CAPC Responds to Payment and Policy FAQs

CAPC Webinar March 12, 2024

Center to Advance Palliative Care™

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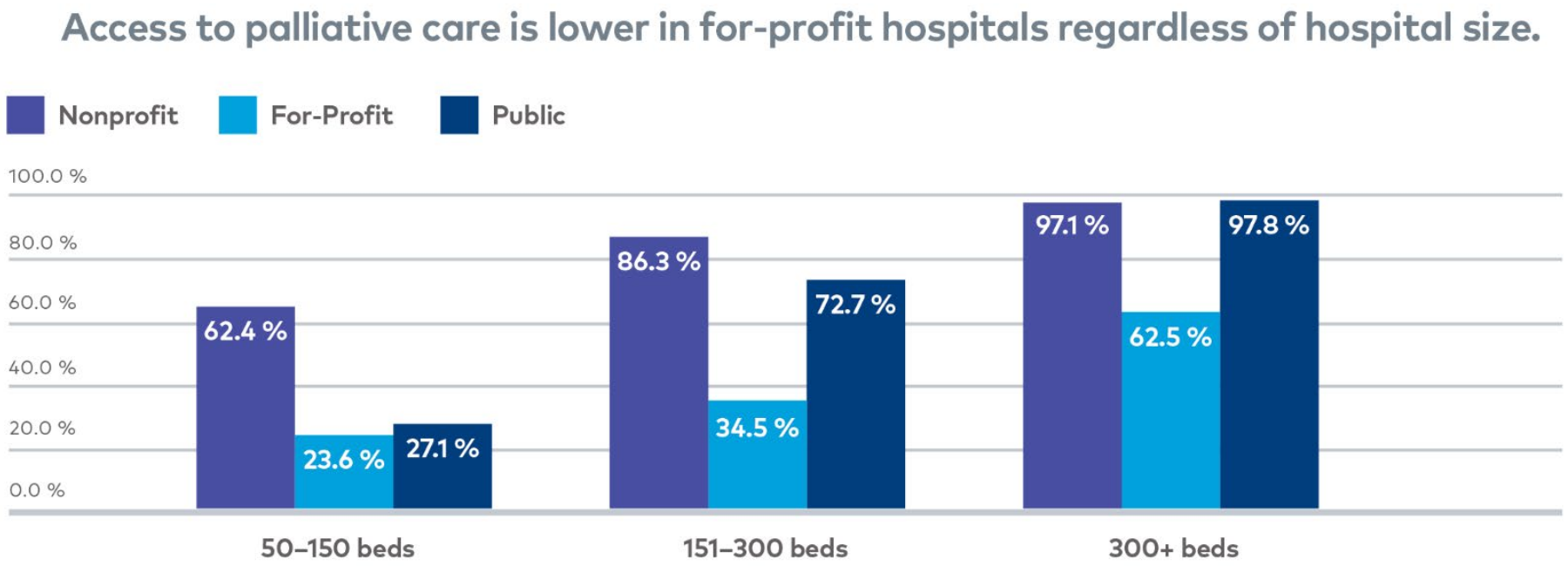
OUTLINE

- ❑ Background on Palliative Care Payment, Policy, and Quality
- ❑ Lessons from the Serious Illness Quality Alignment Hub
- ❑ Common Questions and Responses

There is a Pressing Need for Better Access to High-Quality Palliative Care

- At least 13 million adults and roughly 500-700,000 children are living with a serious illness in the United States
- Access to specialty palliative care services is uneven



Source: 2019 State-by-State Report Card

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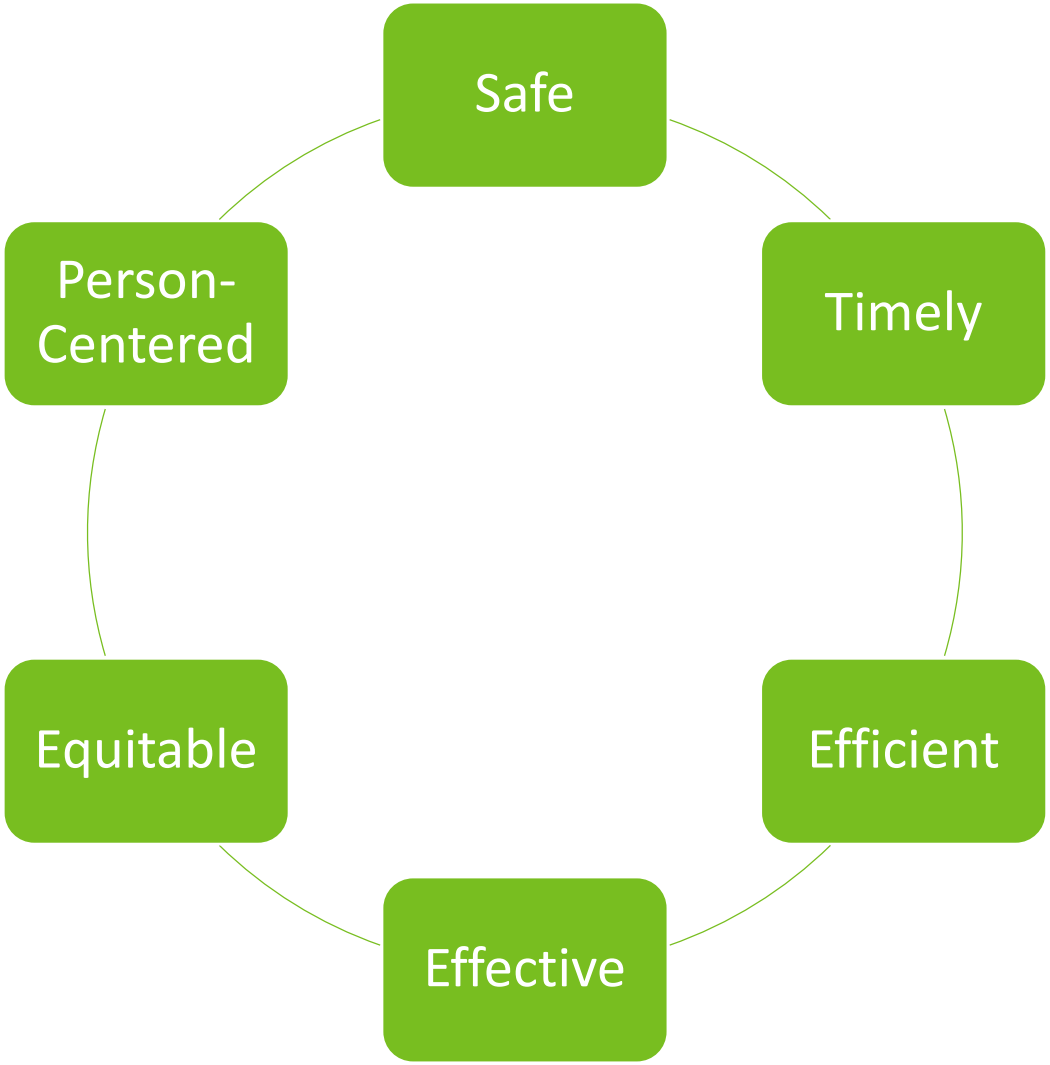
“High-Quality” Can Mean Different Things



