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Judy: Thank you for joining us today. We'll just wait a moment while everybody joins in on the Zoom. Thank you for joining us today. I'm gonna pause just a minute, I see some of the numbers going up as people join us on the Zoom. Thank you for joining us today. I'm Judy Thomas, CEO of the Coalition for Compassionate Care of California. We're excited to be able to share with you today our experience with making community-based palliative care a more routine part of healthcare, through the development and evaluation of consensus standards for community-based palliative care.

We believe the information we will be sharing with you today will be of value to a wide range of audience, including policymakers and advocates, health plans, healthcare providers, as well as researchers. Just a couple of housekeeping items as we get started here. First, this webinar is being recorded. And you'll receive an email in the next few days with a link to both the recording and the slides. And second, we will be using the chat box for questions. So, please feel free to post questions in the chat throughout the webinar. And we will pause during the webinar to answer questions.

For those of you who aren't familiar with the Coalition for Compassionate Care of California, we are a nonprofit dedicated to creating a future where people can live their best lives possible during serious illness. And we do that by making conversations about serious illness a part of everyday life, and palliative care a part of everyday healthcare, wherever people receive care. We know that this change is bigger than any one of us can do on our own, and that's why we work collaboratively across all stakeholders to change the system for everyone.

I'd like to take a moment to thank our sponsors. First and foremost, I would like to thank the California Health Care Foundation, whose generous financial support funded the demonstration project that tested and evaluated the impact of the consensus standards and is the focus of this webinar series. I'd also like to thank the John A. Hartford Foundation and Atlantic Philanthropies, whose financial support, through the Practice Change Leaders Program, made development of the consensus standards possible. And lastly, I'd

like to thank our national partners that sponsored this webinar series, including NHPCO, C-TAC, and HCCI.

Today's webinar is the second of a three part series. Last week, we talked about the rationale and impact of the consensus standards. And today, we will be examining the financial outcomes associated with the standards, and exploring whether those outcomes are sufficient to make community-based palliative care sustainable. Next week, we hope you'll join us for the third webinar in the series, when we will delve more deeply into lessons learned and how to build on these learnings to drive increased consistency in quality and community-based palliative care.

Please note that each webinar has a separate registration and Zoom link, so you must register individually for each webinar you wish to attend. It's always my distinct pleasure to introduce our presenters for this series. Brian Castle is a PhD researcher in palliative care, as well as associate professor at Virginia Commonwealth University of Medicine, where he is the leader of the cross disciplinary of palliative care research interest group. Dr. Castle's research focuses on outcomes of specialty palliative care, especially economic outcomes.

Also joining us today will be Kathleen Kerr, who is a healthcare consultant in palliative care quality assessment and program evaluation. Currently, her work is focused on scaling sustainable models of community-based palliative care, with particular emphasis on payer provider partnerships, and supporting programs to operate in under resourced and rural areas. Kathleen will be joining us behind the scenes and helping with moderating questions. And I'm Judy Thomas, CEO of the Coalition for Compassionate Care, which I've been leading for the past 20 years and my background is in healthcare law and policy.

Here's just a brief overview of today's webinar. First, we'll do a brief review of the standards for community-based palliative care. And then, we'll delve into the demonstration project results, using claims data to examine enrollment, duration, disease characteristics, and reasons why care ended. Plus, costs before and after palliative care enrollment. Then we'll look at quality assessment of a payment model from payer and provider perspective. And lastly, we'll have time for discussion. So, thank you for joining us today. It's my pleasure to turn this over to Brian.

Brian: Thank you, Judy. Appreciate that. And glad to be here, glad to be a

part of this team with the wonderful participation by providers, and payers, and numerous other stakeholders and support from the foundation as well. I thought we'd start off with someone else's voice, stating the need for standardization of home-based palliative care.

A few years ago, Brook Calton and Christine Ritchie, physicians, had this to say in an editorial in JAGS, "We need to take a multifaceted approach to ensure home-based palliative care programs are to some extent standardized and held accountable for the care they provide. It is critical for the future of home-based palliative care and for patients and families' health and safety, that when an organization says, 'Yes, we have a home-based palliative care program,' that patients, families, referring clinicians, and payers know what they are getting."

