Medicaid Palliative Care Benefits: Actuary Analysis and NASHP's State Institute to Improve Care for People with Serious Illness

January 24, 2023

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

The John A. Hartford Foundation

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Webinar Agenda

- **Welcome** (Wendy Fox-Grage, NASHP)
- **Introduction** (Marcus Escobedo, The John A. Hartford Foundation)
- **Hawaii's Medicaid Palliative Care Benefits** (Judy Mohr Peterson, PhD, Hawaii Medicaid Director)
- **Actuarial Analysis of Medicaid Experience** (Elrycc Berkman, Optumas)
- **State Institute to Improve Care for People with Serious Illness** (Wendy Fox-Grage, NASHP)

Introduction

Marcus Escobedo
Vice President, Communications & Senior Program Officer
The John A. Hartford Foundation

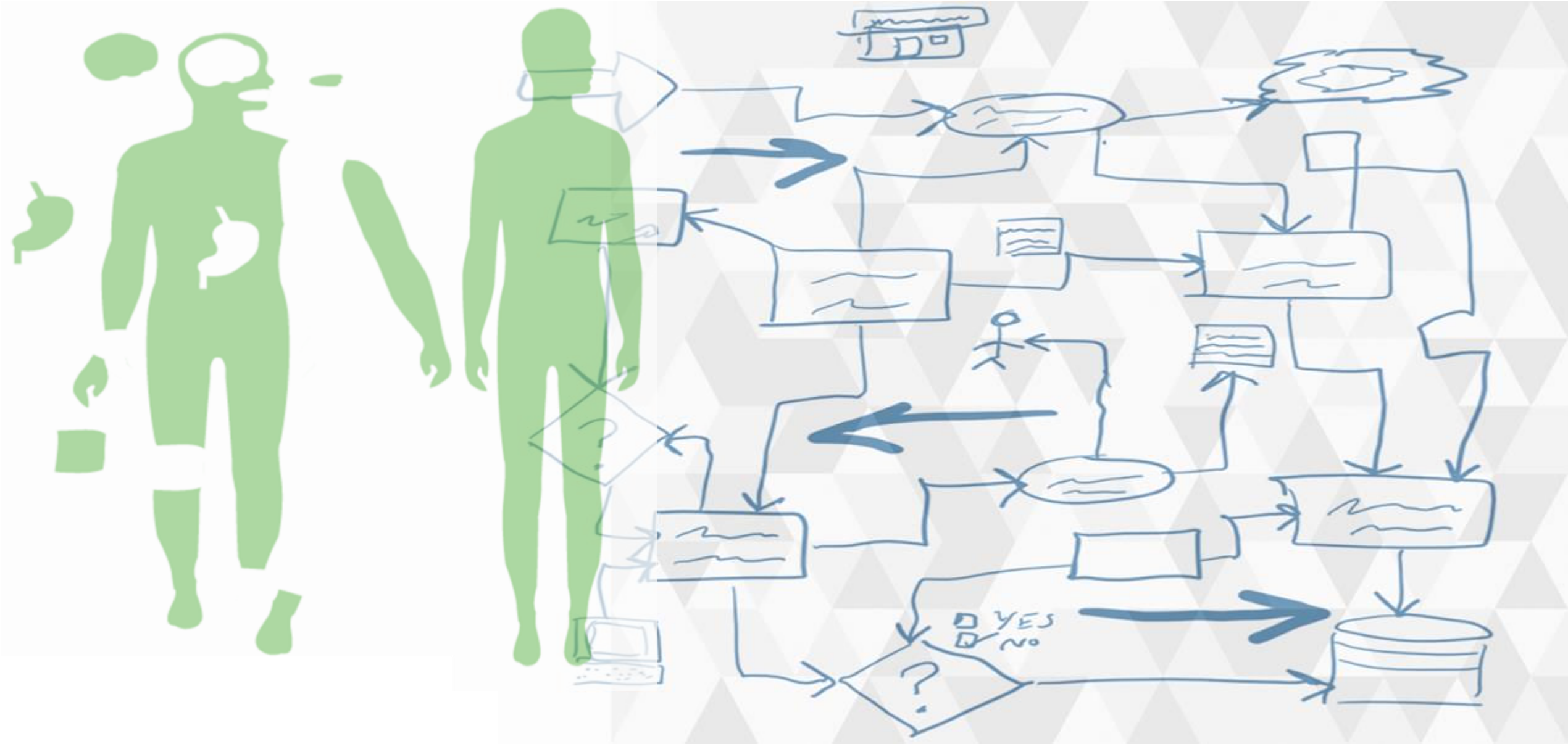
Medicaid Palliative Care Benefits

Judy Mohr Peterson, PhD

Hawaii Medicaid Director

January 24, 2023

Fragmented confusing healthcare system



Care for People with Complex Care Needs

While hospice care that addresses the needs of individuals at the end of life is covered, people with complex conditions are not receiving needed services across the continuum of care. Therefore, develop non-hospital (home/community) palliative care benefit.

Living as well as you can for as long as you can.

What Is Palliative Care?

Specialized medical care for people living with a serious illness to provide an extra layer of support to promote the best quality of life for **both the patient and the family.**

Based on the ***needs of the patient (person-centered),*** not on the patient's prognosis.

Provided ***along with curative treatment***

Appropriate at ***any age and at any stage*** **in a serious illness**

Provided by a *specially-trained team of doctors, nurses, and other specialists* who work together with a patient's other doctors

Implementation of benefit

Eligibility criteria, Service array, Define providers (teams); Develop Payment/Rate methodologies

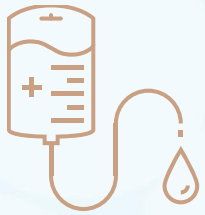
State Plan amendment submitted - RAI: Challenge - defining the benefit to fit into one of the SSA 1905(a) benefits such as Home Health, Hospice.

The Continuum of Care for Members with Serious Illness

	Community-Based Palliative Care	Home Health - 1905(a)	Hospice	Home and Community Based Services (only waivered)
Eligibility Criteria	Serious illness and homebound, with expectation on ongoing decline, patient assessment for eligibility/need	Homebound, often provided post-hospitalization	Terminal illness, with prognosis < 6 months, forego disease-related treatments, physician attestation of prognosis	Would otherwise require care in an institutional setting, such as a nursing home