“Access” Also Means Different Things

- Availability of Specialty Palliative Care Team
- Equitable Utilization of Specialty Palliative Care Consults
- Any Care Delivered in Line with Palliative Care Principles and Practices

Key Players at Work

"We need to change palliative care from a "nice-to-have" to a "must have" in this country."

-- Diane Meier, MD

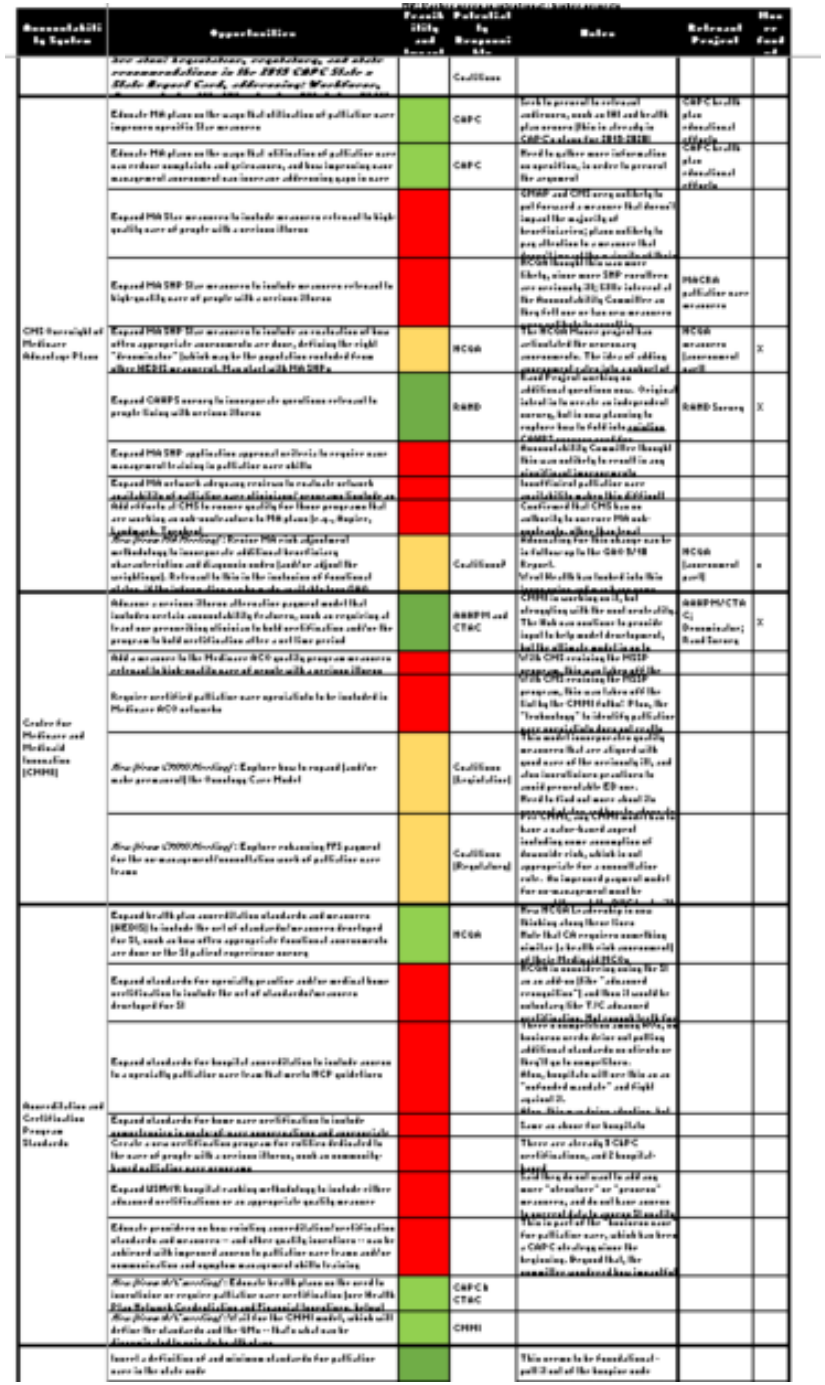
"So what can we do to require or incentivize access to high-quality palliative care?"

Information-Gathering Across 8 Accountability Systems

Serious Illness Quality Alignment HUB

- CMS oversight of Medicare Advantage (MA) plans
- CMS requirements and incentives for health care providers
- Center for Medicare and Medicaid Innovation (CMMI) model requirements and measures
- Accreditation and certification program standards and measures
- Health Plan network credentialing and financial incentives
- Accountable Care Organization (ACO) infrastructure and network management
- State regulation of health plans and providers
- Purchaser demands on health plans, ACOs and vendors

The Hub Discussed and Evaluated 64 Ideas for both Feasibility and Impact



And gained some Valuable insights . . .