That was written halfway through our demonstration project. But we really appreciate the call for standardization in the field, which continues to this day. I'd like to briefly review a couple of things that Kathleen and Judy covered last week, before we dive into the data. The consensus standards for community-based palliative care delivery were created from a convened group by the Coalition for Compassionate Care of California, starting in 2016. Bringing together payers, providers, policy advocates, researchers, and other stakeholders. Their work resulted in the standards, which were released in March of 2017.

The standards are intended to specify minimums in home-based palliative care delivery that would be acceptable to any payer or provider. They're intended to inform contracting for home-based palliative care. And in general, they're aligned with the Medi-Cal or Medicaid palliative care mandate, sometimes called SB1004. And that's shown here on the right side, the parallel program of standards, in a sense, that in many ways is very similar to the consensus standards, which are not limited to a specific line or business or insurance type.

As Kathleen and Judy reviewed last week, the standards cover five domains. Eligibility for services, what services are to be expected and provided, what kinds of staffing and providers would be doing that work, and those three are the same domains both in the consensus standards and in the SB1004 guidance. Two domains that are specific to the consensus standards are payment model and measurement and reporting. Today, we'll be talking mostly about payment model issues, but also, some of that touches on things

regarding eligibility for services and the services received.

Before we proceed with some of the data, I'd just like to make it clear that these additional standards in delivering palliative care are not meant to replace, or in any way supersede clinical guidelines from NCP or elsewhere. So, as you all know, the National Consensus Project Clinical Guidelines provide the foundation for palliative care and palliative medicine in any setting. In addition to that, not instead of, standards like the ones that we have developed and are promulgating and are meant to operationalize delivery of palliative care in a specific setting, home-based or community-based palliative care.

And these are intended to set expectations for contracting between payers and providers. And as such, in contrast to clinical guidelines, which are focused really on the providers, these consensus standards addressed the needs of both providers and payers. After the standards were developed and released, the foundation sponsored a demonstration project, which has gone on for the past three or four years. The goals of this were to implement standards with a set of payers and providers. And through that, to evaluate outcomes and variation in care or delivery.

Overall, the goal was to determine if these kinds of standards make it easier for payers or providers to develop and implement contracts for home-based palliative care, that increase access to quality and sustainable community-based palliative care services. So, the features of this demonstration project were that the participants, several payers and a number of providers, were assembled in 2018. The payers and providers were delivering and paying for community-based palliative care in Sacramento and/or Los Angeles areas.

Their contract requirements for community-based palliative care met or went beyond the standards, or the SB1004 requirements for Medicaid. Many, but not all of the providers involved had contracts with multiple participating payers. The claims analyses that we'll be talking about today focus on new palliative care enrollees, who enrolled between January 2019 and March 2020. And the claims data extended beyond that as well, while data collection and a slew of group activities with the stakeholders went on through December of 2021.

Again, the project was led by the Coalition for Compassionate

Care of California, funded by the California Health Care Foundation, and supported by an evaluation team and advisory group. So, let's get a little bit closer to talking about the data. The data that we received from the generous payers, who were willing to share this information, focused on Sacramento and Los Angeles. One of the payers only dealt with Medi-Cal beneficiaries, in terms of offering palliative care contracting. And two, offered community-based palliative care contracts across all three types of insurance, Medicaid, Medicare Advantage, and commercial.

The palliative care enrollment and data and claims data were gone from calendar years 2018 to 2020. Again, starting with a 15 month window in 2019 and the beginning of 2020 for new enrollments. The questions that we pose to the claims data, and we'll go through these today, focus on things such as how long were patients enrolled in palliative care and what ended it, what ended their participation, how much variation was there in community-based palliative care duration, and the focus diseases for those patients, the severity of illness, their reasons for ending enrollment, and their baseline costs.

So, as you're aware from last week, if you attended last week, a great deal of our focus in the evaluation and the demonstration project is to evaluate how much standardization and how much variation remains when people are basing their contracting and their clinical models on these standards that have been developed. And finally, what are the costs per patient before and after palliative care enrollment?

Okay. So, in the data set that we received from the three payers and put together the three data sets, there were 902 palliative care enrollees from January 2019 to March 2020, across three payers, across two regions, and across the three insurance types. As you can see, one of the payers really dominated the number of cases, especially for both Medicare and commercial. For Medicaid, there's a much better – an even distribution across the three payers or plans, with 21 percent, 28 percent, and 51 percent across the three. So, you'll see in a number of the analyses we do, when we drill down to the plan level, we'll do that only within Medicaid.

