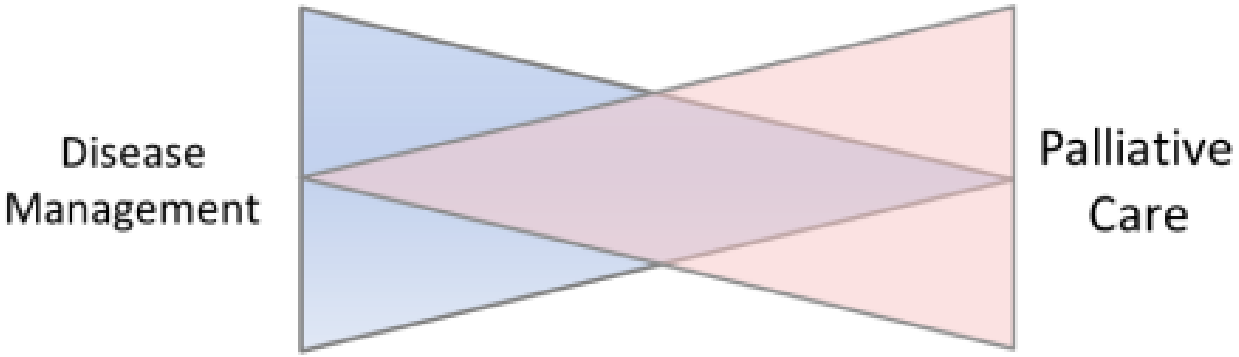


Providence St. Joseph Health

The Core Interdisciplinary Team

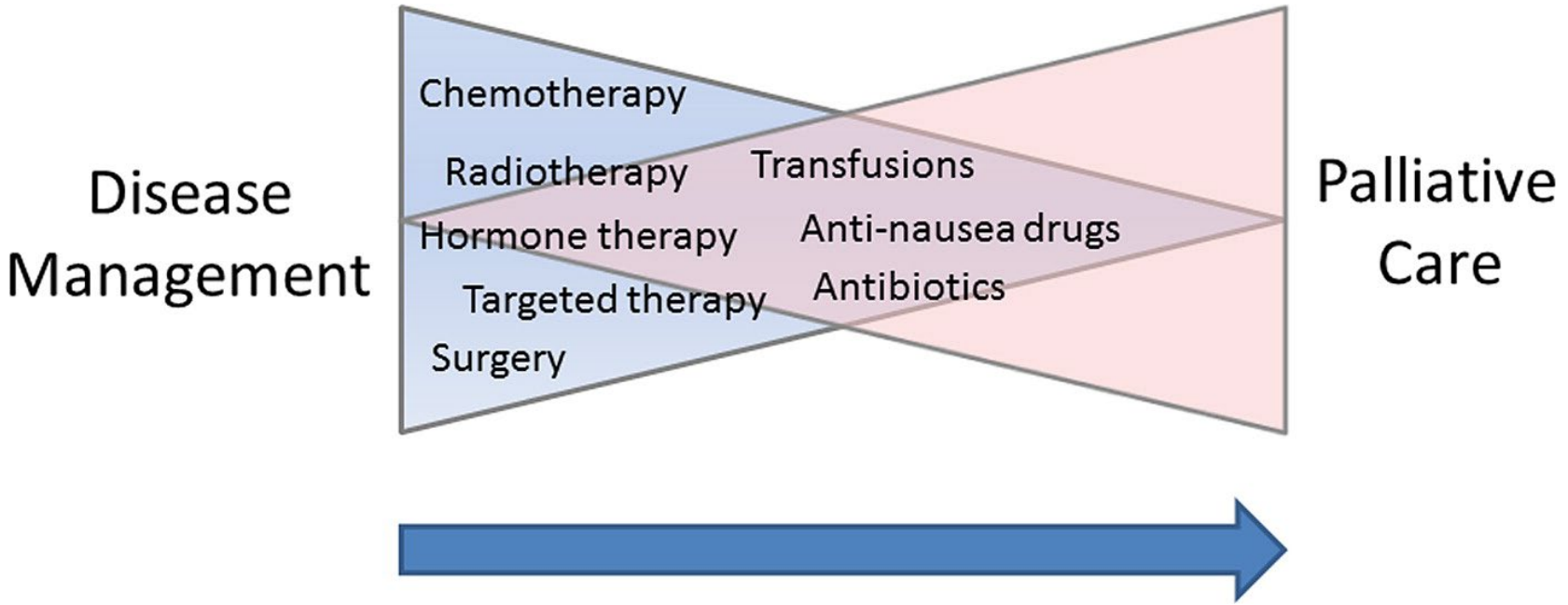