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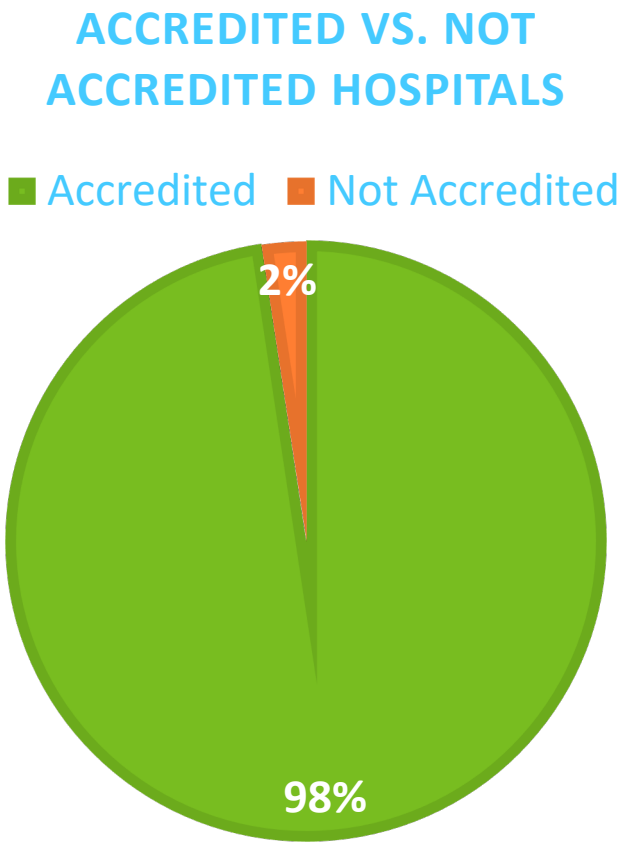
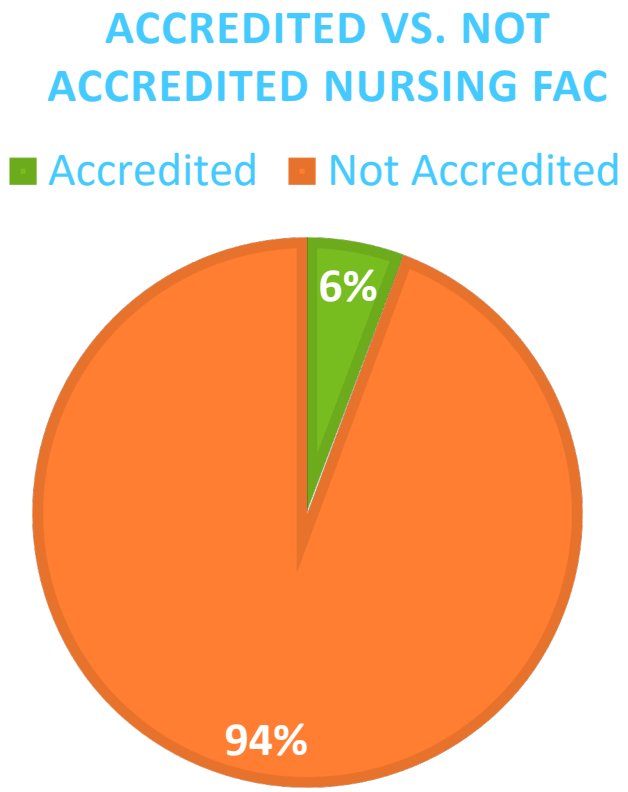
Certifications Not Tied to Payment Cannot Drive Change





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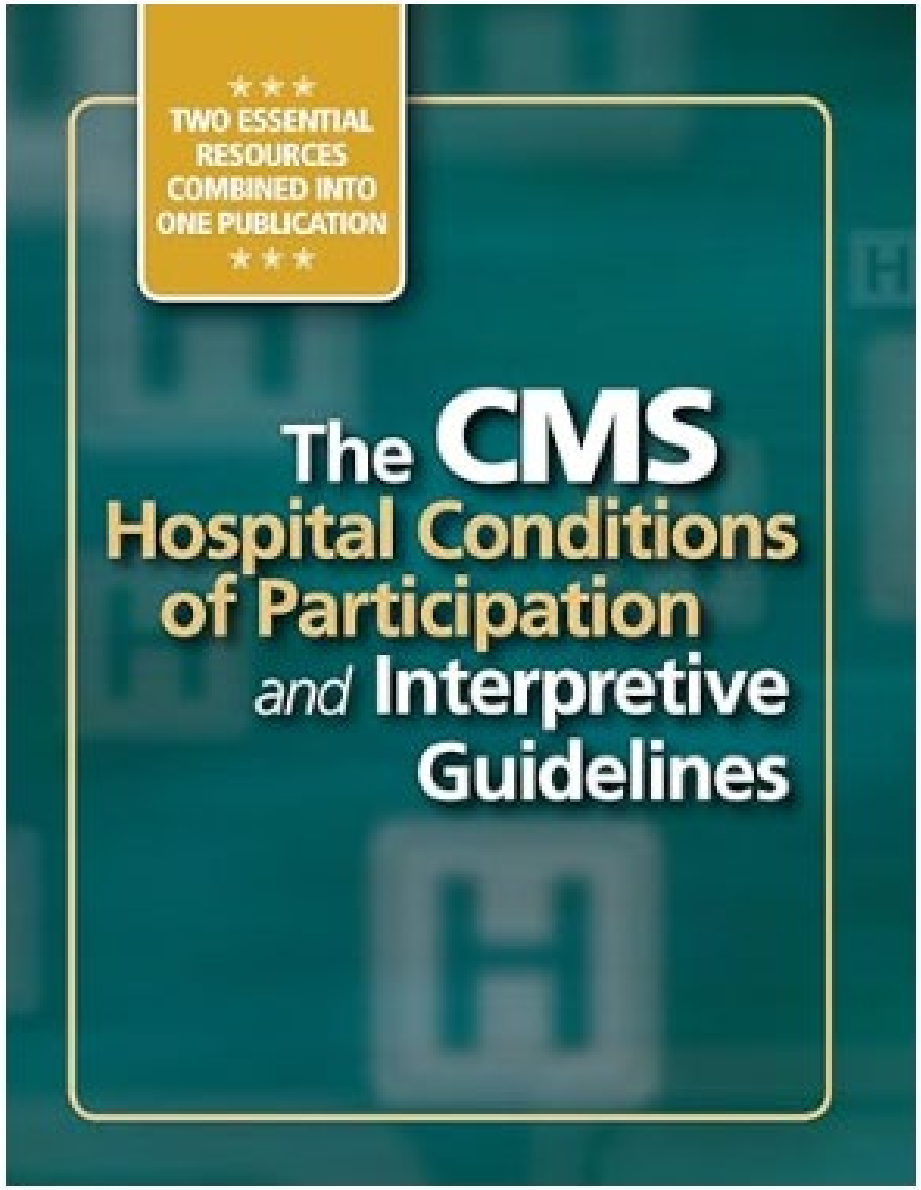
Hospital Requirement? Medicare Hospital Conditions of Participation (CoPs) Have Never Included Consultative Services