The number of providers contracted per payer in each region and the number of patients served by each provider varied quite a bit. Here, you can see that there's quite a few contracted by payer one, and fewer by payers two and three. The number of patients per provider that were enrolled in that 15 month window of interest,

there was quite a few providers who only had a handful of patients enrolled in that 15 month window. Some of them enrolled quite a few, dozens, if not more than 100.

You can see from the colors here that a lot of providers provided care contracted only with one payer and some of them had two or three different payers that they were contracted with. What kinds of clinical conditions did these patients have? We looked at the four diagnoses, the top four diagnoses, attached to each claim that their payers paid in the year prior to palliative care enrollment, and looked at each of the conditions that are in the Charlson Comorbidity Index. You can see here the distribution of those.

I'll point out that there is four diseases, liver disease, heart failure, COPD, and cancer, that are – I don't want to say just targeted, but for which there are disease-specific eligibility criteria in both the consensus standards and SB1004. So, highlighted those just to make it clear that those are the ones that there's sort of a minimum expectation that those patients will have access to palliative care. And the standards also allow for other patients who are palliative care relevant to receive palliative care as well.

You can see that all kinds of conditions are represented here, among the Charlson conditions. Tallying those conditions up into the weighted Charlson Comorbidity Index looks like this, you have a distribution from zero to 15. This is a weighted score, with some diseases having a weight of greater than one. The light blue ones here are what are generally considered to be non or mild levels of Charlson Comorbidity. So, that's 24, almost 25 percent of the enrolled palliative care recipients. Another 21 percent have moderate degree of comorbid conditions. And the remainder, 54 percent, have severe.

The main Charlson Comorbidity Index is something we can then look at, to do some comparisons between payers and a little bit beyond that as well. So, you can see here that payer one was enrolling palliative care recipients with a very consistent Charlson Comorbidity around five. Payer two had more variation, and payer three had, on average, a score of six or greater. These two horizontal lines represent those cut offs described earlier, in terms of the low, mild, and moderate levels of Charlson.

In terms of dominant diseases, one thing we wanted to look at was the variation within disease and within the insurance type. So, you can see for cancer, not a whole lot of variation in the Charlson

among those recipients, and a little bit more for some of the other diseases, particularly these other diseases that were not called out as targeted diseases in the standards. And see that the mean Charlson, the lowest was for commercial neurological patients, and the highest was for Medicaid, renal failure patients.

Again, in both of these charts, you can see that some of the recipients for palliative care fall underneath the severe level of Charlson comorbidity. A separate thing we did with the data from the claims, in the year prior to the palliative care enrollment, was to force each person into a bucket or a category of disease, based on their insurance company's expenditures over the year prior.

So, doing this takes out some of the comorbidity, the multimorbidity, in a sense, or at least hides it and says, "Okay, the people who primarily had cancer in the year before, or [inaudible] [00:18:35] healthcare utilization, it's primarily driven by cancer, represent over a third of the palliative care enrollees, heart failure, 13 percent, COPD, 10 percent, etc. And again, these are two diseases of interest in palliative care that were not called out in the standards. Breaking this out by the insurance type, you can see that for commercial insurance, more than half of the patients had a predominant disease of cancer.

For Medicaid, two categories shared about half, CHF and cancer. And for Medicare, somewhat odd, for Medicare Advantage recipients of this spread, where the modal type of predominant disease doesn't really exist in this group. It's just a catch all category of lots of other conditions and diseases, outside of these life limiting progressive diseases that we often see in palliative care and hospice. So, that caught our eye, and it's something we'll come back to in a little bit.

The length of enrollment is a very key issue for payers and providers both. So, we spent some time looking at this and talking about this with the providers and payers who were involved in the project. Here's the distribution, looking at 24 months plus, what percentage of palliative care recipients were receiving the palliative care for, let's say two months was around 11 percent. Three months was around seven and a half percent. So, you can see that distribution, not at all a normal distribution, almost a perfect triangle there. 51 percent had an enrollment length of up to six months, 29 percent were seven to 12 months, and another 20 percent were 13 plus months.