Basic Model of Integrated Palliative Care

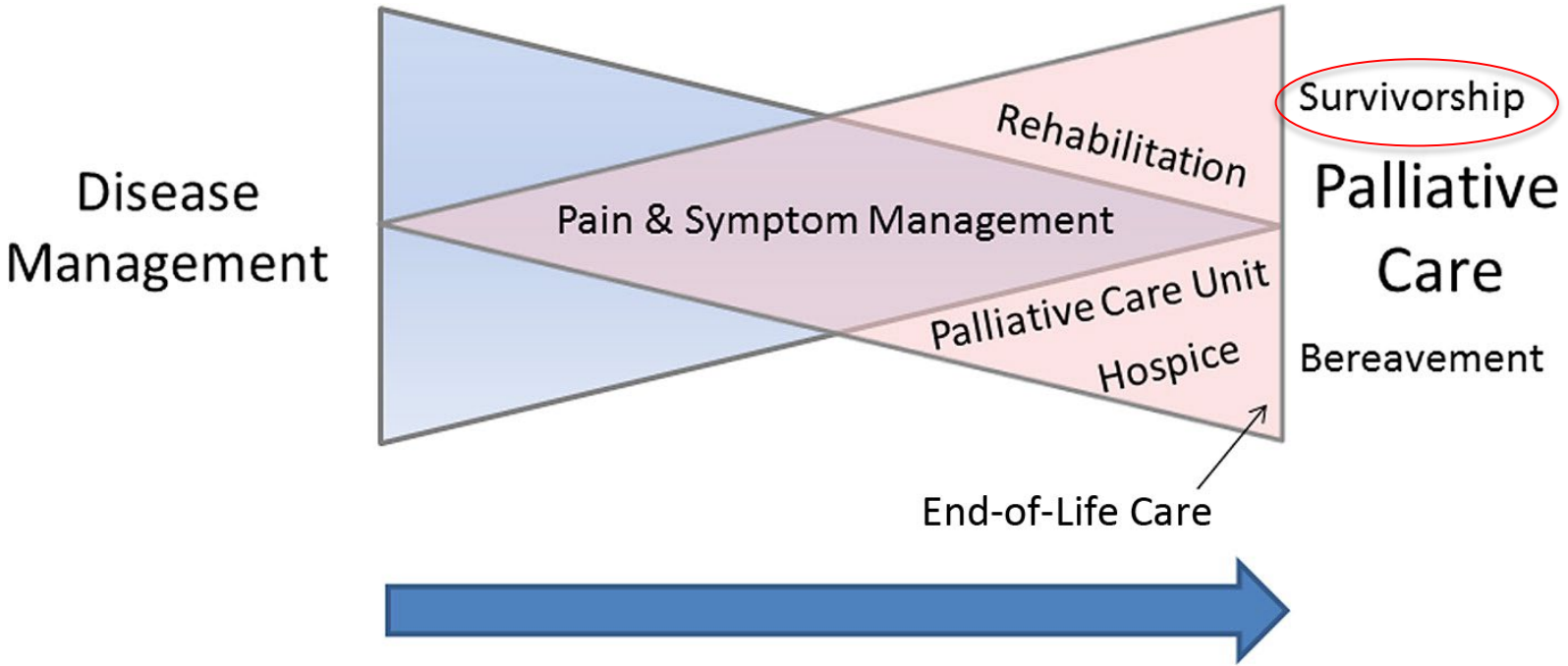


- Hawley PH. *J Pain Sympt Mgt*. 2014 Jan;47(1):e2-e5.

