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Policy and Payment Trends Impacting Palliative Care Today and Tomorrow

Palliative care delivery and payments models are evolving quickly, as are the policies that affect them. This session will provide an overview of key legislative, regulatory and market changes that are impacting palliative care practice today, and will shape its near future.

PCQC 2022 Quality Matters Conference:

Policy and Payment Trends Impacting Palliative Care Today, and Tomorrow

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PALLIATIVE MEDICINE
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

PCQC

Disclosures

→ I have no relevant financial disclosures

→ I am currently active in volunteer policy work with:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- National Coalition for Hospice and Palliative Care (NCHPC)
- Patient Care Quality of Life Coalition (PQLC)
- National Academies of Science Engineering and Medicine (NASEM)
- Palliative Care Quality Collaborative (PCQC)
- Center to Advance Palliative Care (CAPC)
- American Medical Association (AMA) Relative Value Scale Update Committee (RUC)
- Association of Departments of Family Medicine (ADFM)
- American College of Physicians (ACP)

Objectives

→ Understand key federal legislative priorities in palliative and serious illness care

→ Appreciate the impact of regulatory actions on palliative and serious illness care payment and delivery


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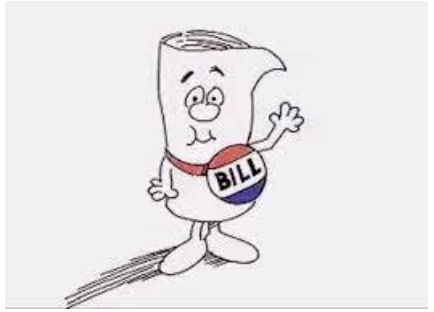
Frequently Used Terms



→ **Legislation:** laws and statutes enacted by federal and state governments

→ **Regulation**: rules and procedures created by federal and state agencies to implement laws and statutes

→ **Stakeholders:** individuals or groups with interest and/or influence over specific legislation and/or regulation

→ **Policy**: a course or principle of action adopted or proposed by a government, party, business, or individual.