The median months enrolled varied a bit by insurance type, 4.7 months on average, median for Medicaid, 5.5 months for commercial, and 6.3 months for Medicare Advantage. We drilled down a little bit within that Medicaid to look at the three plans and those ranged even more than the insurance types, ranging from 3.1 for the lowest, 5.7 and 6.5 for the higher. So, a two times difference between two different plans and how long, on average, their Medicaid recipients were receiving palliative care.

Looking at this in terms of the disease types, you can see, on average, 5.8 months across all of the recipients. Looking at those who we could fit into a COPD bucket, they were the highest at 7.8 months of palliative care. The lowest of these four primary diseases was cancer at 3.8. So, about half of a COPD patient enrollment. These other two diseases we were curious about, renal and neuro, were more similar to COPD.

A third thing that we looked at in the enrollment data, so this is not from claims per se, but from the additional information provided by the payers, in concert with the providers, for why people ended palliative care. So, we had the enrollment date, we had the disenrollment date, we had sometimes reenrollment and disenrollment dates. But we also had, why did they stop palliative care enrollment? And we group those many reasons into a handful of categories. And these bar charts are best read from the bottom up.

So, 33 percent of commercial palliative care recipients ended their palliative care enrollment in death or hospice. Another 18 percent and 26 percent, issues related to a change in their condition or a change in terms of their insurance and eligibility. Only 3 percent were lost. And 21 percent had patient refusal or patient choice as the reason for discontinuing palliative care. This looks a little bit different from Medicaid and for Medicare Advantage. You can see for Medicaid, 1/3 of the patients get lost to follow-up. But a smaller portion of them had a patient choice or a patient refusal at only 11 percent.

Medicare looks a little bit more similar to commercial, but here you see 48 percent altogether, exiting from palliative care into hospice or due to death. Going down, within Medicaid, we were discouraged to see how much variation there would be between three plans, who were all providing palliative care to Medicaid recipients. And again, you can see just as much variation between the plans as you could see, if not more, between insurance types.

So, payer one, very few lost to follow-up, much higher in that for payers two and three. 17 percent for payer one, we're kind of walking away from the program, in terms of patient choice, versus 7 percent for payer two, etc.

And one more graph of the reasons why people ended their palliative care enrollment. So, we looked at this by disease, and again, you can see quite a bit of difference here. For cancer, more than 50 percent leaving, due to death or transitioning into hospice. Much, much lower for liver disease, and in between that for CHF and COPD. And here for liver and for CHF, we see a higher group of lost to follow-up than you do for the others. And we're gonna take a little bit of a pause here, before we go into some of the costs and the more detailed financial analyses, to see if people have questions. Kathleen?

Kathleen: Okay. Thanks, Brian. A couple of things that I think you can clear up quickly, there's a question about what portion of the enrollees had multiple comorbidities? Do you have any data on that?

Brian: Almost all of them. So, some of the people who had cancer only had cancer, but for most of the other diseases, people tended to have more than one of those Charlson conditions.

Kathleen: Great, thank you. Then, there was also a reflection that it looked like the palliative care patients were identified really late and that they were maybe a hospice population, could you flashback to that enrollment duration slide, to get a sense of what the enrollment distribution was like?

Brian: Yes. Yeah, so there's quite a few. I don't know that this is unique to this study. I think I've seen this in a number of papers and talking to people around the country. You do have a group of folks who were pretty late in being identified, in terms of their disease and their frailty. And so, they are exiting quickly from palliative care. I don't think that most of the providers would think that this is their target length of enrollment. I think their target is closer to what the means and medians are, if not longer.

Kathleen: Yeah. So, if you look at the information in your textbox, about half the folks were six months or less, and half were more than six months, and some even more than 24 months.

Brian: Yeah, there are a few that were more than 24 months, but not many, just like 1 percent. But definitely, 1/5 were more than a

year.

Kathleen: Got it. Thank you. And then, a final question, can you offer any more detail about the patient choice or insurance as a reason for disenrollment, just to let folks get a better sense of what was in those categories?

Brian: Sure. Let me just look at my screen notes here. So, the lost other category included a lot of different entries in this data field. It included missed schedules and visits, or never was available, unable to reach, member transitioned to another palliative care program, that's more of a other than a lost. And just kind of unknown. So, you're really not in contact with the program when you can't even be categorized by one of these reasons for disenrolling. And it might be that some of those people are deceased. We just really don't know.

