

Community-Based Palliative Care: Lessons on Standardization and Scaling

Session #2 of 3: Affordability and Sustainability of Palliative Care Services across Medicaid, Medicare, and Commercial Insurance

February 2, 2022



1

Housekeeping

- This webinar is being recorded.
- Information on how to access the recording and slides from this webinar will be emailed to you in a few days.
- Post questions and comments in the chat box at any time.

2



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- ✔ Founded in 1998
- ✔ Collaborative approach
- ✔ Committed to improving serious illness care

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California Health Care Foundation



Community-Based Palliative Care: Lessons on Standardization and Scaling



- ✓ **January 26, 2022, 11:00am-12:00pm PST**
Community-Based Palliative Care Standards: Rationale and Impact
- **February 2, 2022, 11:00am-12:00pm PST**
Affordability and Sustainability of Palliative Care Services across Medicaid, Medicare, and Commercial Insurance
- **February 9, 2022, 11:00am-12:00pm PST**
Building on California's Efforts to Drive Consistency and Quality in Palliative Care. *How payers, providers, and policymakers can leverage what was learned about developing or implementing standards for community-based palliative care.*
 - <https://coalitionccc.org/CCCC/Our-Work/2022-CAIC-Webinar-Series.aspx>

5

5

Series Presenters



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6

6

Today's session



- Brief review of the standards for community-based palliative care
- Demonstration project results: Claims data analyses
 - Enrollment duration, disease characteristics, reasons why ended
 - Costs before and after palliative care enrollment
- Qualitative assessment of payment model from payers & providers
- Discussion

The webinar is being recorded.

Yes, the presentation slides and a link to the recording will be distributed to session registrants.

7

7

Meeting the need



“We need to take a multifaceted approach to ensure home-based palliative care programs are to some extent standardized, and held accountable for the care they provide. It is critical for the future of home-based palliative care, and for patients’ and families’ health and safety, that when an organization says, *“Yes! We have a home-based palliative care program!”* that patients, families, referring clinicians, and payers know what they are getting.”

“Yes! We Have a Home-Based Palliative Care Program!”.
Calton BA, Ritchie C. JAGS 2019 Jun;67(6):1113-1114.

8

8

Consensus Standards for CBPC Delivery



- 2016: CCCC convened development team – the California Advanced Illness Collaborative (CAIC) – including payers, CBPC providers, policy advocates, researchers
- March 2017: Standards released
- Intended to specify **minimums** acceptable to any payer or provider
- Intended to inform contracting for **home-based** palliative care
- Generally aligned with Medi-Cal palliative care mandate (SB 1004)

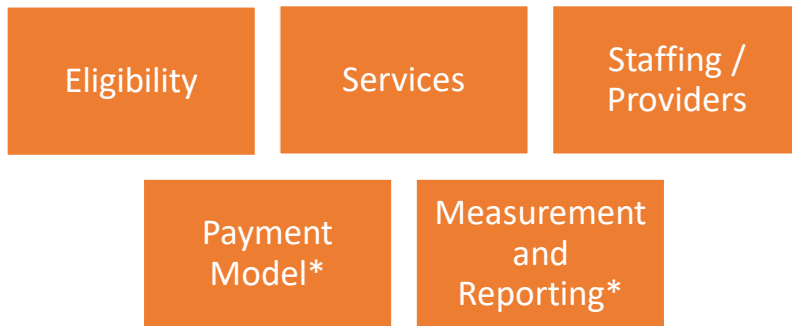


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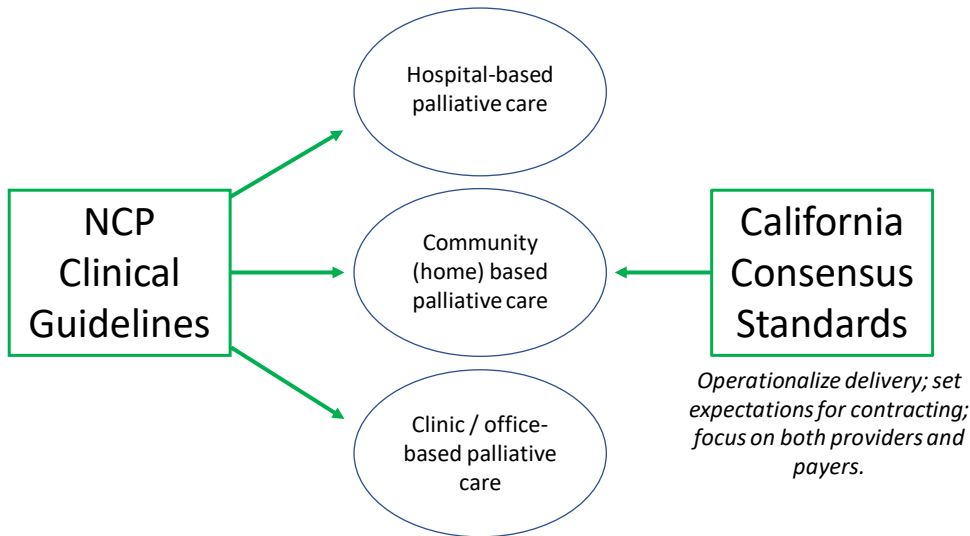
<https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx>

What the Standards Address



** Not addressed in Medi-Cal palliative care (SB 1004) guidance*

In addition to clinical guidelines



11

11

Demonstration Project 2018-2021



Goals: Implement standards with payers and providers. Evaluate outcomes and variation in care delivery. Determine if the Standards make it easier for payers and providers to develop and implement contracts that increase access to quality, sustainable CBPC services.

