Integrated palliative care in a Medicare Advantage marketplace: a provider’s perspective

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The case for integrated palliative care

<table>
<thead>
<tr>
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<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td><strong>Inpatient PC</strong></td>
<td>-- Often occurs at key transitions in illness course</td>
<td>-- Episodic, discontinuous</td>
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<td>-- Crisis/ high need situations</td>
<td>-- Tends to occur late in the disease course</td>
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<td>-- High level of technical expertise</td>
<td>-- Doesn’t avoid the index hospitalization</td>
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<td>-- Avoids unwanted interventions in-hospital, shortens LOS</td>
<td>-- Time pressure for goal-setting</td>
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<td>-- Increases referral into hospice</td>
<td>-- Hospice referrals may be late</td>
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<td><strong>Home-based PC</strong></td>
<td>-- More complete picture of pt/family needs</td>
<td>-- Less integrated with subspecialist care</td>
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<td>-- Time to develop goals of care</td>
<td>-- Less MD/technical expertise</td>
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<td>-- Greater continuity of care</td>
<td>-- Lots of driving</td>
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<td>-- Potential to avoid an index hospitalization (if avoidable)</td>
<td>-- Longer service period → greater cost expenditures</td>
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<td>-- Increases referral into hospice</td>
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## Aligning payer-provider incentives

<table>
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<tr>
<th>Palliative Care Goals</th>
<th>Program element</th>
<th>Hospital</th>
<th>Payer</th>
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<tr>
<td>Upstream access to PC services</td>
<td>Community and/or inpatient</td>
<td>++++/Uncertain</td>
<td>++++</td>
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<tr>
<td>Reduce unwanted, ineffective hospitalizations</td>
<td>Community-based PC</td>
<td>Uncertain</td>
<td>++++</td>
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<tr>
<td>Increase hospice referrals and LOS</td>
<td>Community and/or inpatient</td>
<td>Uncertain</td>
<td>++++</td>
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<tr>
<td>Match hospital-based care intensity to patient goals/values</td>
<td>Inpatient</td>
<td>++++</td>
<td>+/0</td>
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Forging a provider-payer partnership for integrated palliative care services

– Partners – BTMG, CPMC, and AIM
  • BTMG – full-risk provider group for 10K MA enrollees
  • CPMC – Sutter Health quarternary hospital with deep BTMG relationship
  • AIM – Sutter Care at Home care management program

– Care model
  • Proactive case-finding at time of index hospitalization
  • Inpatient palliative evaluation and Day 1 consult for each subsequent hospitalization
  • Post-discharge AIM care management
  • Tight coordination between hospital-based PC and AIM
Building a financial model for integrated PC services

- Medicare payment data for AIM demonstration
  - Baseline hospice rate at CPMC = 37% → 57% with AIM
  - Last month of life costs
    - $34K w/o hospice
    - $18K with hospice
      » Note: > 1/3 of hospice admits <7d
    - $8K for MA patient with hospice
  - Last week of life costs 4x as much as 2nd to last week
  - Last month of life costs 3x as much as 2nd to last month

- Early inpatient PC consultation reduces hospital costs by 14-24%
  - Likely reduces subsequent hospitalizations and hospice, though unclear impact if AIM in place
Building a financial model for integrated PC services

– Hospice entry is obvious quality incentive
  • patient-centered
  • clearly modifiable by PC/AIM
  • major financial implication, esp for MA payer
– From both quality and cost standpoint, hospice LOS $\geq$ 7 days should be considered
– For patients NOT entering hospice
  • Soliciting and honoring preferences
  • Avoiding hospitalizations close to death
Proposed payment model

– Overall goals
  • Cover program costs
  • Break-even for insurers
  • Distribute risk and excess savings “fairly”
  • Incentivize high quality care

– Combination of:
  • PMPM
  • Quality and shared savings incentives
    – Hospice LOS ≥ 7 days
    – Avoid hospitalization in last month of life

– At current AIM performance level, payment model achieves:
  • Break-even for providers
  • ROI = 1.5 for payers
  • Risk shared about evenly
Business case for integrated PC (n=200)

$1.46* million/yr
Direct payments avoided

$240K/yr PMPM
$360K/yr incentive payments

ROI = 1.44*

* Based on measured AIM-associated reimbursement savings in the absence of additional savings from proactive case-finding or inpatient PC.
Quality monitoring

- Case-finding
- Implementation fidelity
- Process of care
- Outcomes of care
Quality monitoring

• Case-finding
  – Time-in-program – special attention to short-stay and long-stay pts
  – “Missed” patients
    • Died without being touched
    • Referred into hospice without being identified
    • Referred for inpt PC without being identified

• Implementation fidelity
  – Were program services implemented according to plan?
Quality monitoring

• Process of care
  – Goals of care discussions and timing
  – Advance care planning, esp POLST and timing
  – DNR orders and timing

• Outcomes of care
  – Hospice referral and timing
  – Utilization – hospitalizations, LOS, ICU, LSTs
  – “Goal-congruent care”
  – Experience of care – location of death, satisfaction
  – Payments and costs of care