Services	Pain and symptom management; advance care planning; shared decision making; care coordination; 24/7 availability of clinical nursing, home health aide, medical, social work	Speech therapy, occupational therapy, physical therapy, respiratory therapy, wound care, IV placements, clinical nursing visits	Pain and symptom management; advance care planning; shared decision making; care coordination; 24/7 availability of clinical nursing, home health aide, medical, social work	Case management, homemaker services, home health aide services, personal care services, adult day health, habilitation, respite care
Concurrent Care	Concurrent treatment not limited, ranging from conservative to aggressive.	Concurrent treatment not limited, ranging from conservative to aggressive.	Not available, except for children under age 21.	Services stop while admitted to skilled nursing facility or other inpatient setting.
Treatment Goals	Coordinate medical treatments, manage pain and symptoms, and ensure patient and caregiver goals are documented and met.	Short term, limited therapies, focused on functional improvement	Limited and focused on pain and symptom management; Coordination of durable medical equipment, medications, and in-home supplies.	Personal assistance; limited supportive services

Hawaii Eligibility Criteria: Serious Illness

To receive palliative care services must have a severe medical condition that is known to be life-limiting and demonstrate progressive, ongoing decline in function through an evidence-based screening tool for function



PREVALENT DISEASES

Advanced cancer (Stage 3 or 4, locally advanced or metastatic cancer; leukemia or lymphoma)

Congestive heart failure (CHF) (NYHA Class III or IV criteria

Chronic obstructive pulmonary disease (COPD)

COMPLEX CHRONIC CONDITIONS

Chronic kidney disease (Stage III or IV)

End-stage renal disease (ESRD)

End Stage Liver Disease or Cirrhosis

COGNITIVE AND FUNCTIONAL LIMITATIONS

Alzheimer's Disease or other **dementias**

Neurologic Disorders, such as motor neuron disease, Parkinson's Disease, Muscular Dystrophy, Multiple Sclerosis, or another progressive neurologic disorder

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Hawaii Palliative Care Array of Services:

Provided when medically necessary, aligned with patient goals for care, and directed on behalf of the patient and family