Features:

- Participants assembled in 2018
- Multiple payers and providers delivering CBPC in Sacramento and/or Los Angeles
- Contract requirements met or exceeded the Standards or SB 1004 requirements
- Many but not all providers had contracts with multiple participating payers
- Claims analyses focus on new palliative enrollees Jan 2019-Mar 2020
- Qualitative data collection and group activities through Dec 2021
- Project led by CCCC, funded by CHCF, supported by evaluation team and advisory group

12

12

Enrollment and claims data analyses



Three payers provided claims data

- Focus regions: Sacramento and Los Angeles
- 1 Medi-Cal (SB 1004) only, 2 offering CBPC across multiple types of insurance
- PC enrollment data and claims data from CY2018-2020, for those starting PC Jan 2019 – March 2020.

Questions posed to the claims data

- How long were patients enrolled in palliative care? What ended it?
- How much variation was there in CBPC duration, diseases, severity of illness, reasons for ending enrollment, and baseline costs?
- What were the costs per patient before and after PC enrollment?

13

13

902 enrolled across
3 payers,
2 regions,
3 insurance types

Number of beneficiaries enrolled in CBPC services January 2019 – March 2020.

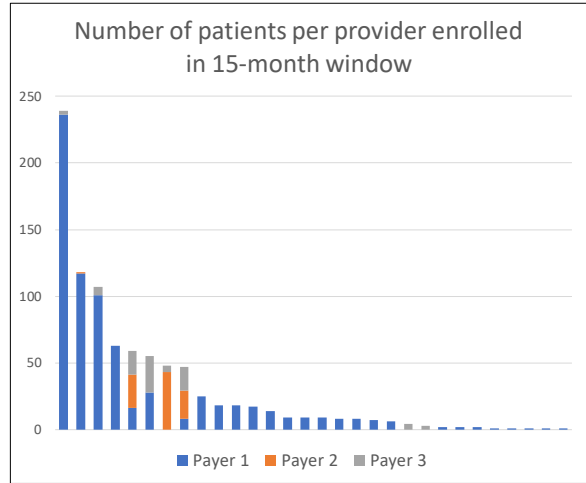
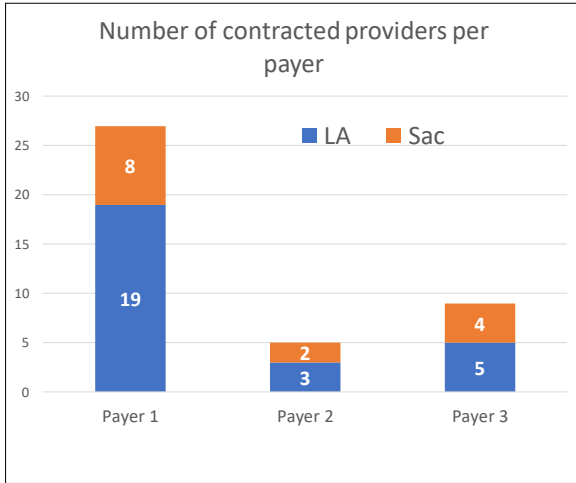
Medicaid is the insurance type that is most evenly distributed across the three payers (plans): 21%, 28%, 51%.

Payer	Ins Type	Region		
		LA	Sacramento	Total
Payer 1	Commercial	327	34	361
	Medicaid	34	0	34
	Medicare	305	28	333
	Total	666	62	728
Payer 2	Commercial	29	1	30
	Medicaid	31	15	46
	Medicare	9	5	14
	Total	69	21	90
Payer 3	Medicaid	36	48	84
	Total	36	48	84
Total	Commercial	356	35	391
	Medicaid	101	63	164
	Medicare	314	33	347
	Total	771	131	902

14

14

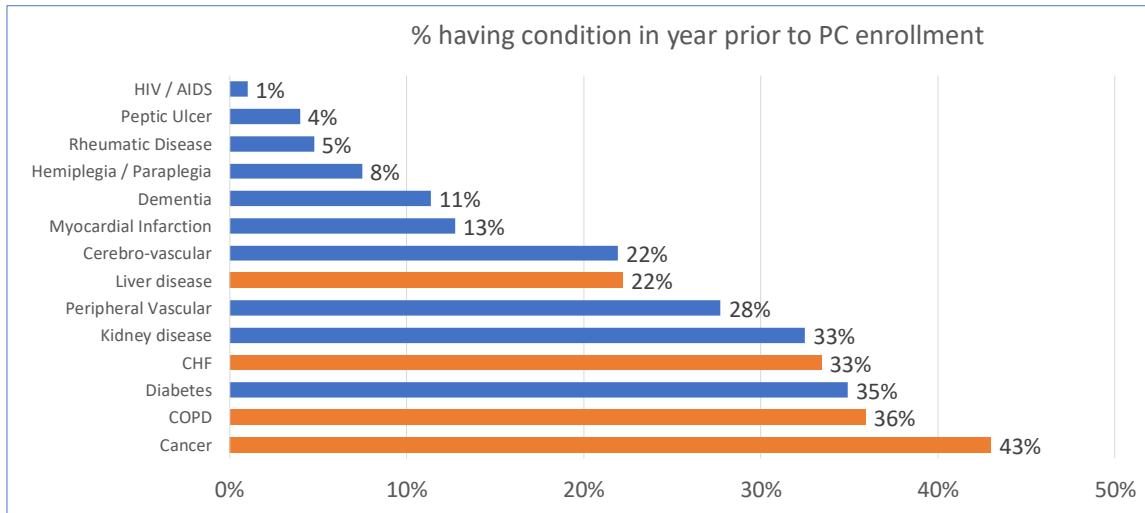
Providers per payer and patients per provider



