Palliative Care: Economics and Policy Panel

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Learning Objectives

1. Discuss the rationale and challenges of incorporating an integrated palliative care program in a clinical practice setting.

2. Describe the benefits of an integrated palliative care program for patients, providers, and the health care system.

3. Illustrate opportunities for incorporating palliative care programs into health care reform efforts and conversations about the financial health of organizations.

Disclosure

We have no actual or potential conflict of interest in relation to this program/presentation.

Integrated palliative care program development: Rationale and challenges (1/2)

Rationale

- Comprehensive multidisciplinary care team can provide patients with high quality care, improve quality of life and provide value to a variety of stakeholders
- Patients are living longer with chronic diseases and treatment options are becoming more complex and costly requiring optimal patient management
- Integrated palliative care team imbedded in the clinic allows joint visits with patients – can increase prognostic awareness and facilitate informed decision making
- Palliative care is a large focus of value-based care programs to increase quality of care and reduce costs

American Society of Clinical Oncology Educational Book 38 (May 23, 2018) 111-121

Integrated palliative care program development: Rationale and challenges (2/2)

Challenges

- Inconsistent definition and understanding of palliative care
- Limited understanding of palliative care benefits to patient, family, payer and health system
- Confusion about the essentials of an effective palliative care program (staffing)
- Weak reimbursement for palliative care

https://transcend-strategy.com 2021/05/18

Benefits of integrated palliative care programs

- Puts the patient’s desires, goals and decisions first
- Supports the patient and family
- Helps patients and families understand treatment plans and resources (navigation)
- Improves quality of life
- Provides pain and symptom control
- Focuses on body, mind, and spirit
- Reduces unnecessary hospital visits

https://palomarhealth.org

Financial impact of integrated palliative care programs (1/3)

Palliative care reduces variable hospital costs per day

- Average - $3,237 per admission
- Cancer - $4,251 per admission
- 4+ diagnoses - $4,865 per admission

JAMA Intern Med, 2018;178(6):820-829.

Financial impact of integrated palliative care programs (2/3)

Home Palliative Care Savings

- Costs reduced for multiple insurance lines – study of 506 patients
- Overall medical costs for 396 patients in the palliative care group showed a gross savings of $24,643 per member per year (16.7% decrease in cost) compared to the control group

A review of 46 articles evaluating the efficacy of palliative care concluded that palliative care is most frequently less costly relative to control groups

Journal of Palliative Medicine Vol 25, Number 4, 2022, 591-595. Palliat Med 2014;28:130-150.

Financial impact of integrated palliative care programs (3/3)

Integrated Multidisciplinary Palliative Care Program Cost Reduction

- Pharmacy
- Laboratory
- Decreased ER and hospital utilization
- Decreased LOS when hospitalized (43% fewer days overall, 33% fewer days in ICU)

Financial benefit for all stakeholders: patients, payers, institutions

Crit Car Med,2015 May;43(5):1102-11.
J Palliat Med,2014 Feb;17(2):219-35

Evidence of the Value of Palliative Care

1. Palliative Care seems to decrease costs and may improve life expectancy in Cancer patients.
2. Receipt of Palliative Care in hospital settings decreases acute care costs.
   - More for Cancer patients
   - More for patients with co-morbidities
3. Receipt of Palliative Care for non-Cancer diagnoses.
   - Decreases ER utilization
   - Less hospitalizations
   - Modestly lower symptom burden
   - No real difference in quality of life scores
4. Palliative Care practitioners during acute phase of COVID19 Pandemic improved:
   - Communication
   - Decreased physician burnout

5. Multiple inpatient approaches to Palliative Care have demonstrated cost effectiveness in a health system.
6. Palliative consultation with Nurse / Social Worker model in community settings reduces total medicine costs, ICU admissions, hospital admissions, and hospital days.
7. Prospective identification of patients who are at risk for poor short-term outcomes and high spend is possible with predictive analytics and Palliative Care decreases total costs and acute care costs.

Some Local Experience

Expenditures						
+/- 3 Months	# PTS		Spend Pre	Spend Post	Increase/(Decrease)	% Change
	88	Sum	$ 1,499,126	$ 1,109,113	$ (390,014)	-26%
		Avg	$ 17,036	$ 12,604	$ (4,432)	
+/- 6 Months	# PTS		Spend Pre	Spend Post	Increase/(Decrease)	% Change
	55	Sum	$ 1,387,457	$ 1,101,712	$ (285,745)	-21%
		Avg	$ 25,226	$ 20,031	$ (5,195)	
+/- 12 Months	# PTS		Spend Pre	Spend Post	Increase/(Decrease)	% Change
	20	Sum	$ 735,284	$ 882,209	$ 146,925	20%
		Avg	$ 36,764	$ 44,110	$ 7,346	

