

Policy Issue: Expand SPC Programs as a Value-Based Model

Effective supportive palliative care (SPC) requires an interdisciplinary team approach. Such teams are labor intensive and reimbursement poor. Unlike hospice, SPC teams, whether functioning in the hospital, nursing home, office, or home setting do not receive per diem payments, yet they save payers, including Medicaid, money.¹ Unfortunately, for Medicaid and other payers, about 50% of Texas hospitals lack SPC programs. Likewise, only a small number of office and community-based SPC programs have been identified in Texas. As a major purchaser of health-care, particularly for individuals with serious illnesses, the state itself can reform program and benefit designs to drive system-wide changes leading to earlier access to palliative care services, better outcomes and experience for patients and families, and lower healthcare costs for all Texans.

Recommendation

Texas Medicaid should use financial incentives and other strategies to promote the establishment of high quality interdisciplinary palliative care programs and services. The pathway for increasing SPC access through Medicaid value-based initiatives includes:

- a) Commissioning a comprehensive claims based study by an academic research team using a state-of-the-art analytic/return on investment model to quantify the expected benefits to Texas, including Medicaid cost savings, from expanding the availability of SPC services;
- b) Engaging Medicaid Managed Care Organizations (MCOs), hospitals, and other providers on the benefits of palliative care for reducing readmissions and other preventable hospital stays;
- c) Recognizing hospitals and community based programs that meet the high standards for Joint Commission or other similar palliative care certification, including by providing a modest financial reward;
- d) Making advance planning a benefit of the state's Medicaid program and considering additional incentives to facilitate advance planning conversations, especially for new nursing home residents.

¹ Morrison RS, Dietrich J, Ladwig S, et al. *Health Affairs*. March 2011; 30 (3):454-463).

Discussion

Palliative care stands out as a successful model for value-based healthcare. With timely SPC services, numerous studies convincingly demonstrate that:

- Patients endure less pain and other suffering,² have fewer hospital readmissions,² survive longer for diagnoses of metastatic cancer,³ receive fewer non-beneficial interventions,⁴ have shorter intensive care unit (ICU) lengths of stay,⁵ receive treatments more congruent with their wishes,⁶ and have higher patient satisfaction.^{7,8}
- Families experience reduced surrogate decision maker conflict and emotional distress with advance care planning,⁹ improved family (and patient) satisfaction, less depression, better bereavement, and less post-traumatic stress symptoms when a seriously ill family member dies;¹⁰ and
- Payers, whether commercial, governmental, or private, see significantly lower costs – especially with early SPC consultation.^{11,12,13}

² Lorenz K, Lynn J, et al. *Ann Intern Med.* 2008; 148: 147-159; Wagner-Johnson N, Carson K, Grossman S. *JPSM.* Feb 2010; 39 (2):180-185; Purcell WT, Grossman SA, et al. Abstract No. 2963, *Proc Am Soc Clin Oncol* 22: 2003; Riolfi M, Buja A, et al. *Palliat Med.* 2014 May; 28(5):403-411.

³ Temel JS, Greer JA, et al. *NEJM* 2010;363:733-42; Bakitas M, Tosteson T, et al. *J Clin Oncol* 32:5s, 2014 (suppl: abstr 9512) Lilly CM, De Meo DL, et al. *Am J Med.* 2000; 109: 469-475.

⁴ Purcell WT, Grossman SA, et al. Abstract No. 2963, *Proc Am Soc Clin Oncol* 22: 2003.

⁵ Norton SA, Hogan LA, et al. *Crit Care Med.* 2007 Jun;35 (6):1530-5; Campbell ML, Guzman JA. *Chest.* 2003 Jan; 123(1):26-71.

⁶ Lautrette A, Darmon M, et al. *NEJM.* Feb 2007, 356(5), 469-478.

⁷ Parker SM, Remington R, et al. Patient outcomes and satisfaction with care following palliative care consultation. *J or Hospice and Palliative Nursing.* 2013, 15(4) 225-232.

⁸ Chand P, Gabriel T, et al. Inpatient palliative care consultation: describing patient satisfaction. *Perm J.* 2013;17(1): 53-55

⁹ Chiarcharo J, Praepannaral B et al. *Annals ATS.* 2015, 12(10):1528-1532; Allen RS, Allen JY, et al. *JAGS.* 2008, 56(10):1904-1909.

¹⁰ Cassarett D, Packard A, et al. *J Am Geriatr Soc.* 2008:56:593-99; Dionne-Odom JN, Anres A, et al. *J Clin Oncol* 32:5s,2014 (suppl: abstr LBA9513); Heyland DK, Allan DE, et al. *Open Medicine.* 2009, 3(2): 101-110.

11 Morrison, RS, Penrod JD, et al. *Arch Intern Med.* 2008; 168(16):1783-1790; Penrod JD, Deb P, et al. *J Palliat Med.* 2010 Aug;13(8):973-79; Morrison RS, Dietrich J, et al. *Health Affairs.* 2011 Mar;30(3):454-63; McCarthy I, Philastre MR, Fine RL, et al. *Health Services Research.* 2015; 50(1): 217-236; May P, Garrido MM, Cassell JB, et al. *J Clin Oncol.* 2015, 33(25): 2745-2752; Sweeney L, Halpert A, et al. *Am J Manag Care.* 2007 Feb;13(2):84-92.