Disease Management-Enhanced Model



Palliative Care-Enhanced Model



Potential triggers for treatment goal discussions

- Prognosis-related triggers (e.g., the “surprise question”)
  - “Would I be surprised if this patient dies within the next year or two?”
- Older than 80 and hospitalized
- Specific diagnoses: Stage IV cancer, NYHA Class IV heart dz, ESKD on dialysis, pancreatic Ca, GBM, dementia w/ FAST score of 7
- Multiple advance comorbid conditions
- Progressive functional decline
- Absence of disease-specific treatment options

Skill Sets for Primary and Specialty Palliative Care

- Primary Palliative Care
  - Pain/symptom management
  - Depression/anxiety management
  - Discussions about
    - Prognosis
    - Goals of treatment
    - Suffering
    - Code status
  - Quill & Abernathy, *NEJM* 2013
- Specialty Palliative Care
  - Complex pain/sx mgt
  - Management of complex depression, anxiety, grief, existential distress
  - Assistance with conflict resolution regarding goals or methods of treatment
    - Within families
    - Between staff and families
    - Among treatment teams
  - Assistance in cases of “futility”

Primary Palliative Care

- Nearly all physicians provide some level of palliative care
- Three key areas of care required for all patients
  - Assessment and control of pain and symptoms
  - Provision of psycho-emotional, social and family support and care
  - Discerning treatment goals and aligning with available treatment options
    - Includes **assessment** and referral to specialist services when needs exceed the primary provider or service's capacity (resources or clinical expertise)

Specialized Palliative Care

- Provide specialist care to patients with complex symptoms or decisions around treatment goals
- Provide consultation and direct care in partnership with primary service/practitioner
- Substantive work is with patients who have life limiting illness
- Interdisciplinary team provides additional resources

Palliative Care is not simply upstream hospice

- Today, palliative care specialists:
  - Provide palliative treatment in earlier stages of disease alongside disease-directed medical care
  - Improve quality of care and medical decision making regardless of the stage of illness
  - Are increasingly integral to capitated (risk) services provided to patients with advanced and chronic progressive illness(es)
- Historical model: either curative care or comfort care
- Concurrent care model: curative care and palliative care together
  - Palliative care = supportive care

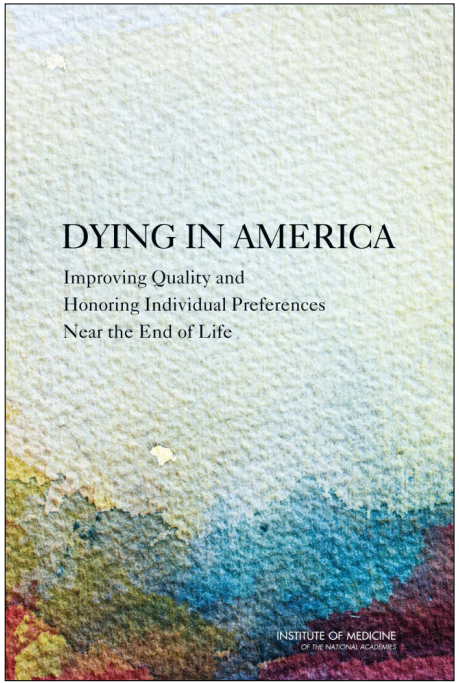
Benefits of team-based approach

- Central concept to both PC and the patient-centered medical home
- Encourages multiple perspectives
- More efficient use of time and resources
- Shares workload
- Encourages team communication
- Allows individuals to maximize their contributions within scope of their license, education, abilities, and interests

Primary Care Providers are critical for access to palliative care for all

"All people with advanced serious illness should have access to skilled palliative care or, when appropriate, hospice care in all settings where they receive care (including health care facilities, the home, and the community). "

Institute of Medicine (Sept 2014)



Medicaid: Filling a Gap with Palliative Care Services

As part of a comprehensive review of services, we found that:

1. There is no palliative care “benefit” available in any setting.
2. Palliative Care Services are being delivered in 68% of all hospitals with over 100 beds, most through an interdisciplinary team. These are reimbursed through the DRG payment
3. Palliative Care Consultations are required as part of the prior authorization for certain invasive procedures (e.g., LVAD)
4. Some palliative care assessments and consultations are available in the clinic or at home today, but these services are billed “a la carte”, and often to not include an interdisciplinary team that can support a person’s holistic needs longitudinally. Access is subject to workforce availability and provider competency, with no current network adequacy requirements.
5. The only time PC is part of a coordinated benefit is through hospice care, which focuses on managing comfort at the end of life rather than supporting people with serious illness who continue to pursue treatment.
6. Concurrent care services for hospice are available for children under EPSDT, but access is limited due to the need to meet 6-month prognosis requirements.

This lack of coordinated palliative care in the community leaves a **gap in care** for people with a serious illness that should be closed with a coordinated benefit that **requires an interdisciplinary team and a payment model that supports all aspects of palliative care**.