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Chronic conditions

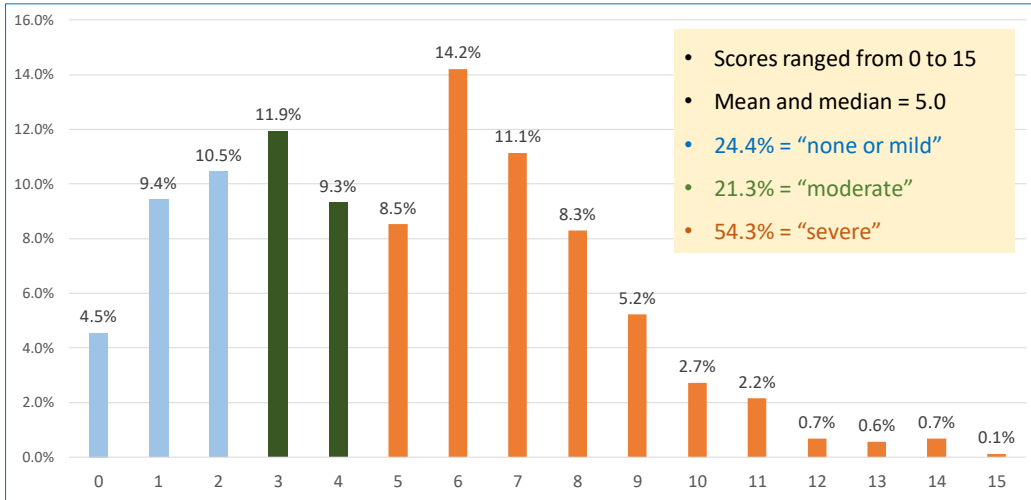


The Charlson Comorbidity Index is a method for using diagnoses in claims data to evaluate whether patients (beneficiaries) have conditions that are associated with morbidity and mortality. They are useful to assess both individually, as shown here, or in a weighted index as shown on the following two slides. [Charlson et al., 1987](#) describes the development and validation of this approach.

16

16

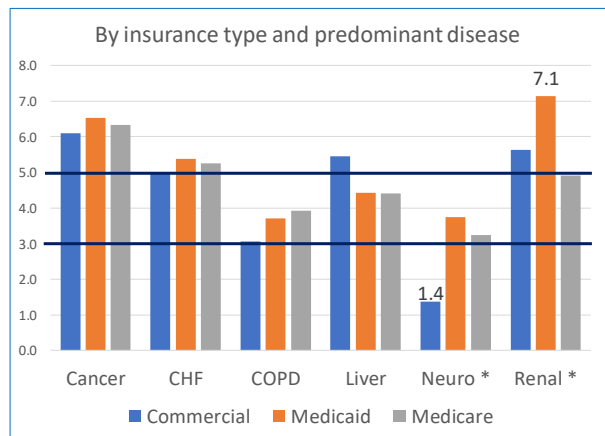
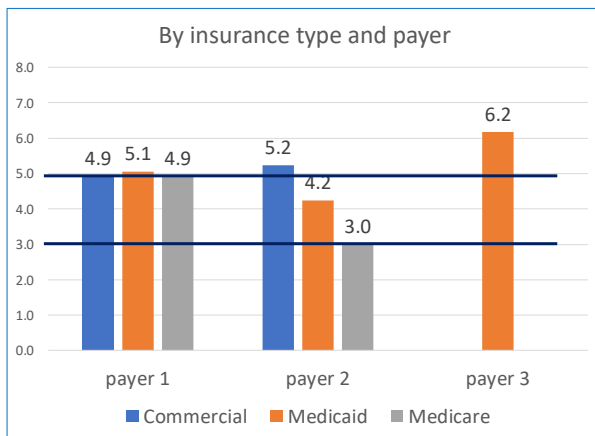
Charlson Comorbidity Index



The CCI was computed for each person; it is a weighted score of 17 conditions evaluated from top 4 diagnosis codes on all claims in year prior to palliative care enrollment. See [Charlson 1987](#) for further background on this scale. 17

17

Mean Charlson Comorbidity Index



* No disease-specific eligibility criteria are listed in the Standards for Neurological diseases and Renal Failure, but the Standards allow for other relevant conditions within general criteria. The CCI was computed for each person; it is a weighted score of 17 conditions evaluated from top 4 diagnosis codes on all claims in year prior to palliative care enrollment. See [Charlson 1987](#) for further background on this scale. Horizontal lines reflect the 0-2 for "none or mild", 3-4 for "moderate" and 5+ for "severe". 18