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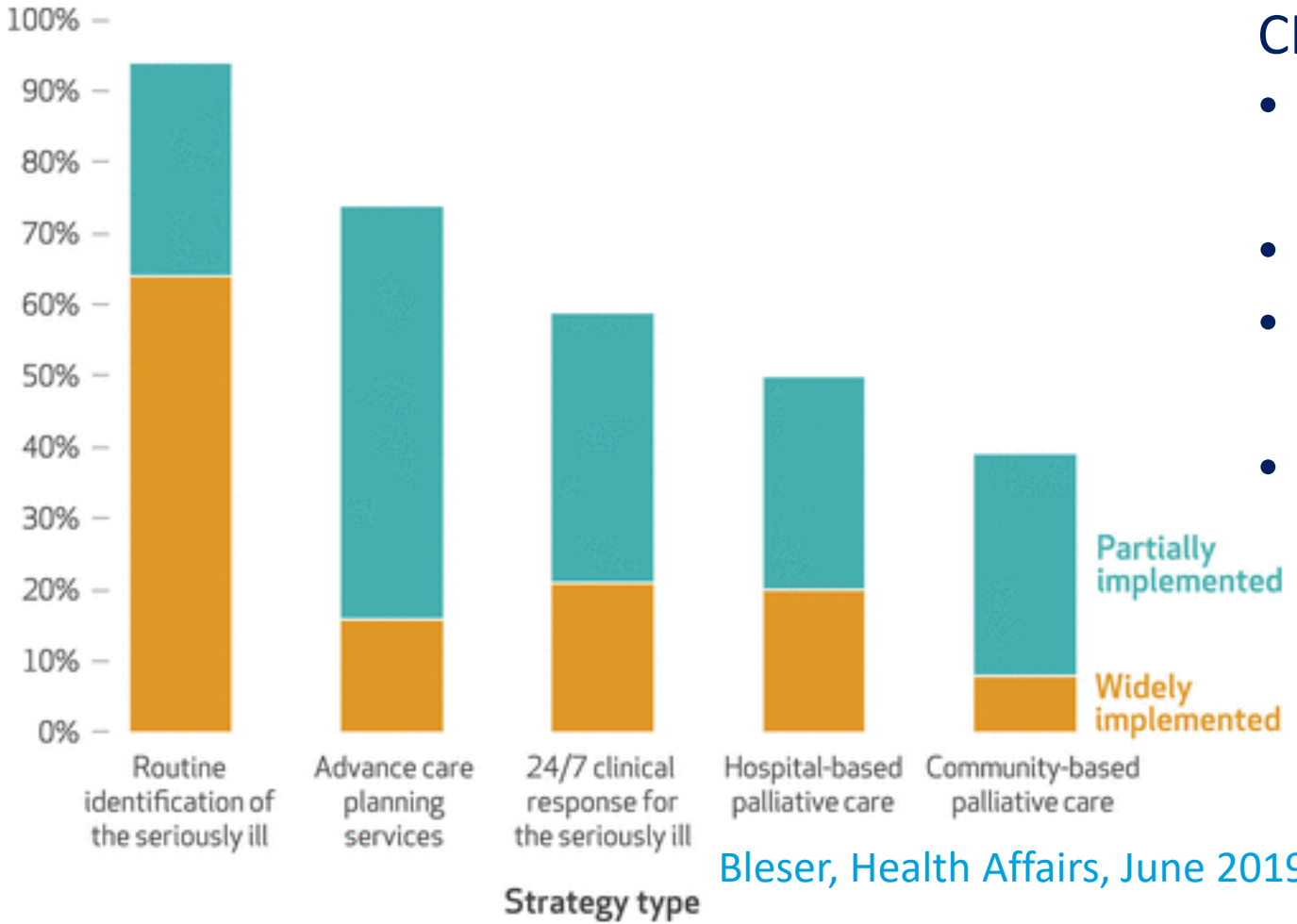
Shared Savings Payment Models (like Medicare's) Present Strong Challenges

Exhibit 1 Percent of ACOs that implemented serious illness identification or care strategies, by strategy type and breadth of implementation, 2018



CHALLENGES INCLUDE:

- High mortality impacts attribution
- Cash flow challenges!
- Lack of data integration - can't target
- No directly related quality measures

Bleser, Health Affairs, June 2019

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Purchasers, covering working families, are interested, but have other priorities

Palliative Care Resources for Employers and Other Health Care Purchasers

CPR and CAPC have created a suite of tools to give employers and other health care purchasers resources and technical assistance for implementation of strategies to assure reliable access to high-quality palliative care.

TYPE: Toolkit
COST: $399

What's Next? Purchaser Priorities with Catalyst for Payment Reform & Willis Towers Watson

Learn how purchasers can align their asks and demands of health plans and other stakeholders in critical areas of interest to employers and other health care purchasers.