Hospice and Palliative Care Policy Challenges

→ Workforce

→ Access

→ Payment

Workforce in Crisis

54%

Clinicians report burnout

60%

Learners report burnout

80%

Front-Line HCWs report violence

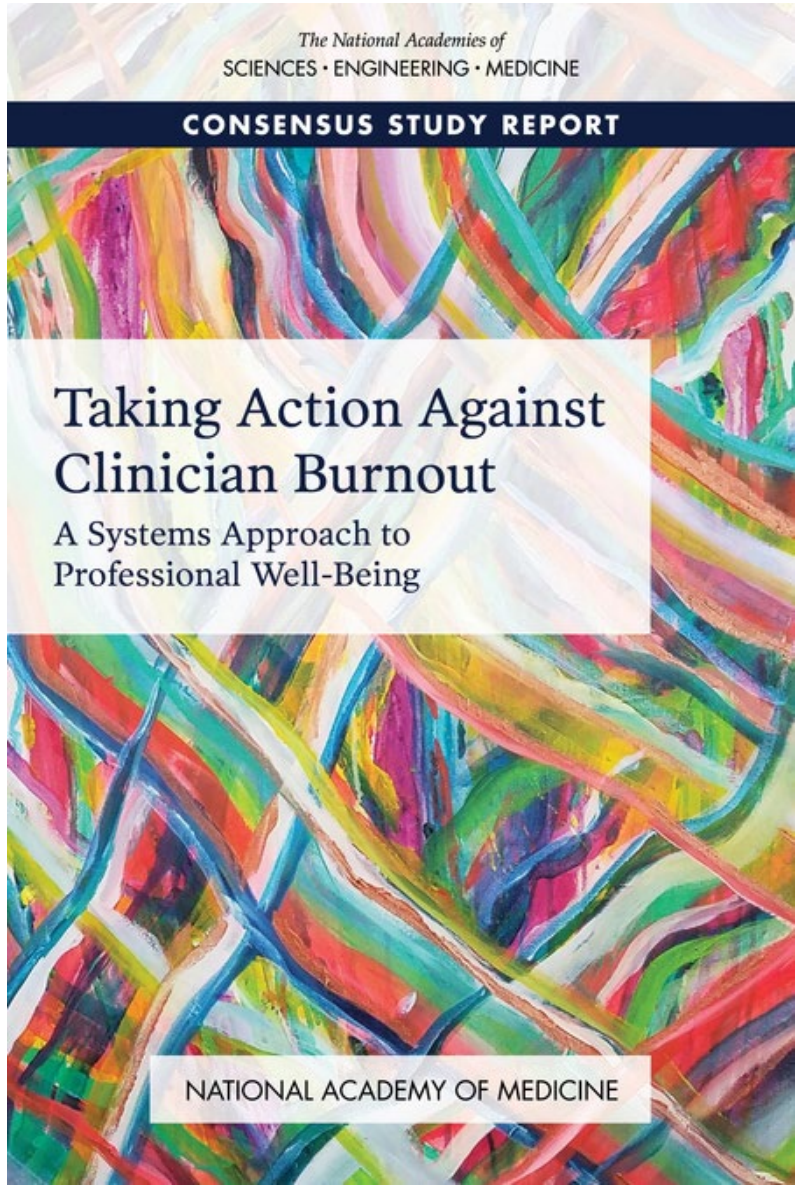
21%

Planning to leave

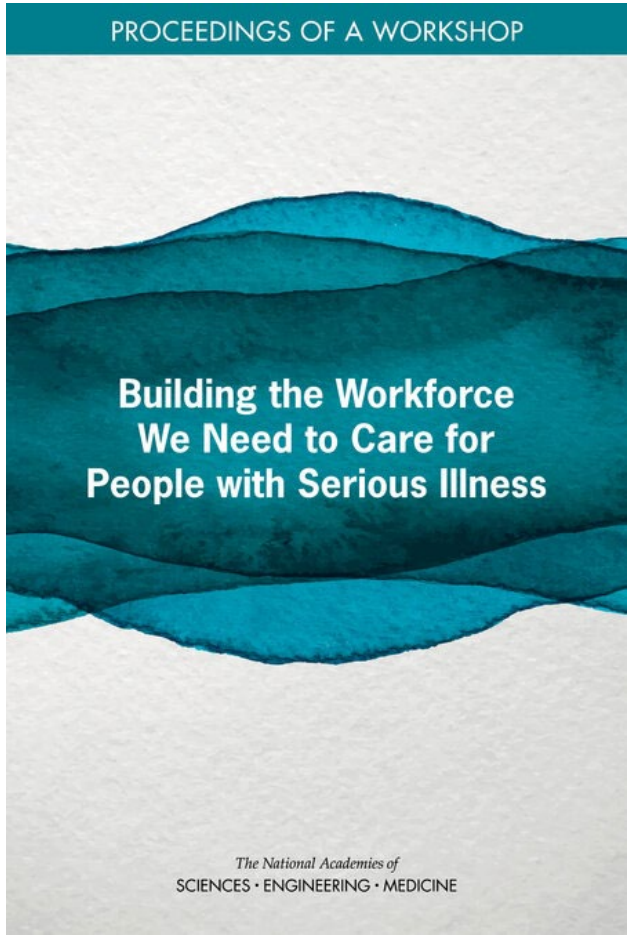
30%

Want fewer hours

3 million by 2033



Workforce in Hospice and Palliative Care



HEALTH PROFESSIONALS

By Arif H. Kamal, Steven P. Wolf, Jesse Troy, Victoria Leff, Constance Dahlin, Joseph D. Rotella, George Handzo, Phillip E. Rodgers, and Evan R. Myers

Policy Changes Key To Promoting Sustainability And Growth Of The Specialty Palliative Care Workforce

- → ***Pass Palliative Care and Hospice Education and Training Act (PCHETA)***
- → ***Increase funding for interprofessional specialty palliative care training***
- → ***Sustainable payment models for interdisciplinary palliative care teams***
- → ***Funding for more rigorous workforce research***
- → ***Policies and practices to reduce and prevent burnout***

Palliative Care and Hospice Education and Training Act (PCHETA)

→ Modeled after federal legislation that established Geriatrics in the US

→ Would create:

