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PALLIATIVE CARE: CHARTING A COURSE
MEETING OF THE PATIENT QUALITY OF LIFE COALITION
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PRESENTATION ROADMAP

- Review the current status of palliative care coverage and payment
- Talk about possible overarching policy goals
- Acknowledge important contextual issues
- Pose key questions in need of discussion
- Identify a possible option menu for further discussion and development
THE CURRENT SITUATION IN BRIEF

- Private insurance coverage of palliative care services varies but is considered “better” than Medicare/Medicaid

- According to the Center to Advance Palliative Care, notable private insurer policies/programs include the following:
  - Aetna: (1) under the Compassionate Care program, embedded care managers (employed and trained by Aetna) in physician practices, with PMPM incentive payment contingent on meeting certain quality outcomes; (2) “liberalized” hospice benefit for patients with up to a 12-month prognosis
  - Excellus BlueCross BlueShield: (1) comprehensive home-based palliative care program, CompassionNet, for pediatric population (palliative care teams and case managers employed by Lifetime Care, an affiliated hospice and home care agency); (2) enhanced payment to clinicians who have completed a Medical Orders for Life-Sustaining Treatment (MOLST) training course, involving a time-based counseling model; and (3) palliative care measures are included in the Excellus Hospital Performance Incentive Program
  - Highmark, Inc.: (1) incentive payment to hospitals based on palliative care-related metrics; (2) reimburses hospices for providing non-hospice palliative care home visits under its Advanced Illness Services program (lifetime limits of 10 visits, plus 24/7 telephonic or in-home access to palliative care team in case of unmanageable pain and symptoms)

- Palliative care is also sometimes covered under state-funded programs or by philanthropic organizations
THE CURRENT SITUATION: MEDICARE/ MEDICAID

• Palliative care covered as part of the hospice benefit
• Palliative care arguably covered under hospital inpatient payment (especially given evidence that palliative care ends up reducing hospital costs for the patients who receive such services)
• Some discrete palliative care services paid under various fee schedules, most notably as physician evaluation and management services, and also under home health benefits
• Palliative care services covered by at least some Medicare Advantage plans (e.g., Highmark, Inc. covers 10 home-based palliative care visits for seriously ill beneficiaries)
• Under Medicaid/CHIP, children can access hospice and curative care simultaneously (section 2302 of the ACA)
• Medicaid programs can provide palliative care services through waivers
POSSIBLE OVERARCHING GOALS

• Ensure appropriate coverage and payment for high quality palliative care furnished across multiple settings and by a range of providers.

• Be realistic about what can be accomplished in the current policy and political environment.

• Focus on important gaps in coverage.

• Attempt to craft proposals that can be easily understood by policy makers.
THE CONTEXT: MOST ASSUREDLY NOT A VACUUM!

- The health care delivery system reform space is very crowded, with a number of initiatives having potential relevance for palliative care.
  - Medicare payments for chronic care management
  - Medicare Shared Savings Program and other accountable care organizations
  - Ongoing bundled payment initiatives
  - Medical home programs and experiments
  - Medicare Care Choices Model (pending); $400 per beneficiary per month hospice fee for services not billable under Medicare Parts A, B, and D
  - Oncology Care Payment Model; details pending
• The CMS Innovation Center has provided grants for a number of “one off” palliative care-related programs and projects. Examples include the following:
  ➢ Four Seasons Compassion for Life, North Carolina, “Increasing patient and system value with community based palliative care”
  ➢ University Hospitals Case Medical Center, Ohio, “Evidence-Conformant Oncology Care” (model includes early and ongoing palliative care consultation)
  ➢ The Trustees of the University of Pennsylvania, “Comprehensive longitudinal advanced illness management (CLAIM), which is testing a comprehensive set of home care services for patients with cancer who have substantial palliative care needs
  ➢ Suttercare Corporation, California, “Advanced Illness Management (AIM)”
  ➢ The Rector and Visitors of the University of Virginia, “Proactive Palliative Care and Palliative Radiation Model”
MORE CONTEXT

• Congress has an array of “must do” work with potentially high price tags.
  ➢ SGR reform and Medicare extenders are notable examples.
  ➢ Necessarily increases the challenge of getting other “cost” items approved.

• The Republicans are the majority party in both the House and Senate--but are far from united.

• There appears to be a growing “cloud” over at least a subset of Medicare hospice providers (e.g., high live-discharge rates, relatively high profit margins, charges of targeting “profitable” patients, questions about quality of care, questions of duplicate or “too high” payments for hospice patients in nursing homes, MedPAC calls for hospice payment reform, etc.).
  ➢ Advocates of palliative care coverage and payment outside of the hospice context should be mindful of these reputational factors affecting hospices, which are already recognized sources of palliative care.
CHARTING A COURSE: KEY QUESTIONS FOR DISCUSSION

• What are the specific services and settings for which better coverage and payment is most needed?

• Who should be paid for those services (e.g., a hospital, physician group practice, home health agency, hospice, and/or some other entity)?

• In the Medicare context, can the services fit under an existing benefit category (e.g., physicians’ services) or must a new or modified benefit category be Congressionally approved?

• Is there enough evidence/rationale to support new “national” or payer-wide policy or would a demonstration project be more defensible (but still an acceptable outcome)?
A POSSIBLE OPTION MENU
(IN NO PARTICULAR ORDER)

• Create one or more new CPT codes describing palliative care services (perhaps service bundles) for payment under Medicare and other payer physician fee schedules

• Develop a new bundled payment system for selected conditions that incorporates palliative care services (Cf. Consolidated Payments for Oncology Care payment system developed by the ASCO Payment Reform Work Group)

• Consider a Palliative Care Medical Home concept, under which physicians would receive a monthly payment for certain patients and perhaps qualify for shared savings or bonus payments

• Grant waivers to ACOs under the Medicare Shared Savings Program to provide broader coverage of palliative care services (e.g., to ACOs under two-sided shared savings/shared risk models)
• Add palliative care performance measures to the Medicare Hospital Value-Based Purchasing Program, the value-based payment modifier under the Medicare physician fee schedule, or other pay-for-performance-type payment programs

• Add a palliative care benefit category to Medicare or modify an existing benefit category (many variations possible)

• Pay palliative care specialists to coach/assist other physicians in providing basic or primary palliative care services

• Secure separate Medicare payment for the advance care planning codes (CPT 99497-99498)
MORE MENU ITEMS

• Add palliative care performance measures for public reporting and/or to determine whether a provider qualifies for shared savings or bonus payments

• Add requirements to the hospital, nursing home, home health, and other provider conditions of participation

• Enhance support for palliative care professional education and training programs

• Other?
TIME FOR EASY QUESTIONS AND THOUGHTFUL COMMENTS