Topics include: high and rising prices, provider competition, transparency, payment and care delivery reform, and benefit and network design. This webinar features expert consultants from Willis Towers Watson: Jeffrey Levin-Scherz, MD and Population Health Leader, and Drew Hodgson, FSA MAAA and National Health Care Practice Delivery Leader.

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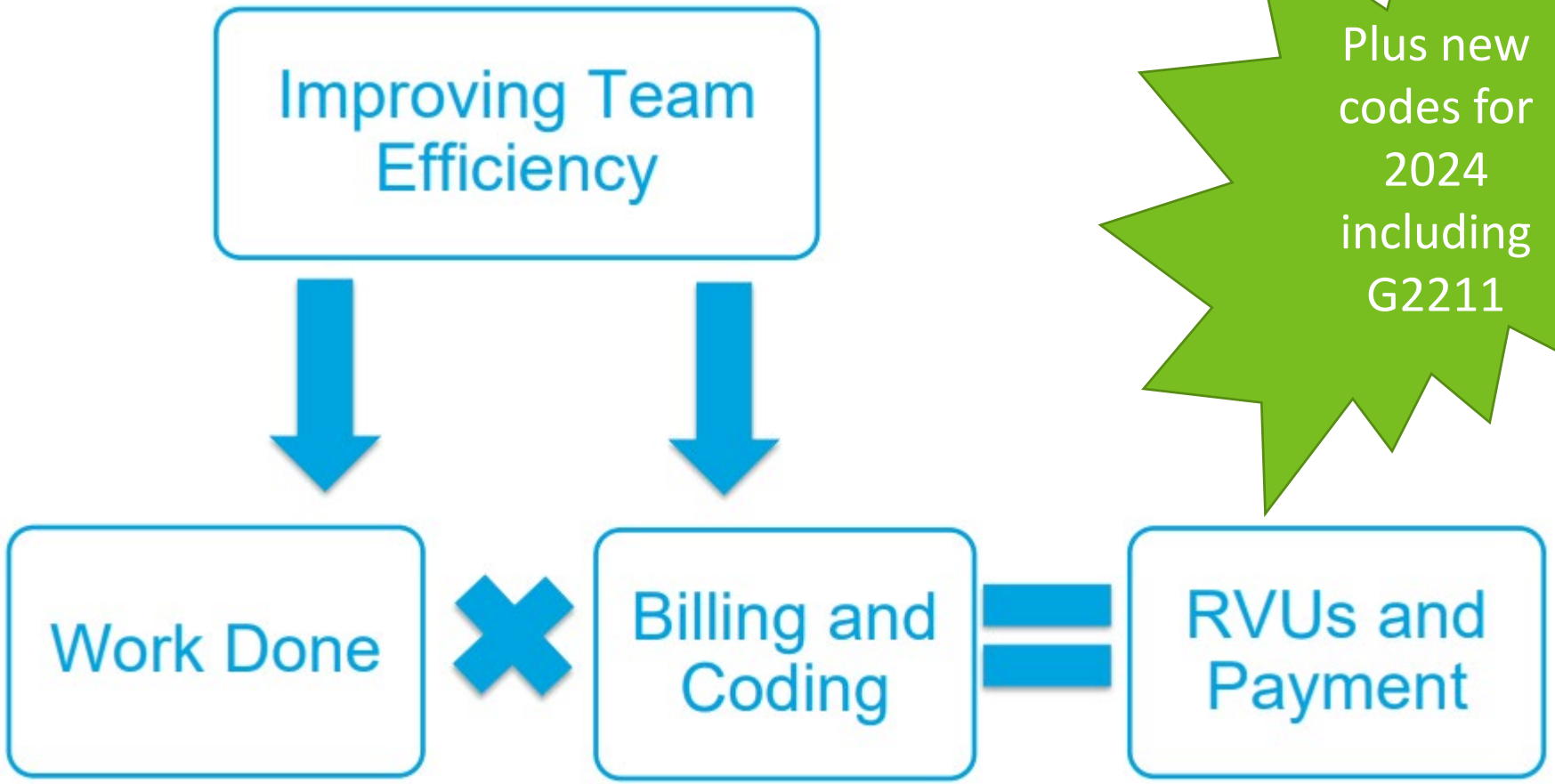
“What can we do to get palliative care paid for?”

Palliative Care IS currently paid for under Medicare, Medicaid, and Private Insurance

→ "Palliative care is specialized **medical care** for people living with a serious illness."

→ "Part B Covers: Services or supplies that are needed to diagnose or **treat your medical condition** and that meet accepted standards of medical practice."

Fee-for-Service Can Get You 60-80% Towards Break-even



Plus new codes for 2024 including G2211

There are efforts to advance alternative payment for palliative care, but there are also road blocks