18

Predominant diseases



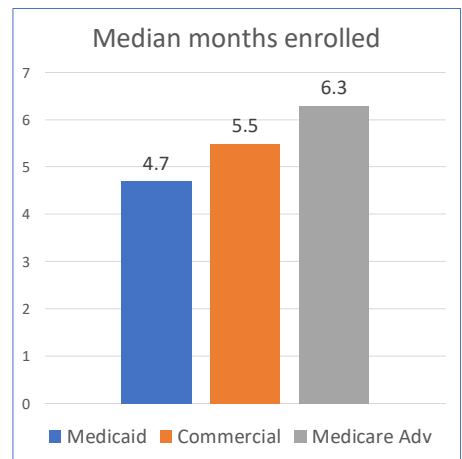
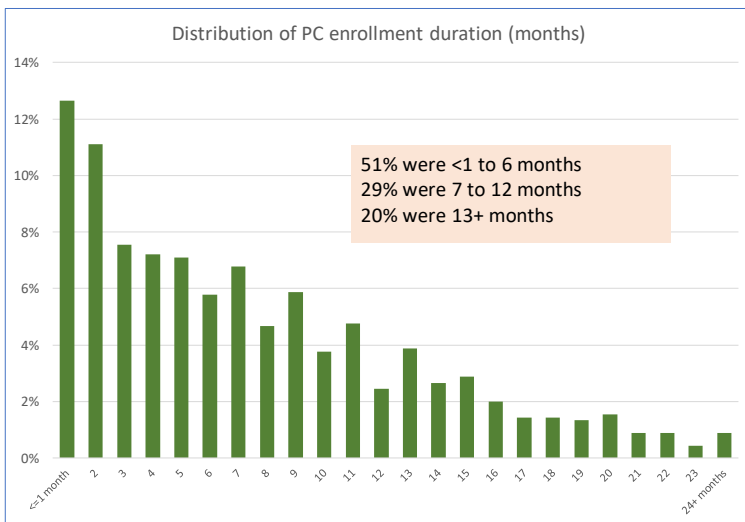
	Frequency	Percent
Cancer	314	34.8%
CHF	119	13.2%
COPD	92	10.2%
Neuro *	75	8.3%
Renal *	69	7.6%
Liver	30	3.3%
Other	203	22.5%
Total	902	100.0%

	Commercial	Medicaid	Medicare
Cancer	54.5%	25.0%	17.3%
CHF	5.1%	29.9%	14.4%
COPD	9.0%	12.8%	10.4%
Neuro *	6.9%	2.4%	12.7%
Renal *	5.6%	9.1%	9.2%
Liver	2.8%	8.5%	1.4%
Other	16.1%	12.1%	34.6%
Total	100%	100%	100%

* No disease-specific eligibility criteria are listed for Neurological diseases and Renal Failure in the standards, but the standards allow for other relevant conditions within general criteria.

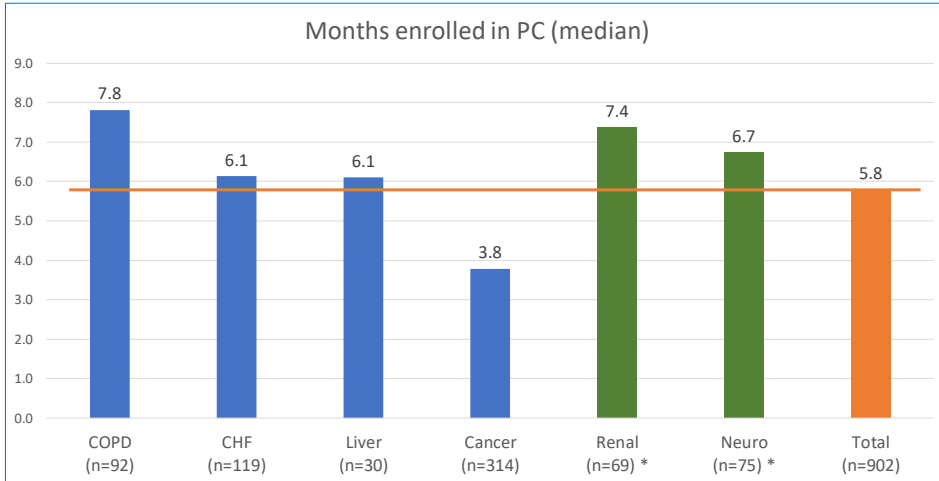
Predominant diseases assigned via analyses of claims data from year prior to palliative care enrollment.

PC enrollment (months)