Kathleen: Got it. Thank you.

Brian: Actually, let me take that back. Few of those people would be deceased, if any, because we know when their last claim was and we know when their insurance enrollment ended. So, we know that they weren't dead from the claim standard. Anything else to cover now?

Kathleen: No, I think that's it. Thank you, sir.

Brian: So, let's move on to the financial results. And these are from the payer perspective. So, this is taking the total cost of care from the payer perspective, as much as possible. That's what we tried to do in evaluating palliative care programs in the community with these kinds of value-based contracts. So, at this stage of the analyses, we can only present to you the within patient, like a pre and post analysis. And I apologize for not having that be between beneficiary, between person analyses of a matched comparison cohort. We just don't have those ready yet for public display.

So, we use 95 percent confidence intervals, you'll see those on the slides. For the pre/post analyses, we did a series of analyses, of 30 days before and after, 60 days before and after, etc. You'll see those displayed separately. For each period of time, we looked claims together as either being hospitalization related or all other. So, it's not just an acute hospitalization, payment to a hospital, but also, professional fees for that hospitalization. Most analyses, as you'll see, we did within insurance type. But the first slide, it was

actually across all of those together.

The costs after palliative care enrollment are inclusive of palliative care payments. The costs after palliative care enrollment are also inclusive of hospice claims for Medicaid and commercial, who were still on the hook for those hospice claims. But not for Medicare Advantage. And costs continued to accrue and are analyzed in the post period, even if the person disenrolls from palliative care, but remains with the payer. Okay, so, we're kind of ignoring disenrollment, in a sense, for people who are alive. Or at least not known to be deceased.

So, this first slide looks at the three insurance types combined. And it's a set of four analyses in these four time periods. There were 804 beneficiaries, who had at least 30 days before palliative care enrollment, of insurance information, or they were insured. And 30 days post. And similar for these other ones, we can see how the end then reduces for these, as you require more continuous enrollment with the insurance company before and after palliative care. Hospital costs in blue and all other costs in orange.

So, to take this first analysis, in the 30 days before palliative care enrollment, 804 people across the study had an average expenditure with their insurance company of \$15,652. And in the 30 days afterwards, had an expenditure of \$11,314. This drop is a cost reduction of 27.7 percent. And unless indicated otherwise with a non-significant, looking at the 95 percent confidence intervals, these were statistically significant. So, in the 60 day analysis, 29.2 percent cost savings. In the 90 days before and 90 days after analysis, 25 percent cost savings. And in the four months before and the four months after, a 31 percent cost savings.

You can see in each of these, that the bulk of the expenditure by the insurance company is for hospital-related claims. And if anything, there is a slight increase in the other kinds of claims. And we've seen that in other studies as well, of community-based palliative care, where you're not reducing all form of utilization, but you are shifting utilization from the most expensive site of care to less expensive sites of care. So, these numbers at the top represent the total for that period, not a total per month. So, this is \$33,000 over 90 days and \$25,000 over 90 days.

Now, we're gonna go through each of the separate insurance types, or what a payer would call a line of business, separately. And there's good reasons for doing that. Largely around, there's a very

different scale, in terms of the dollar amounts that you're gonna see on here for each of these. So, we see up to the \$35,000 on this graph of Medicaid recipients. So, all four of these analyses were likewise significant. Here is the 30 day analysis, a 43 percent drop in costs from a payer perspective, 51 percent looking at 60 days before and after, 42 percent looking at 90 days before and after. And 49 percent looking at four months before and after, 120 days.

And the attrition here, in terms of the sample size is not too bad. So, even though, eventually, a lot of Medicaid recipients and others are gonna have loss to follow-up or whatnot, if they had at least 30 days of palliative care and insurance, they tended to have four months or more. So, all four of those are significant. The summary here at the top, the costs are reduced by the 42, the 51 percent, depending on which time period you're looking at over time.

I would also like to say, we'll come back to this later, there have not been many palliative care studies, especially in community-based palliative care of the Medicaid population, beneficiaries of Medicaid, nor of commercial beneficiaries receiving palliative care. So, these two slides may be a little bit more novel than other things that we tend to see in the literature with Medicare recipients. Here's what it looks like when there is no statistical significance between the before and after costs. So, the NS meaning non-significant. Here, we're talking about 367 to 266 recipients with commercial insurance. And the scale here is double what it was in the Medicaid graph, which went up to 35 or \$40,000.