Some Local Experience

Inpatient Admissions						
+/- 3 Months	# pts		IP Pre	IP Post	Increase/(Decrease)	% Change
	88	Sum	53	25	(28)	-53%
		Avg	0.60	0.28	(0.32)	
+/- 6 Months	# pts		IP Pre	IP Post	Increase/(Decrease)	% Change
	55	Sum	43	25	(18)	-42%
		Avg	0.78	0.45	(0.33)	
+/- 12 Months	# pts		IP Pre	IP Post	Increase/(Decrease)	% Change
	20	Sum	16	17	1	6%
		Avg	0.8	0.85	0.05	

Some Local Experience

ED Visits

+/- 3 Months	# pts		ED Pre	ED Post	Increase/(Decrease)	% Change
	88	Sum	64	40	(24)	-38%
		Avg	0.73	0.45	(0.27)	
+/- 6 Months	**# pts**		**ED Pre**	**ED Post**	**Increase/(Decrease)**	**% Change**
	55	Sum	80	68	(12)	-15%
		Avg	1.45	1.24	(0.22)	
+/- 12 Months	**# pts**		**ED Pre**	**ED Post**	**Increase/(Decrease)**	**% Change**
	20	Sum	46	53	7	15%
		Avg	2.3	2.65	0.35	

Barriers to Wide-Spread Adoption of Palliative Care

1. Workforce
   - Primary
   - Specialty Palliative Care including all members of IDT
2. Lack of aligned fiscal incentives
3. Rural resources and provider care models
4. Historically no readily available palliative quality data to demonstrate value
5. Payer momentum in Maine
6. Reimbursement is poor for Part B billing relative to time investment
7. Patients are too sick to aggregate effectively for provider efficiency
8. Payment model for interdisciplinary work

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What does “Delivery System Reform” include?

Figure 1. CMS Innovation Center Vision and 5 **Strategic Objectives** for Advancing System Transformation.

Alternative Payment Models (APMs)

Goal: 40% of MaineCare payments are tied to value by the end of 2022

- **APMs are a tool to drive desired outcomes – they are not the end goal.**

- Increased payments under APMs by ~15 percentage points over the last two years to 36% of payments for CY 2020
- Formalized methods for ongoing measurement
- Advancing accountability

Palliative Care – Part of the Continuum

Chronic Care Management

Hospice Services

Palliative Care Services

LD 1064: An Act to Advance Palliative Care Utilization in the State

Directs MaineCare to pay for palliative care services

- Interdisciplinary team
- Regardless of setting
- Includes quality control measures to promote high-value care
- Uses national standards such as the *Clinical Practice Guidelines for Quality Palliative Care* developed by the National Coalition for Hospice and Palliative Care
- Periodically convene a stakeholder group to advise the Department

Office of MaineCare Services
Palliative Care Benefit and Payment Model Development Process

Benefit Model Development
- Research & Documentation
- Stakeholder Engagement
- Subject-Matter Expert Consultation

Rate Study
- Vendor Consultation
- Stakeholder Engagement

Benefit Policy Drafting
- CMS Consultation and Approval
- Stakeholder Engagement
- Policy Adoption

Palliative Care Model Development Policy Challenges

Eligibility

- Criteria for Adults & Children
- Clinical Criteria

Provider & Patient Education

- Palliative Care Versus Hospice
- Provider & Consumer Awareness

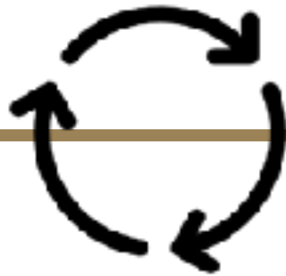
Services and Rates

- In-Home Services & Supports
- Rural & Ultra Rural Costs

Palliative Care Services w/in a Value-Based Framework

Create shared interests across providers by aligning value-based contracting

Example: Require referral to palliative care consultation in primary care APM.



Goals: Cost control and improved health outcomes

Use available total cost of care contracts to drive population health planning and systems coordination

Provide infrastructure and education supports (data and training)

Quadruple Aim Alignment

Palliative Care and Healthcare System Reform

- Interdisciplinary Care Management Team
- Comprehensive, Whole-Person Plan of Care
- Improved Quality of Life
- 24/7 Clinical Crisis Support
- Patient and Family Supports

- Reduced Avoidable Acute & Emergent Care Utilization
- Better Health & Patient Experience Outcomes
- Reduced Total Cost of Care
- Effective Team-Based Care Management

Patient Benefits — **Quality & Cost Impacts**

Quadruple Aim

Questions?

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