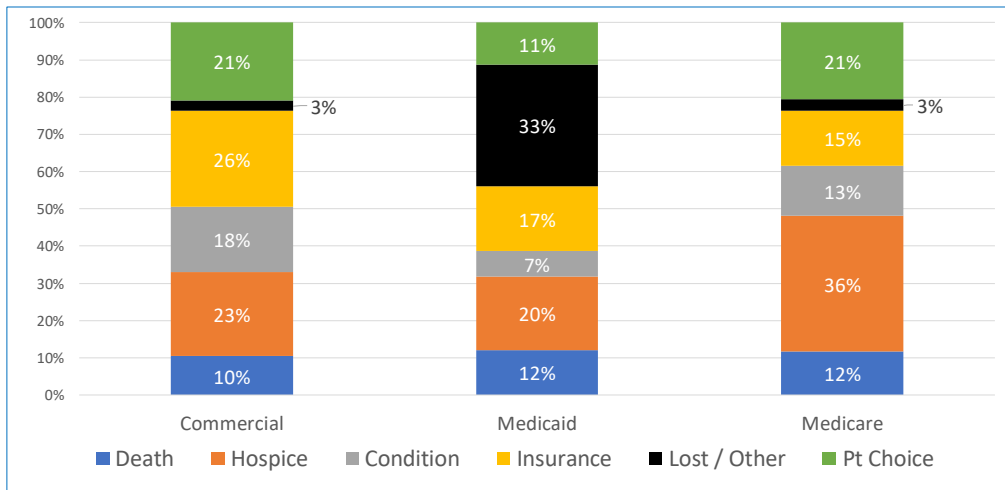
Medicaid by plan:
3.1, 5.7, 6.5 months

Duration by predominant disease



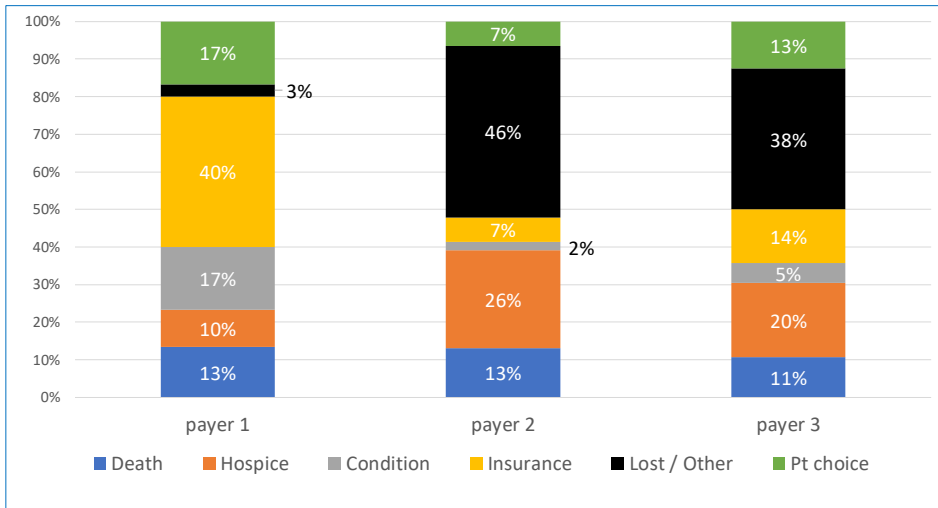
* No disease-specific eligibility criteria are listed for Neurological diseases and Renal Failure in the standards, but the standards allow for other relevant conditions using general criteria. Total includes others.

Reason PC ended: by insurance type



Condition: "Goals met", "condition improved", "no longer appropriate", "no longer met criteria".
 Insurance: "Change in insurance", "eligibility terminated", "no longer authorized", "[payer] decision".

Reasons PC ended: Medicaid only

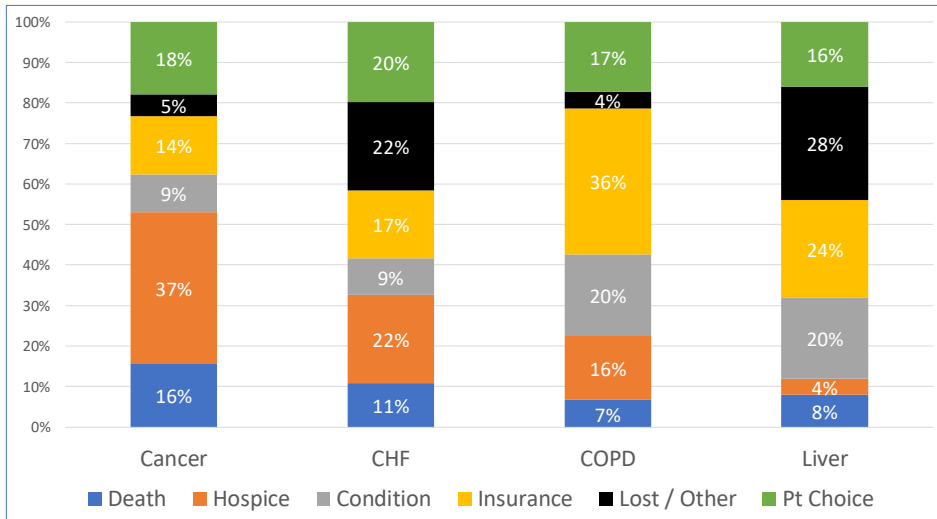


Condition: "Goals met", "condition improved", "no longer appropriate", "no longer met criteria".
 Insurance: "Change in insurance", "eligibility terminated", "no longer authorized", "[payer] decision".

23

23

Reasons PC ended by predominant disease



Condition: "Goals met", "condition improved", "no longer appropriate", "no longer met criteria".
 Insurance: "Change in insurance", "eligibility terminated", "no longer authorized", "[payer] decision".

24

24

Reflections and questions



- Reflections
 - Even with Standards in place, there is still a lot of room for payers and providers to make implementation choices about structures and processes. That is what introduces variation in outcomes.
 - Some of the variation is expected – or at least not unexpected – and is not viewed by stakeholders as a problem. For example, variation in enrollment duration by disease and by insurance type.
- Questions?