So, what you can see here for these three time periods that were analyzed, 26 percent drop in costs, 24 percent drop in costs, and a 31 percent drop in costs. Again, with the hospitalization portion of the total cost of care from the insurance companies, representing the bulk, and the thing that is really changing between before palliative care and with palliative care. So, this is not statistically significant. Clearly, though, I would say that it doesn't cost more to provide palliative care to these folks. So, getting that extra layer of support, for people who really need it, might not be saving a statistically significant amount of money for the insurance company. But nor would I say is it costing them anymore.

So, the patients and families are getting this tremendously beneficial form of care, without, I would say pretty confidently, an increase in the cost to the insurer. And if that doesn't make sense, put something in the chat and we'll come back to that. Medicare

Advantage is a different beast in this demonstration project. In none of the four time periods that we analyzed, was there a significant cost reduction from before palliative care to with palliative care. The y-axis now has shifted down even further than it was with Medicaid, topping out at 15,000 here, or about 12,000 in any given time period. Pretty low cost, compared to the commercial and the Medicaid data that we looked at just a moment ago.

So, here, you see in the 30 days before and after palliative care, enrollment began. Patients were only, if you will, had expenditures on average of \$4,300, and that doesn't change much to \$3,500. It's not going up. So, again, the interpretation I would give this, as I did with the one analysis for the commercial beneficiaries, is these data indicate that it's not costing the payers any more to add this layer of support for patients and families. Nor, does it seem to be saving them a statistically significant amount of money. You might say that these are not insignificant amounts of money, but statistically speaking, these differences are the same as no difference.

So, at the end, you're going from 312 Medicare Advantage recipients in the 30 day analysis to 262. And again, for both the commercial and the Medicare Advantage, really, these data are dominated by one payer. It's the Medicaid where we see all three plans contributing more to the dataset, in terms of the number of cases. So, let's take a moment to summarize that and review that, what we just heard and what we have found. The scale is quite different for the three insurance types and that's one of the reasons we recommend that people analyze their lines of business or insurance types separately, 27,000 versus 11,000 versus 4,000 in the 30 days before palliative care.

A summary of the cost difference analyses, kinda working backwards from the order we had originally. Medicare not statistically significant, commercial 24 to 30 percent in reductions for three out of the four time periods, 42 to 51 percent for Medicaid, all four time periods. And putting that all together, they are not the justifiable 25 to 31 percent reduction in total cost of care for all insurance types combined, across the four time periods. And just to reiterate something we had shown in the diseases and conditions, and enrollment and reasons for ending palliative care, the number of palliative care provider groups engaged in enrolling, differed by insurance type.

The predominant diseases and comorbidity index in the year before palliative care enrollment, also differed by insurance type. And how long people were in palliative care and why they ended it, also tend to differ by insurance type. So, I would say as a researcher, we need more research in our field of the mixture, the real life mixture of commercial and Medicare Advantage and Medicaid recipients receiving palliative care. How do these data compare to what has already been shown in published studies?

Well, here's a quick summary of nine studies, one RCT and eight observational studies. Almost all on Medicare populations by the way, you can see that the cost reduction is in that same ballpark as we're showing. Now, these are between group analyses, that's a little bit more rigorous. But even so, I wanted to give you some sense of, are the percentage cost differences that we're finding in the pre/post to date outlandish? Or off the mark, compared to what's been published? And I would say no, they're right in that ballpark for what has been published previously with Medicare. Except, of course, for our own Medicare Advantage data in here.

So, let's talk about that briefly. Why was there no significant effect among the Medicare Advantage beneficiaries in this demonstration project? And I'm crossing arms, I'm getting defensive here. At least, so far using the pre/post analyses. Well, 1/3 of those Medicare Advantage cases did not have a predominant, progressive, life limiting disease, such as cancer, CHF, COPD, liver failure, renal failure, or dementia, or other neurological disease. They had lower comorbidity index than other insurance types.