- Palliative Care and Hospice Education and Training Centers
- Academic Career Development and Career Incentive Awards
- Workforce Development, including Nursing Training
- Public Education and Awareness
- Research Funding

→ Key legislative priority for many organizations: AAHPM, NHPCO, NCHPC, PQLC and others

PCHETA's Journey

→ First introduced in 2011 (112th Congress), reintroduced every Congress since

→ Passed the House in the 115th and 116th Congresses

- 115th (2018): Stalled in the Senate HELP Committee
- 116th (2020): Introduced, did not move forward

→ Passed House in 117th Congress (current)

- Key provisions added to 2021 *Build Back Better Act*, didn't pass
- Efforts will continue in 'lame duck' session

What's gotten PCHETA this far?

→ Persistence

→ Broadening stakeholder base

→ Intentionally bipartisan support

→ Compromise

→ Creativity and flexibility

→ Constituent advocacy

Other Relevant Workforce Legislation

→ *Provider Training in Palliative Care Act* (Senate)

→ *Specialty Physicians Advancing Rural Care (SPARC) Act* (Senate)

→ *Resident Physician Shortage Reduction Act* (Senate and House)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Access to Hospice and Palliative Care: Federal

→ Federal legislative activity (mix of House and Senate bills):

- *Expanding Access to Palliative Care Act*
- *Improving Access to Transfusion Care for Hospice Patients Act*
- *Improving Access to Advance Care Planning Act*
- *Seniors Chronic Care Management Improvement Act*
- *Improving Seniors Timely Access to Care Act*
- *Children's Program of All Inclusive Coordinated Care (ChiPACC)*
- *Supporting our Seniors Act*

Access to Hospice and Palliative Care: State

→ Significant activity at the state level; recommend NASHP website

→ 25 states now have Palliative Care Advisory Task Forces (including AL, GA, SC)

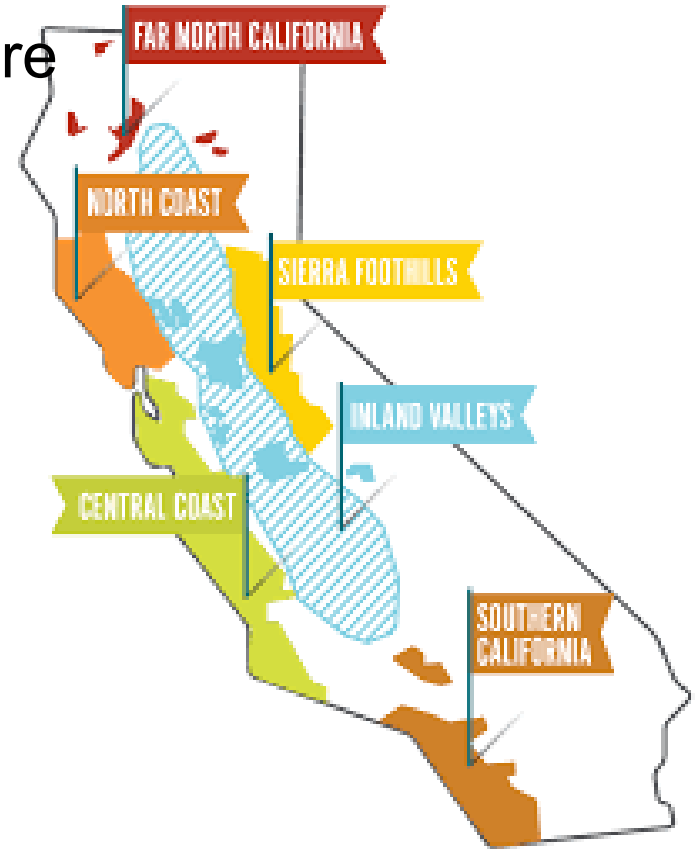
→ Other states have created Palliative Care Information Programs

→ California is the first state to fund Palliative Care through Medicaid

State-level Access: California SB 1004 (2018)

→ Requires Medi-CAL managed Medicaid plans to ensure access to palliative care

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Plan of Care
- Care Coordination
- Pain and Symptom Management
- Mental Health and Medical Social Services



→ From 2018 – 2019: number of PC programs doubled.