25

25

Financial results (payer perspective)

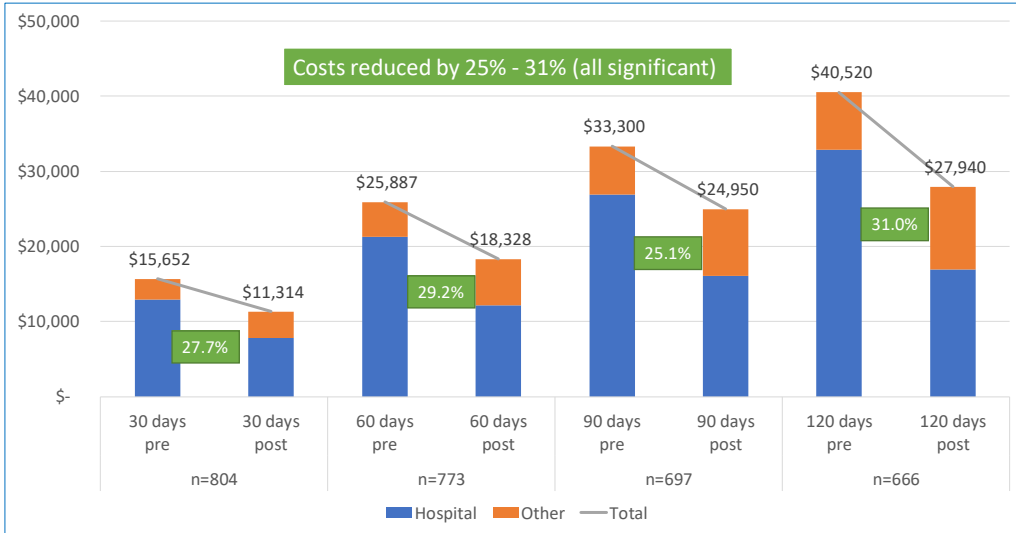


- Within-person (pre-PC vs after-PC-enrollment) using 95% confidence intervals to evaluate statistical significance
- Looked at four time periods: 30/60/90/120 days before & after enrollment
- Tallied expenditures as either “hospitalization-related” or “other”
- Most analyses conducted within insurance type to handle differences in prices, capitation, and hospice claims
- Costs after PC enrollment are inclusive of PC payments
- Costs after PC enrollment are inclusive of hospice claims for Medicaid and Commercial beneficiaries
- Costs continue to accrue even if the person dis-enrolls from PC, but remains with the payer