Decisions Needed to Develop a Benefit

1. Define palliative care services
2. Identify gaps in coverage/services
3. Determine what services need to be covered and how
4. Determine the policy route to take
5. Identify the population in need
6. Setting a baseline based on experience
7. Determine how many people might access services
8. Determine the cost of the services offered
9. Determine if the costs can cover services delivered and how much the state can afford
10. Understand the value of delivering the benefit
11. Determine the impact on the premium and if there is budget neutrality/cost savings

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Improving Health Equity through Increased Representation

Stakeholder feedback is needed to ensure that the benefit designed meets the needs of people with serious illness in the state and their caregivers. Community stakeholders and clinical leaders are crucial to **ensuring access and representation in the local community**.

What needs to be collected:

- Determining who would be most appropriate for services
- Determining provider capacity, competencies, and training needed to deliver services
- Understanding the “ideal” care model
- Understanding the up-front capital investment needed to deliver services and ongoing costs, including staffing, administration, and other infrastructure
- Setting expectations for outcomes from services, including quality and reporting
- Identifying additional needs to support equity and access, including public engagement, provider education and training, and consumer protections

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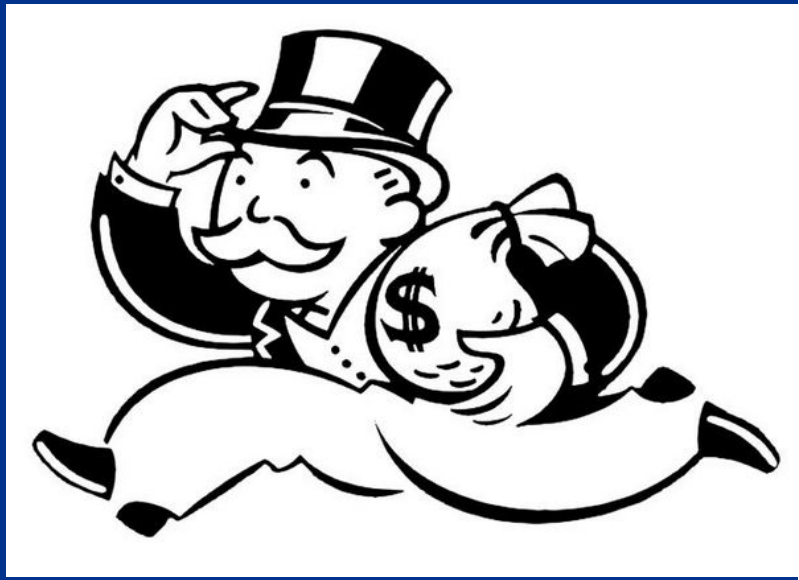
Types of CBPC

- Clinic
  - Free standing
  - Embedded in specialty clinic
- Home health
- Hospice
- SNF, LTC, ALF, AFH
- Tele-health

Who Sponsors CBPC Programs?

- Hospitals
- Home Health programs
- Hospices
- Medical Groups
- Independent Programs
- Volunteer Coalitions
- PACE
- Integrated Payer-Provider Systems



Traits of Successful CBPC Programs

- Value-based contracts
  - Fee-for-service alone not financially sustainable
- Strong provider presence
- Patients assigned a level of acuity that determines frequency and comprehensiveness of encounters
- Clearly defined scope of services
- Strong relationship with primary care and relevant subspecialties
- 24-hour call center
  - May be shared with hospice or acute care PC service

Advice From a Successful CBPC Program

- Define success measurements from the outset
- Know your costs
- Plan for costs of expansion, growth, education, training
- Leverage support, assets from pre-existing infrastructure
- Be prepared to course correct based on feedback and data

- Adapted from Russell Kiefer, Providence Home and Community Care, Southern California

Sample Care Model

- Initial assessment - RN
  - Reviews eligibility guidelines, determine whether to admit to service or if home health or hospice is more appropriate
- Initial assessment – provider
  - Symptom assessment, general management plan
- Based on acuity, determine frequency of scheduled visits
- After hours calls received by triage nurse, who calls on-call provider or follows up the next day
- Social work involved in care planning and/or by referral
- Spiritual care by referral

Population Profile & Risk Assessment

Population Profile

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Overall population and coverage types

People with diagnosis of serious illness

People with serious illness + utilization

Population prevalence by age category and condition

Risk Assessment

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Baseline inpatient costs and utilization

Baseline emergency department costs and utilization

Baseline hospice utilization

Estimated utilization of palliative care services

Estimated savings based on fully realized benefit and initial 5-year rollout

"Break even" amount by coverage type (differs for Medicaid and Duals)