Access: Telehealth in Palliative Care

→ Access to Telehealth dramatically scaled during COVID-19 Pandemic

- Previous 'originating site' and geographic restrictions lifted temporarily
- Allowed for real time audio-video and real time audio-only services
- Expansions will expire at the end of the COVID-19 Public Health Emergency

→ Broad support for permanent access to telehealth payment

- *Telehealth Modernization Act* (House and Senate)
- *Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) Act* (House and Senate)
- *Advancing Telehealth Beyond COVID-19 Act* (House)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Payment Policy Trends and Challenges

→ **Payment for IDT care remains challenging outside the hospice benefit**

→ Move from Fee-for-Service to Value-Based Payment is slow and circuitous

→ Medicare Physician Fee Schedule is improving, while large cuts loom

→ Consolidation and ‘vertical integration’ with health plans continues

→ Influence of Medicare Advantage plans is rapidly expanding; CMS very likely to ‘carve in’ the Medicare Hospice Benefit

Medicare Quality Payment Program

MIPS/MVP

Merit-based Incentive Payment System/MIPS Value Pathways

Performance-based payment adjustments based on quality, cost, care improvement and interoperability

APM

Alternative Payment Models

Provides greater incentives to improve quality and control costs for specific clinical conditions, care episodes or populations

Centers for Medicare and Medicaid Innovation (CMMI)

Palliative Care in Alternative Payment Models

→ *2017: Patient and Caregiver Support for Serious Illness (PACSSI),* recommended for testing but not implemented

→ Close engagement with CMMI leaders and key stakeholders

→ Relationships built have led to ongoing input into integrating palliative and serious illness care into other models in the CMMI portfolio

- State-of-the-Science Quality Measures for Serious Illness Care
- Promotion of interdisciplinary Palliative Care teams

Fee-for Service Payment: Improving, but…

→ Positive Changes to Evaluation and Management (E/M) Services

- Measurable increase in RVU value (7% – 12% annual revenue increase)
- Substantially streamlined documentation requirements
- Can now bill on either complexity or 'total time on day of service'

→ Advance Care Planning codes have retained their RVU values, and new Principal Care Management (PCM) codes can be billed by multiple practices during the same month

→ Budget neutrality then requires that overall payments get cut via 'conversion factor' (4.5% for 2023); often fixed by emergency legislation

Medicare Advantage Plans

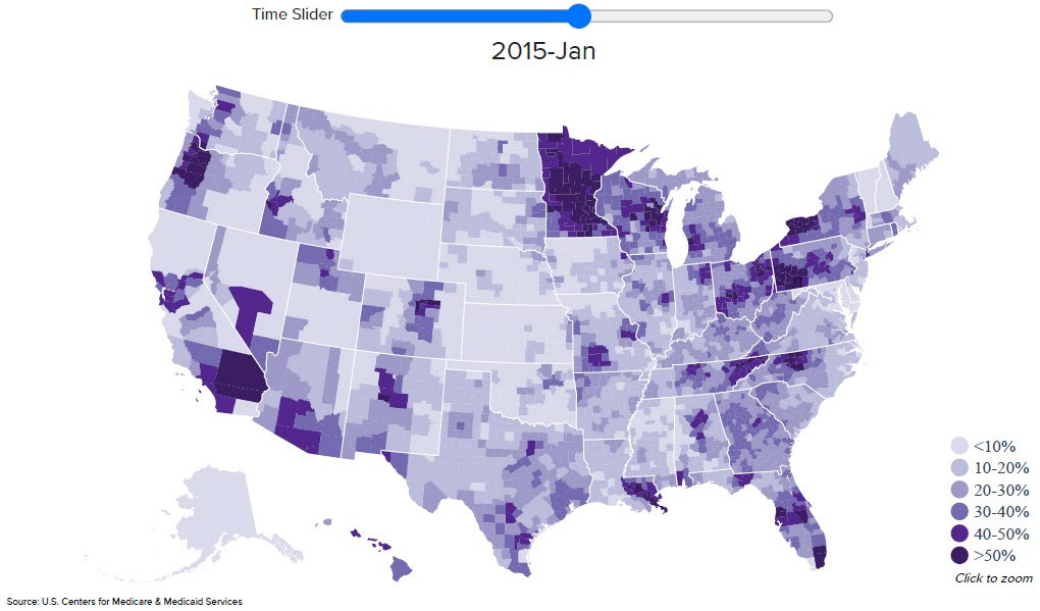
→ Enables commercial insurers to enroll Medicare beneficiaries and ‘bundle’ Part A (hospital), Part B (provider) and Part D (drug) services