26

26

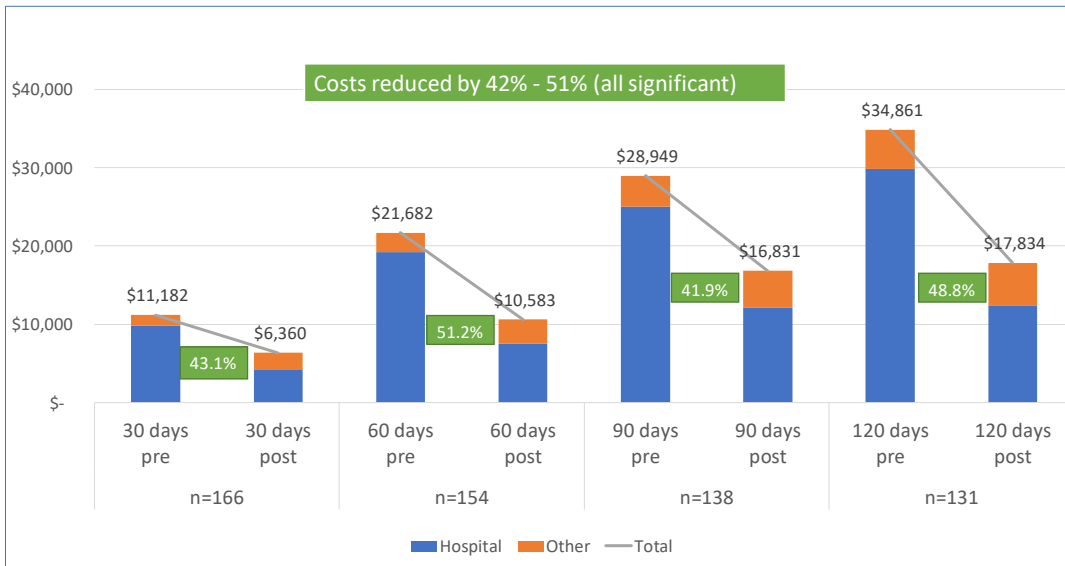
All insurance types combined



27

27

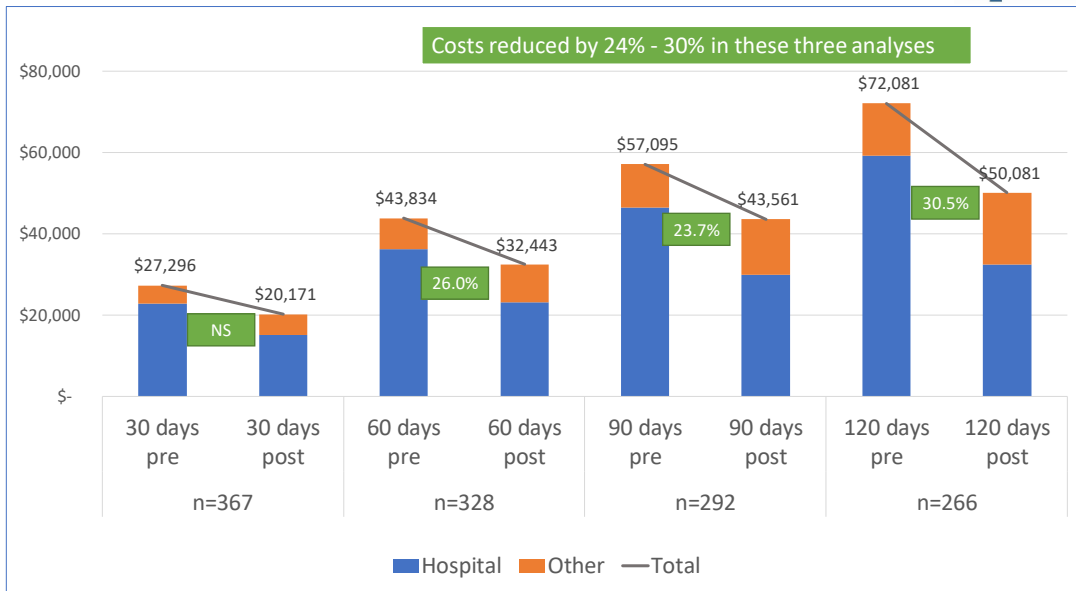
Medicaid



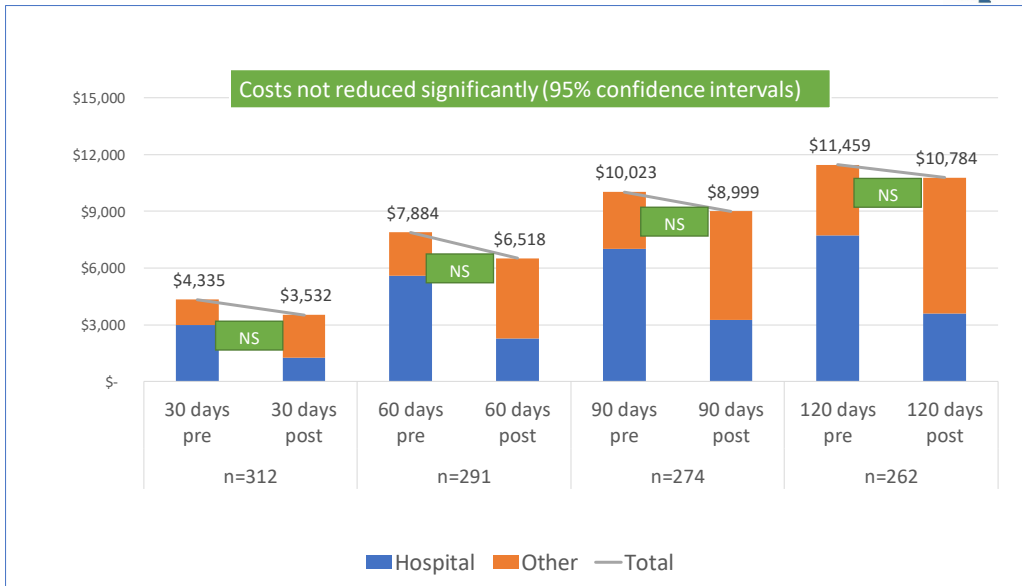
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28

Commercial



Medicare Adv (none significant)



Summary: claims data analyses



- **Baseline cost is quite different by insurance type**
 - Commercial 30 days pre: \$27,296
 - Medicaid 30 days pre: \$11,182
 - Medicare Adv 30 days pre: \$ 4,335
- **Cost Differences**
 - Medicare = 6-19% lower cost, but not statistically signif.
 - Commercial = 24-30% reductions in cost, 3 of 4 time periods statistically signif.
 - Medicaid = 42-51% reductions in cost, all 4 time periods statistically signif.
 - Overall = 25-31% reduction in cost for all insurance types combined, all 4 time periods signif.
- **Insurance types also show differences in:**
 - Number of PC provider groups engaged and enrolling
 - Predominant diseases & comorbidity index in year before PC enrollment
 - PC duration and why ended PC

31

31

In the context of published studies



- **RCT (Brumley 2007)**
- 8 observational studies have used comparison groups – not limited to pre-versus-post within-patient analyses
- Magnitude aligns: Cost savings in observational studies are similar to that of the RCT
- **Decedent cohort used in 5 studies;** avoids potential regression to the mean

Program	Insurance type	Cost reduction
Kaiser Permanente	HMO	33%
Buffalo	88% Medicare Adv.	36%
Prohealth	MSSP ACO	37%
Sharp Transitions	Medicare Adv.	49% - 59%
Sutter AIM	Medicare FFS	29%
Mayo	Medicare	68%
Turnkey	Medicare Adv.	20%
CMS MCCM	Medicare – MCCM	40%
Healthnet	58% Medicaid, 21% each Commercial and Medicare Adv.	21% - 51% lower, and 25% higher

32

32

Why no significant effect among MA beneficiaries in this demonstration project (using pre-post analyses)?