→ Payers have not consistently seen a return-on-investment

→ Bower 2024, JPM

→ Diversity in program structure and quality

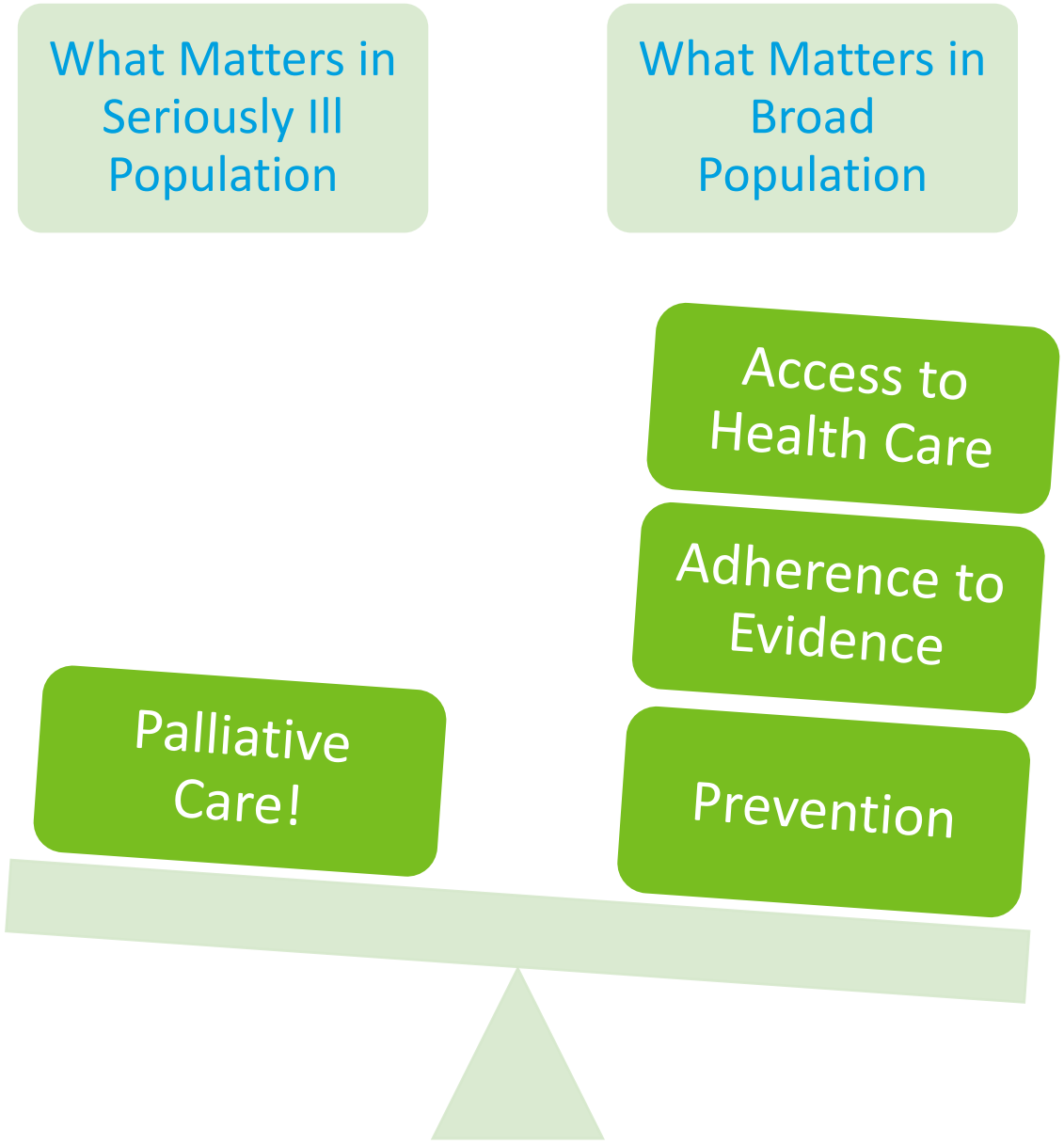
→ Cost savings are not tangible

→ Population risk already attributed to an accountable care organization

“Why can’t we get a quality measure about palliative care baked into Medicare Star Measures to incentivize them to invest?”

People with Serious Illness Are a Small Subset of the Population

When there are "too many measures," sub-set measures unlikely to get much attention



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It Is Not (Yet) Possible to Accurately Measure Receipt of Palliative Care

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There ARE Positive Developments

→ "Heard and Understood" in now approved for use in MIPS

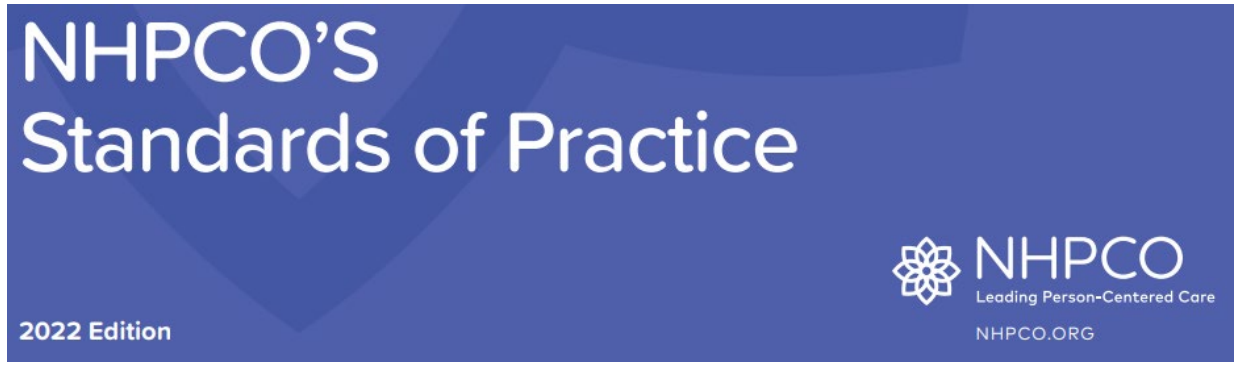
→ "Heard and Understood" has been tested in Cancer Care

→ New CMMI Oncology payment model, Enhancing Oncology Model (EOM), includes measures such as plan of care for pain, electronic capture of symptoms, and hospice use

→ The ACO Reach for High Need Populations includes a "days at home" measure, intended to drive attention to avoidable crises

“Where did 24/7 access come from and how should it be applied?”

Where Our Journey Begins…



Standard:

PFC 1: Hospice services are available twenty-four (24) hours a day, seven (7) days a week.

PFC 1.1 The hospice assures a timely response to patient and family/caregiver telephone calls 24 hours a day, 7 days a week.

PFC 1.2 Professional staff are available to make visits to address patient and family/caregiver needs 24 hours a day, 7 days a week.

PFC 1.3 Interdisciplinary team support is accessible and available 24 hours a day, 7 days a week.

PFC 1.4 Professional staff consultation and visits provide assessment, instruction, support, and interventions, as needed.