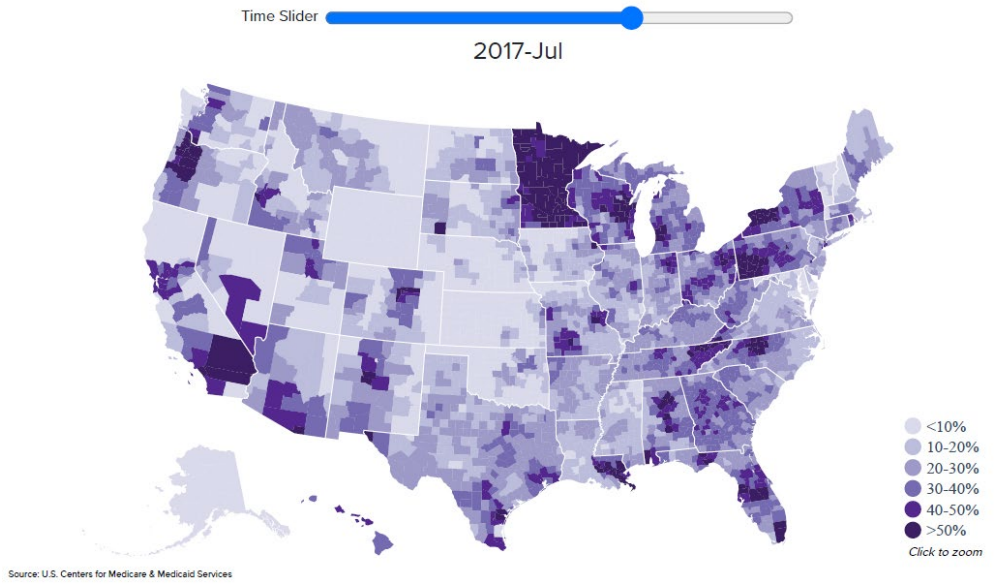
→ CMS incentivizes MA plans to coordinate care, pays a premium that plans can keep if they control costs; many details remain proprietary

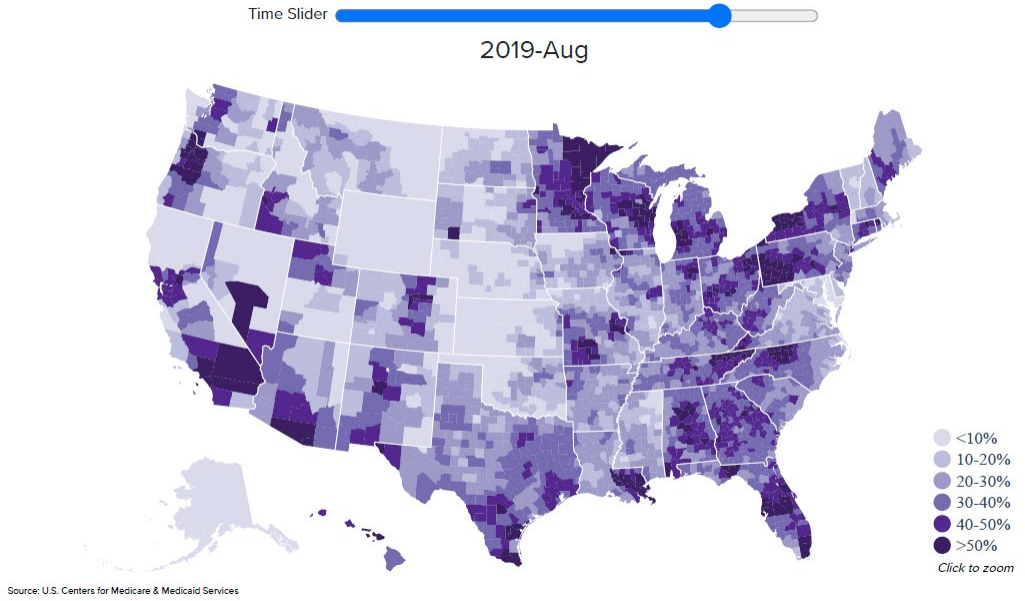
→ 2021 MA spending: $350B; will grow by 8.5% in 2023