¹² McCarthy I, Philastre MR, Fine RL. Cost Savings from Palliative Care Teams and Guidance for a Financially Viable Palliative Care Program. *Health Services Research.* July 2014. Doi: 10.1111/1475-6773.12203

¹³ May P, Normand C, Cassel JB, Del Fabbro E, Fine, RL, et al. Economics of Palliative Care for Hospitalized adults with serious illness: A meta-analysis. *JAMA Intern Med.* Doi:10.1001/jamainternmed.2018.0750.

In other words, evidence-based SPC delivered by skilled interdisciplinary professionals early in the course of serious illness clearly meets the Triple Aim standard for care that achieves better outcomes and higher patient satisfaction at lower total cost.

As with other medical treatments, decisions to provide SPC services should be determined by the needs and wishes of patients and their families. However, cost avoidance associated with SPC also appears substantial, particularly for the nation's major public payers, Medicare and Medicaid. Together, Medicare and Medicaid account for a sizeable portion of serious illness care in the United States and thus are well positioned to lead industry wide efforts to improve outcomes for these patients and their families, as well as to lower costs.¹⁴

In the most recent well-designed study on SPC services in Medicaid, hospital palliative care teams were shown to cut costs for seriously ill Medicaid inpatients in New York by \$4,000 - \$7,500 per discharge, compared to a matched set of patients receiving usual care.¹⁵ Palliative care patients spent less time in intensive care, were less likely to die in intensive care, and were more likely to receive hospice referrals. The authors projected overall savings from expanding access to palliative care teams at between \$84 million and \$252 million for the New York Medicaid program, without accounting for additional cost avoidance from reductions in future hospitalizations.¹⁶ The Council believes Texas should examine its own claims data to estimate return on investment from SPC and follow-up by introducing targeted Medicaid initiatives and incentives to accelerate the spread of this value-based model across the state.

As a large purchaser of healthcare, the state has many opportunities to drive value through benefit designs, educational efforts, and incentives. Texas Medicaid puts a portion of both MCO and hospital reimbursement at risk

¹⁴ NAM (May 2018). Financing and Payment Strategies to Support High-Quality Care for People with Serious Illness: Proceedings of a Workshop.

¹⁵ Ibid (Morrison 2011).

¹⁶ Accounting for medical inflation since the ending time period for the study data (2007), the estimate for cost avoidance in 2017 dollars would be \$113 million to \$341 million.

based on performance. These performance incentives are strongly influenced by rates of potentially preventable events, including avoidable admissions, readmissions, and emergency department visits. Analytic and educational efforts to quantify and report benefits to MCOs and hospitals from reductions in potentially preventable events for seriously ill patients, and the role of SPC in achieving these reductions, even within the current Medicaid payment model, would help encourage formation of new SPC teams.

To further ensure that spending on serious illness care aligns with evidence-based healthcare and value, Texas Medicaid should incorporate additional incentives into Medicaid. To start, Medicaid could provide a small payment adjustment to hospitals that achieve advanced certification for palliative care from The Joint Commission. This certification recognizes hospital inpatient programs that demonstrate exceptional patient and family-centered care. Eligible organizations must maintain a full-time service led by an interdisciplinary team, adhere to guidelines grounded in evidence and expert consensus, practice effective care coordination and communication among all providers in the hospital setting, and have the ability to provide palliative care to its entire inpatient population. Ongoing data collection, performance measurement, and quality improvement are fundamental to the certification process. Similar incentives for high performing community based palliative care programs should also be implemented.

Strengthening Medicaid's role with ACP offers another avenue to pursue value-based care. Texas Medicaid should adopt an ACP benefit in medical policy, as Medicare and California Medicaid have already done and other state Medicaid programs are considering. Structured advance planning promotes earlier access to SPC, less unwanted care and suffering, and lower total healthcare spending. Paying doctors, nurses, and social workers for ACP consultations would result in some additional program spending upfront, but these relatively minor outlays would be more than offset by reductions in avoidable emergency department and hospitalization costs.¹⁷

An initial pilot covering new nursing home residents offers a promising option to leverage ACP for an early, meaningful success. Medicaid covers

¹⁷ The Council's recommendation would make Current Procedural Terminology (CPT) codes 99497 and 99498 payable under Texas Medicaid policy. Currently, the state only covers Medicare cost sharing amounts for clients dually eligible for Medicaid and Medicare.

more than 60% of individuals in Texas nursing homes.¹⁸ These individuals account for over \$3 billion in nursing home costs alone, with additional spending for hospital, professional, and other acute care services.¹⁹ Based on evidence from a randomized controlled trial, when nursing home patients engage in ACP, they use hospital services less frequently and have 33% lower global costs of care.²⁰ Patient and family satisfaction scores also are higher with no change in patient mortality. This increase in patient and family satisfaction combined with lower costs of care epitomizes the best hopes for transforming Medicaid from a volume to a value-based system.

DRAFT

¹⁸ Medicaid's Role in Nursing Home Care. Henry J. Kaiser Family Foundation, June 20, 2017, <https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/> (accessed September 18, 2018).

¹⁹ As reported by HHSC for state fiscal year 2017.

²⁰ Molloy DW, et al. Systematic Implementation of an Advance Directive Program in Nursing Homes: A Randomized Trial. JAMA, March 15, 2000; Vol. 283, No. 11, P 1437-1444.