PFC 1.5 The hospice has reporting mechanisms and procedures to ensure that after regular business hours staff and volunteers are regularly informed and updated on the patient's current status.

https://www.nhpco.org/wp-content/uploads/Standards_of_Practice.pdf

JOURNAL OF PALLIATIVE MEDICINE
Volume 7, Number 5, 2004

Policy Document

National Consensus Project for Quality Palliative Care: Clinical Practice Guidelines for Quality Palliative Care, Executive Summary*

FROM THE NATIONAL CONSENSUS PROJECT FOR QUALITY PALLIATIVE CARE (A CONSORTIUM OF THE AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE, THE CENTER TO ADVANCE PALLIATIVE CARE, HOSPICE AND PALLIATIVE NURSES ASSOCIATION, LAST ACTS PARTNERSHIP, AND NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION).

- The patient and family have access to palliative care expertise and staff 24 hours per day, 7 days per week.

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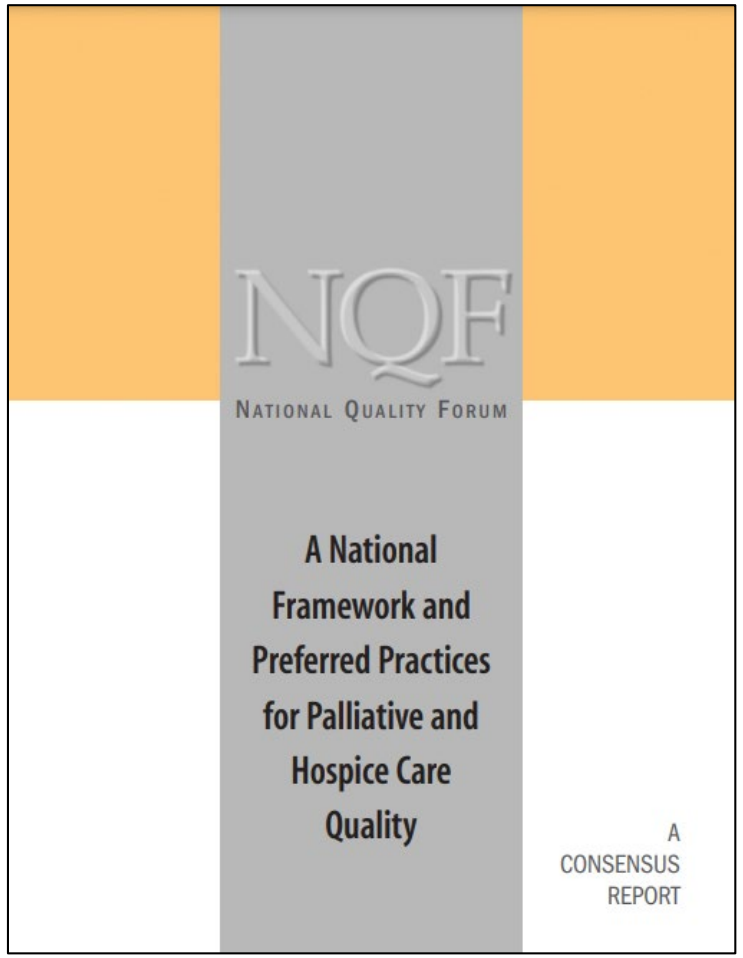
NQF Framework (2006)



- Preferred Practice 2:
  - "2. Provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, 7 days a week."
  - "Rationale: Ensuring the availability of palliative and hospice care 24 hours a day, 7 days a week is a minimum standard supported by NHPCO's *Standards of Practice for Hospice Programs* [2000] and NCP's *Clinical Practice Guidelines for Quality Palliative Care* [2004]"
  - "…it may not always be feasible…in the patient's/family's setting of choice…Thus, the practice calls for responsiveness that might include telephone access and referral to an available setting."

https://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_Preferred_Practices_for_Palliative_and_Hospice_Care_Quality.aspx

JOURNAL OF PALLIATIVE MEDICINE
Volume 11, Number 9, 2008

DOI: 10.1089/jpm.2008.0149

Special Report

Operational Features for Hospital Palliative Care Programs: Consensus Recommendations

David E. Weissman, M.D. and Diane E. Meier, M.D.

RECOMMENDATIONS

Domain	*NQF*[a]	*Must have*	*Should have*
3. Availability[C]	2	Monday–Friday inpatient consultation availability and 24/7 telephone support.	24/7 inpatient consultation availability, especially in hospitals with more than 300 beds.

C. Patients, families and hospital staff need palliative care services that are available for both routine and emergency services.

https://pubmed.ncbi.nlm.nih.gov/19021479/

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And as a result, 24/7 is baked into TJC Advanced Certification

What It Takes To Be Certified

To be ready for the Joint Commission palliative care certification, your palliative care program should:

- Follow an organized approach supported by an interdisciplinary team of health professionals.
- Use standardized clinical practice guidelines or evidence-based practices.
- Have the ability to direct the clinical management of patients and coordinate care.
- Provide the full range of palliative care services to hospitalized patients 24 hours per day, seven days a week (either with on-site or on-call staff).
- Use performance measurement to improve your performance over time.
- Collect data for standardized performance measures. A minimum of four months of performance measure data must be available at the time of the initial on-site certification review.