ASSESSMENT

Comprehensive interdisciplinary palliative care assessment

Individualized care plan

Caregiver needs assessment

CLINICAL SERVICES

Addressing a person's holistic needs and the needs of their caregiver

In-person or telehealth visits by an interdisciplinary team

Medication management and reconciliation

Available 24 hours/day, 7 days a week

Advance Care Planning

Family and caregiver education and training

CARE COORDINATION & COMMUNICATION

Collaboration with patient, family and other providers

Care coordination and patient navigation

Coordination with MCOs for authorization and referral to additional services

Education on hospice services

Hawaii – provide services: Interdisciplinary team supports the person and their family who are to be in the center

Palliative care is delivered by an appropriately trained and prepared **interdisciplinary team**, the members of which have demonstrated competency in palliative care. The interdisciplinary team should, ***at minimum***, consist of the following disciplines*:

- ***Physician, board certified in a related field:*** The physician role must direct clinical care and program oversight. At least one prescribing clinician on the interdisciplinary team must have specialty certification in hospice and/or palliative care. Advanced Practice Nurses with prescribing authority and specialty certification
- **Registered nurse**
- **Licensed clinical social worker**
- **Spiritual care professional**
- Child-Life Specialist (CLS) – Only Required for Pediatrics

- Strongly encouraged team members: Mental Health professionals, Community Health Workers; case managers
- Access to other services: Pharmacists, home health, home health

* As designated in the National Consensus Project Clinical Practice Guidelines

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Actuarial Analysis of Medicaid Experience

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Senior Manager, CBIZ Optumas

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Agenda

- Palliative Care in Medicaid
- Actuarial Analysis
  - Identify Population
  - Review of Costs
  - Define the Benefit
  - Savings Assumption
  - Results

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Palliative Care in Medicaid

- No Medicaid programs offer a comprehensive or “stand-alone” palliative care benefit
- Many states offer a limited set of discrete services for palliative care that fall short of increasing access or uptake
- The benefits related to offering palliative care is gaining traction and becoming more popular
- California was first state to require coverage of palliative care services through Senate Bill (SB) 1004
- Actuarial analysis mirrored CA SB 1004 Medi-Cal Palliative Care Policy

Actuarial Analysis
Methodology

- Identify the population
- Review costs of identified population
- Develop bundled fee schedule benefit amount
- Determine savings assumption
- ROI results

Actuarial Analysis
Identify the Population

- Create disease prevalence summaries
- Used CY18-CY19 experience across three State Medicaid programs, grouped by broad eligibility categories
- Diagnostic information used to identify members with following illnesses: cancer, cardiovascular disease, COPD, kidney failure, advanced liver disease, and neurologic disorders
- Disease prevalence highest among disabled, dually-eligible, and LTSS (waiver and institutional) populations

Actuarial Analysis
Costs of Population

- Conducted a look-back study analyzing the experience for disabled and LTSS populations
- Analysis summarized the experience of Medicaid enrollees with a qualifying illness that had utilized hospice services
- Reviewed experience 3 months, 6 months, and 12 months prior to utilization of hospice services
- Increased utilization of inpatient and emergency services as members approach hospice

Actuarial Analysis
Bundled Fee Amount

- Bundled fee amount based on service and palliative care team demonstrated in CA SB 1004 Medi-Cal Palliative Care Policy:
  - Services: initial assessment, 24/7 telephonic support, pain/symptom management, advanced care planning (including POLST), ongoing shared decision-making, care management plan, care monitoring, caregiver education and counseling, and warm hand-offs across providers
  - Palliative care team: MD/DO, nurse practitioner/physician's assistant, medical director, nurse, social worker, home health aide. In addition, an appropriate team member must be available to provide after-hours triage

Actuarial Analysis
Bundled Fee Amount

- Clinical input to develop monthly visits, duration, and staff allotment by service
- Wage information from the Bureau of Labor Statistics and adjusted by state
- Includes administrative load of 20%
- Benefit developed over a six-month period
- Benefit cost by state:

	Benefit Cost
State 1	$484.24
State 2	$507.40
State 3	$455.90

Actuarial Analysis
Savings Assumption

- Effective administration of benefits will lead to reduced inpatient and emergency services utilization
- Assumed savings:
  - Lower bound – 26% reduction
  - Upper bound – 46% reduction
- Savings assumption considered reasonable for the population considered under this analysis based on information available for comparable studies