Cost Modeling

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Discussions about provider staffing/service expectations, and associated costs

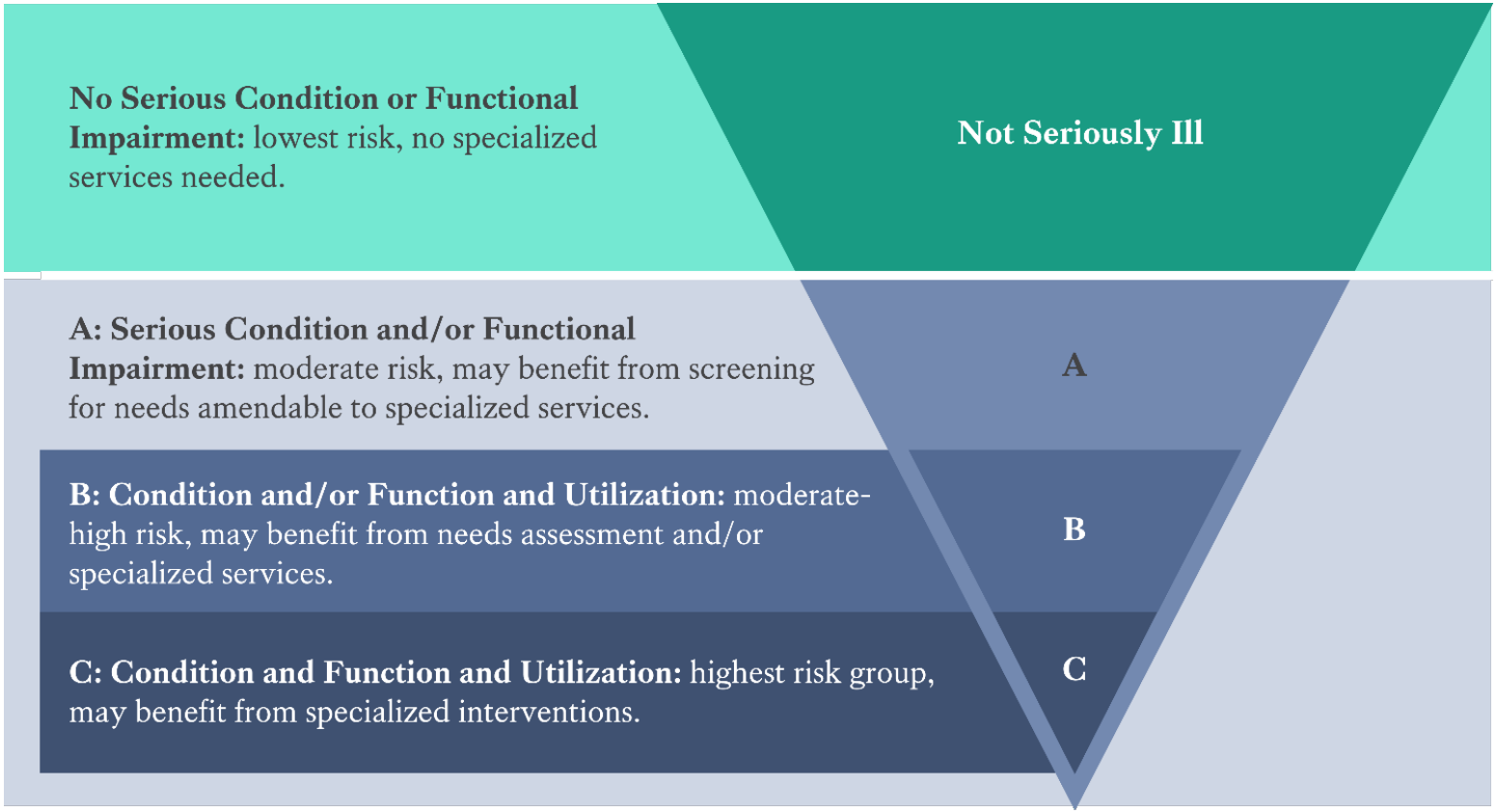
Payment methodology (Tiers? Bundled payments? What's inside and outside the bundled rate?)