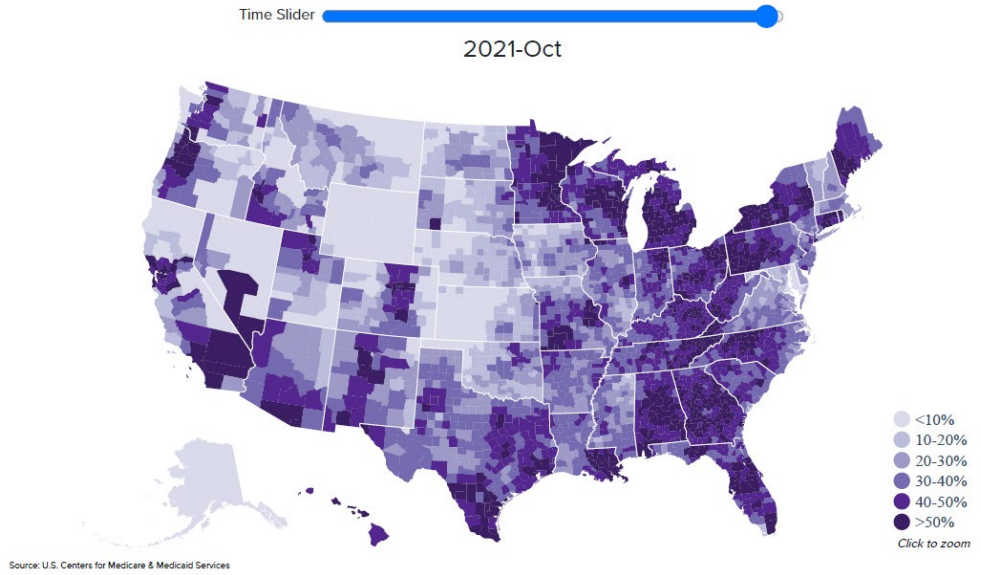
→ 2030: 50% of Medicare Beneficiaries will enrolled in MA Plans

Medicare Advantage Penetration Rates by County, 2015 - 2021









Medicare Advantage and Palliative Care

→MA plans are strongly incentivized to control costs, and (increasingly) attend to quality of care and patient experience

→'Supplemental Benefits' allow MA plans flexibility to deliver PC services

→Market signals show that serious illness care delivery is very attractive:

- *Anthem has acquired Aspire Health*
- *Humana (and private equity firms) have acquired Kindred Hospice*
- *Optum has acquired Landmark and Prospero; Optum now employs 5% of the US physician workforce (60,000 docs)*

Testing the MA 'Hospice Carve-In'

→ Present state: MA-enrolled beneficiaries who elect the Medicare Hospice Benefit automatically transition to Traditional (FFS) Medicare ('carved out')

- Maximizes patient choice, encourages growth of hospices
- Frequently results in a change of providers
- Can be very profitable for MA plans

→ Starting in 2014, MedPAC began calling for Medicare Advantage plans to administer the hospice benefit ('carve in') to improve care coordination and quality/cost accountability

→ In 2016, Senate Finance Committee recommends carve-in

→ 2019: CMS announces it will test 'carve-in' starting in 2021 in VBID program

What Will the MA Hospice Carve-In Mean?

→ Participating MA Plans will administer (i.e. pay for) hospice benefit

→ Plans incentivized to create 'narrow networks' of hospices

- Providers included based on quality and cost performance
- Beneficiaries choose from in-network providers

→ Risk: providers likely to see decreased payments for hospice care

→ Opportunity: MA plans will be incentivized to pay for 'upstream' PC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