Actuarial Analysis
Results – ROI and Potential Savings

- Results for non-dually eligible populations:

	Lower Bound – 26% Reduction		Upper Bound – 46% Reduction	
	Potential PMPM Savings	**ROI**	**Potential PMPM Savings**	**ROI**
State 1	$378.27	0.8	$1,041.73	2.2
State 2	$231.10	0.5	$775.38	1.5
State 3	$460.32	1.0	$1,165.10	2.6

Thank You

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State Institute to Improve Care for People with Serious Illness

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The Importance of Palliative Care and Serious Illness Care

HOME < AGING AND DISABILITIES < PALLIATIVE CARE

TOPIC

Palliative Care

Palliative Care Resource Center

SHARE

State health policy leaders see enormous value in palliative care, which can promote good outcomes and avoid costly, unnecessary, and often unwanted treatments for people who are seriously ill. NASHP provides resources and support for states to implement and expand high-quality palliative care.

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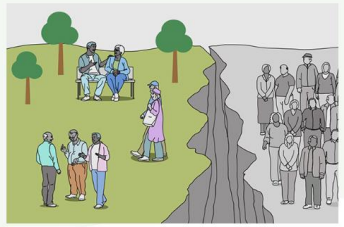
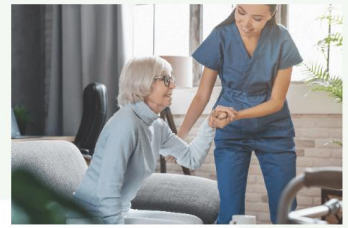
Featured Content

States Make Progress on Palliative Care



Educating the Public about Palliative Care



Strengthening Care for People with Serious Illness: Seven Steps for Building a Community-Based Palliative Care Benefit within Medicaid

Palliative Care in Medicaid: Costing Out the Benefit

Map: Palliative Care Advisory Task Forces

SERIOUS ILLNESS INSTITUTE: Overview

- Up to five teams of state leaders for two years will develop and/or strengthen policies and strategies to improve access to palliative care
- Based on state interest, example topics may include:
  - Advance care planning
  - Care management
  - Reimbursement
  - Managed long-term supports and services
  - Regulations and licensure
- States will have access to Medicaid actuaries to cost out and customize palliative care benefits

SERIOUS ILLNESS INSTITUTE: Objective

- Develop and strengthen state policies and strategies to improve access to palliative care, and thus improve care for people with serious illness
- Provide state leaders with opportunities for peer-to-peer discussion, access to national expertise, and the option for developing a Medicaid palliative care benefit customized to their state's data and needs

SERIOUS ILLNESS INSTITUTE: Benefits of State Participation

- The institute will provide:
  - Development of a **state serious illness policy work plan** to support key policy and programmatic state priorities
  - **Individualized technical support** from NASHP and expert consultation from national and state leaders in palliative care, including the option to develop a custom-made Medicaid palliative care benefit
  - **Four virtual workshops and peer-to-peer learning opportunities** to gain knowledge about state policy strategies to support palliative care and care for people with serious illness
  - **Bimonthly customized virtual state team meetings** with technical experts

SERIOUS ILLNESS INSTITUTE: Application Guidelines

- State teams of up to 4 members:
  - At least **two state officials** or administrators who can implement the state's specific goals and project activities
    - **One state official as team lead** to provide overall leadership and serve as a primary point of contact
  - Additional members may include other state staff; representatives from serious illness advocacy organizations, community-based organizations, providers, or other key organizations that can support the state's goals

SERIOUS ILLNESS INSTITUTE: Application Guidelines

- Applications will include:
  - Specific and measurable policy goals with corresponding activities and a timeline for implementation activities
  - Technical support, expertise, and other resource needs of the state
  - How the state will use the provided technical assistance to make progress toward goals within the institute and after its conclusion

SERIOUS ILLNESS INSTITUTE: Application Timeline

- **January 3, 2023**: Application opened
- **January 24, 2023**: Informational webinar
- **February 24, 2023**: Applications due at 5 p.m. EST
- **March 7, 2023**: Selected states notified
- **March 21, 2023**: Institute begins

Thank you!
Questions?

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