Estimating rates for services that will still achieve budget neutrality ("break even") and other cost savings goals for each state

Development of a Cost Calculator

- Define Eligibility
- Define Outcomes
- Define Care Team
- Define Services

Process of Identifying the Target Population



Billing and Coding for Bundled Payment

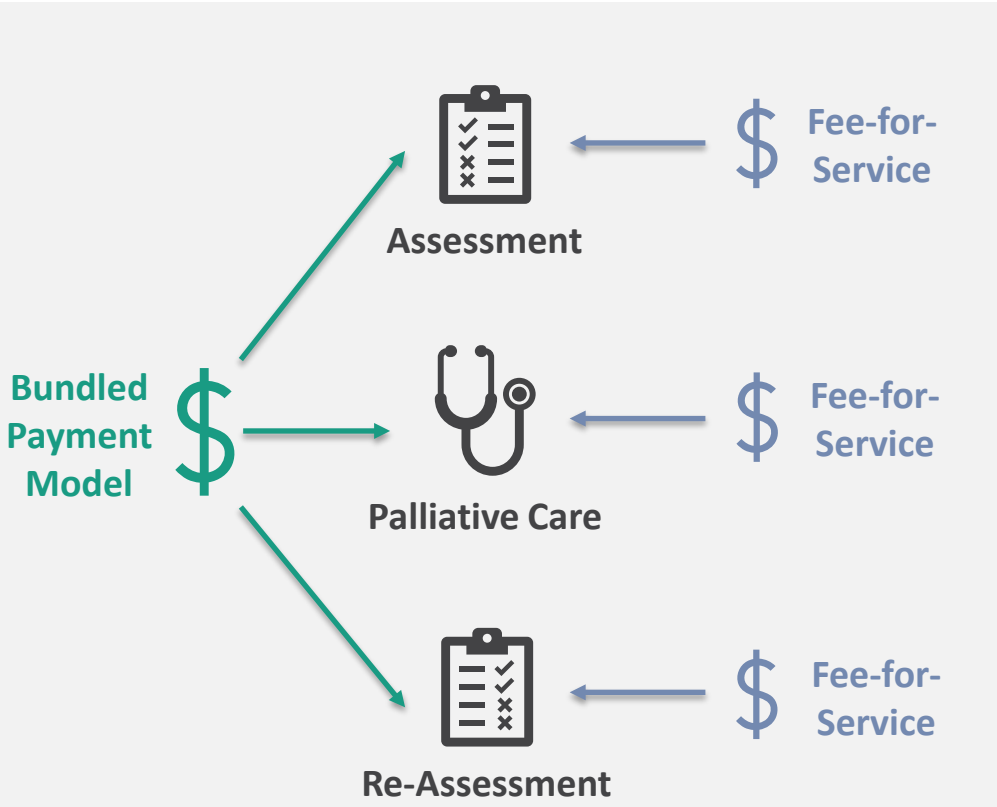
Palliative care delivered by an interdisciplinary team can be supported by episodic reimbursement through a bundled payment rate.

The bundled payment model includes three components:

1. Assessment and referral to Palliative Care Services

2. Re-Assessment for services for ongoing enrollment

3. Per enrolled member-per month bundled payment rate to cover all palliative care services and providers included in the interdisciplinary palliative care team



State Trends and Lessons Learned

Savings and Cost Considerations

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- Differences in baseline costs
- Under-reported costs
- Coding accuracy
- Differences in savings calculated

Utilization Considerations

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- Palliative care drives cost savings
- Reallocate savings to palliative care
- Savings from less inpatient, emergency, and facility stays
- Longer length of stay costs

Resources

- Making the Case for Outpatient Palliative Care - California Health Care Foundation (chcf.org)
  - https://www.chcf.org/publication/making-case-outpatient-palliative-care/#being-ready
- Center to Advance Palliative Care:
  - https://www.capc.org/palliative-care-community/
  - Monograph: “The Case for Community-Based Palliative Care” https://www.capc.org/documents/download/867/ (behind members-only paywall)
- National Quality Forum – Opportunities for Advancing Quality Measurement in Community-Based Serious Illness Care. 2020.
  - NQF: Opportunities for Advancing Quality Measurement in Community-Based Serious Illness Care

Resources

- Quill TE and Abernathy AP. Generalist plus specialist palliative care – creating a more sustainable model. N Engl J Med. 2013; 368(13):1173-1175.
- Center to Advance Palliative Care, “Clinical Training Recommendations for All Clinicians Caring for Patients with Serious Illness.”
  - https://www.capc.org/clinical-training-recommendations-for-all-clinicians-caring-for-patients-with-serious-illness/