- One-third of MA cases did not have a predominant progressive, life-limiting disease such as cancer, CHF, COPD, liver failure, renal failure, or neurological.
- Lower comorbidity index than other insurance types
- “Floor effect” – baseline costs already low
- Payer 1 had almost all of the MA cases. This payer reviewed the enrolled population and observed that not all individuals receiving PC met eligibility criteria. Payer 1 has revised processes for verifying eligibility, and is considering other modalities for less severely ill beneficiaries, such as clinic-based palliative care.

33

33



Questions & discussion about claims analyses

34

34

Standards re: Payment Model*



Payment Models:

Enrolled palliative care members will continue to be eligible for existing services as appropriate under their health plan. Community-based palliative care has demonstrated cost-effectiveness, often by shifting site of care to home and ambulatory settings, as opposed to inpatient care. It is **recommended that outpatient palliative care payment models emphasize value-based reimbursement.**

These value-based payments should **consider** the following value-based payment principles:

1. A process by which payers and providers **align the needs and acuity of the patient and the services covered.**
2. **Per enrolled member-per month case rate** to cover all community-based palliative care services and providers included in the care team, possibly tiered.
3. **Payment incentives** for quality and utilization management.

** Addressed in Calif. Consensus Standards (<https://coalitionccc.org/CCCC/Our-Work/CAIC.aspx>) but not addressed in Medi-Cal palliative care (SB 1004) guidance*

35

35

Payment Model: Operational Variation



- Formal tiers of service with different payment amounts vs. assuming a distribution of acuity/need and a single payment amount
- Supplemental payments in addition to PEMPM for high utilizers

36

36

Payment Model: Payer Experiences



- *Is the payment mechanism for palliative care services in your contracts appropriate?*
- *Is there adequate alignment between the cost of delivering PC and the impact on total cost and quality of care?*

Case rate universally endorsed:

- “Monthly case rates work. We have occasional exceptions for which we will pay extra fee for service charges for “extraordinary” intensity of services”

Alignment between cost and outcomes was less clear

- One plan expressed **concerns about alignment**: “I do not feel there is adequate alignment between the case rate and the impact on total cost and quality. The plan will benefit from a more defined approach regarding which members are eligible and a utilization management process to ensure appropriate enrollment and adequate services are provided during enrollment.” (*Implementation issue*)
- One plan **did not feel they had enough data** to assess impact on fiscal outcomes: “Once the service expands, we will be able to measure this but at this point it is not recognized for cost avoidance.”

37

37

Payment Model: Provider Experiences



- *Do you feel that the payment mechanism for PC services in your contracts is appropriate?*
- *Is the payment you receive enough to make delivering PC sustainable for your organization?*

Case rates preferred but concerns about sustainability

- “The reimbursement needs to be more to be a profitable program.”
- “Case rate is the better payment model. Case rate varies and, in some instances, it is difficult to provide excellent PC services with a lower case rate.
- “Most contracts require care delivery models that exceed reimbursement sustainability”

38

38

Payment Model: Reflections



Hoped for effects?

Promote	Prevent
Covers entire team and cost of all core services; aligned incentives; acceptable to all	Un-reimbursable effort for core team members/services; mis-aligned incentives

- Case rates universally used and endorsed
- Provider concerns about adequacy of payment amount
- Mixed and evolving perceptions of ROI for plans

Presence and significance of variation

- Manageable variation from implementation choices related to payments for high-utilizers
- Problematic variation related to payment amount, which is not addressed in Standards and reflects implementation choices

39

39

Limitations of the demonstration project



- Demonstration project with limited sample size for Medicaid
- Medicare Adv and Commercial cases mostly from one payer
- Pre-vs-post analyses not the most rigorous approach; between-person comparisons are underway
- Perceptions of acceptability from payers and providers, but little known about patient/family experience
- 2019-2020 time period for claims data is early in SB1004 (Medicaid) implementation and then crosses over into pandemic

40

Overall summary & next steps



- Demonstration project goes beyond creation & dissemination of standards, to implementation and evaluation
- Standards + good implementation choices help to reduce unwanted variation and negative outcomes
- Stakeholders (providers and plans) agreed to participate, to share experiences and perceptions, and to share data for evaluation
- To date, the payment model seems to be acceptable to both payers and providers
- Multi-payer, multi-provider, multi-region projects across all three major insurance types are feasible and valuable
- Next steps: Between-person analyses, further dissemination

41

41



Questions and Discussion

42

42

Acknowledgments



The CCCC team gratefully acknowledges the contributions of the health plans and palliative care providers that participated in the demonstration project, who shared their data, wisdom, perceptions and recommendations.

43

43

Next Up in the Series



February 9, 2022, 11:00am-12:00pm PST

Building on California's Efforts to Drive Consistency and Quality in Palliative Care.

How payers, providers, and policymakers can leverage what was learned about developing and implementing standards for community-based palliative care.

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44

44

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Caroline Etland, PhD



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Why the Right Words Matter When Talking about Serious Illness Care

Anna Gosline



Wednesday, April 13

Kimberly D. Acquaviva, PhD, MSW, CSE

Wednesday, June 15

"Can We Still Have a Child After You're Gone?" Navigating the Challenges of Reproductive Planning with Terminally-Ill Patients – Joanna Sharpless, MD

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46

46



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47