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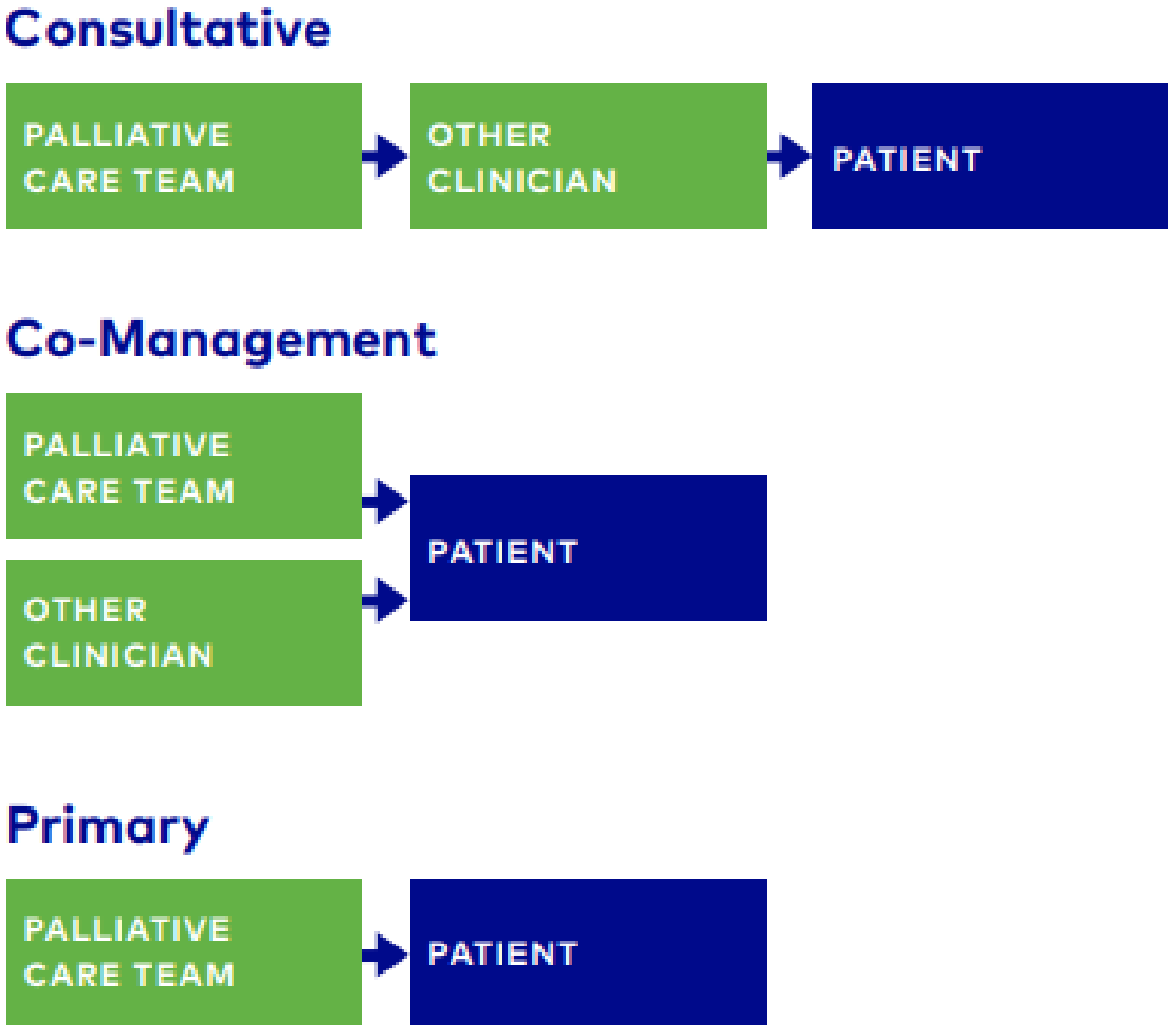
HbPC Models of Clinical Responsibility



capc.org/documents/download/401/

Palliative Care in the Home

A GUIDE TO PROGRAM DESIGN

capc.org/documents/401/

	Advanced Illness Management (AIM)	CarePoint	Four Seasons Palliative Care	Home Connections	JourneyCare Palliative Care
Coverage	24/7 coverage via triage phone service	APRNs make evening and weekend visits; hospice on-call clinicians field calls for palliative care patients 24/7	24/7 telephone access to a palliative care clinician	24/7 access to an on-call RN	24/7 coverage via centralized agency triage line and on-call clinicians

	Meridian Care Journey	Minneapolis VA Spinal Cord Injury Home Care Program	OACIS/ Palliative Care Home-Based Consult Service	Optio Health Services	ProHEALTH Care Support
Coverage	On call coverage provided by PCPs, not the palliative care team, in current consultative model	Hospital triage system provides 24/7 coverage	PCPs in the network provide 24/7 coverage	24/7 coverage via TDH's triage line, with TDH or Optio MDs available as needed	24/7 telephonic coverage in partnership with ProHealth Urgent Care Centers

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Guidelines vs. Policy

- Policies must be supported by the evidence…
- …BUT overly ambitious policies may disenfranchise programs and add unnecessary cost
- “24/7 access to a trained clinician (using telehealth as warranted), with access to patients’ medical records, to provide meaningful support during crises” California SB1004
- Apply lens of primary, co-management, and consultative

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“Why can’t we just get legislation that requires access to high-quality palliative care?”

Federal Legislation – Concurrent Care for Children

- ACA Section 2302 removes the prohibition of receiving curative treatment if Medicaid/CHIP eligible child elects hospice
- Limited guidance from CMS (CAPC Guidance Tracker, informed by University of Tennessee PedEOL Care Research Group)
- Built on hospice chassis (6-month prognosis)
- Efforts to expand PPC access through EPSDT benefits are inconsistent; also increasingly confusing landscape of pediatric models and benefits

State Legislation

- IMPLEMENTATION
  - Champion
  - Funding
  - Education
  - Oversight

Despite these lessons learned, there are promising avenues to advance access, incentives, and requirements . . .

State Payment Actions

- Hawai'i statewide planning process to submit SPA
- Washington passed a law that appropriates $250,000 for the Health Care Authority to "design a standardized payment methodology for a palliative care benefit for the state Medicaid program and the employee and retiree benefits programs"
- Oregon passed a law requiring Coordinated Care Organizations to provide interdisciplinary, in-home palliative care
- Maine, Maryland, and New Jersey passed laws that formalize a process of working towards Medicaid payment for community-based palliative care

Embedding Screening, Goals of Care Conversations, and Access to Specialty Palliative Care

→ Medi-Cal Managed Care Organizations are required to provide a comprehensive health assessment, that includes identifying palliative care needs

→ Arizona's Long-term Services and Supports Managed Care Organizations are required to be trained in end-of-life care and advance care planning

→ Oregon requires their Patient Centered Medical Homes to have a process for coordinating palliative care

→ Illinois amended their Insurance Code to require coverage for community-based pediatric palliative or hospice care

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Additional Questions?