Looking at their utilization, there's what we would call a floor effect. They had utilization that was already low and not very costly, it's hard to go much below that. It's hard to go below the floor. The other reason is a little bit more about the process of implementation and the choices that are made by providers and by payers. Payer one had almost all of these Medicare Advantage cases. They reviewed what was going on, before we even saw the data, reviewed the enrolled population.

And their observation was that not all individuals who were receiving palliative care truly met eligibility criteria that have been spelled out. So, they revised their processes for verifying eligibility. And now, they're considering as well, to say, "Well, these people probably needed something. Maybe they don't need a value-based contract for home-based palliative care. Maybe they

need clinic-based palliative care, if they're still ambulatory. So, these people might need something, but maybe they don't need, yet, the home-based palliative care, which is more intensive and more expensive." So, we appreciated their diligence about that. So, I'm gonna take a breath. And Kathleen, are there any questions?

Kathleen: Way ahead of you, yes. Okay. First of all, just to clarify a little bit of the data that we have available to offer, do we have any information describing visit frequency? Like how often there were contacts?

Brian: No.

Kathleen: No. Okay, great. Thank you. And do we have any information about the characteristics of the provider organizations? Were these independent practices or organizations? Can you say anything about that?

Brian: I don't have that information [inaudible – crosstalk] claims data for analyses. I don't know if you or Judy have a sense of the answer to that question better than I do.

Kathleen: I do. They were all organizations, some health system affiliated, others not, that offered team-based, home-based palliative care, that at least met the minimum requirements, as put forth in the standards or SB1004. Many of them also offered other services for seriously ill individuals, such as hospice or home health. But none were say, individual physicians that offered palliative care independently or singly. Great. Do we have anything about the – there's a really good question. One moment. Do you think the high lost other disenrolled percentage of Medicaid population impacted the pre/post cost changes?

Brian: Do I think that the 33 percent, who were lost for the Medicaid group impacted cost? We didn't lose them. So, this is probably where I misspoke at one point and then retracted what I said. These people were not lost to the insurer, they're still insured. And they are still generating claims from healthcare utilization, but they've lost contact with the palliative care provider. If that makes any sense.

Kathleen: Got it. Thank you.

Brian: So, they're not unresponsive to the provider. But they are not missing from the data, from the claims data. And it's really the

Medicaid – Yeah. Yep.

Kathleen: Yeah. Let's see, just to clarify, these patients started to receive palliative care at different entry points in disease severity, and that may or may not have been picked up in their length of palliative care enrollment, right? So, one explanation for variation across payers or disease groups, is you have some folks that are recently diagnosed and other folks who maybe are a year in. Is that a fair statement?

Brian: Yes.

Kathleen: Great. I have a question about, is the cost of care only looking at cost payable by health insurance? What about costs that may be avoided under Medicaid, long-term care costs, custodial care, etc? Were those accounted for?

Brian: Only care reimbursed through claims was analyzed. It was transparent to us and analyzable. So, anything that was paid separately from claims or that was capitated, if that affects how things appear in claims or whatnot, is not visible.

Kathleen: Yeah. So, another way to say that is, if there was a cost that was incurred by the plan, regardless of what it was for, that was included in the total cost attributed to the patient.

Brian: Yes.

Kathleen: The savings outside of, say, hospitalizations would have been recognized.

Brian: Yes.

Kathleen: Yeah, thank you. Let's see, did you analyze the data through a prognosis filter? Steve, I'm not entirely sure what you mean by that. You might want to say a little more.

Brian: Yeah. We did not go back and try to reconstruct where they were at in their disease trajectory, and then use that to account for any variability.

Kathleen: Got it. We have a question, were the patients' risk stratified, high complexity versus low complexity, to determine intensity of services or visit cadence? And Brian, I can take that. One of the plans that shared their data does use a tiered service structure,

where there's a difference in the intensity of the intervention based on the needs of the patients. So, in a portion of the sample, yes, that was done formally. In others, it was probably done informally, but not according to a difference in a formal tier in a payment model. We have a question; do you have any data on demographic locations, such as rural versus urban?

Brian: We do not. Because the way that we have asked these data to be deidentified, we really know very little, beyond the region that they're in, from three digit ZIP codes, which are not helpful when it comes to socioeconomic status or rurality of the geographic location of the recipient.

Kathleen: But, generally, it was everybody in Los Angeles or Sacramento. And so, those are certainly population centers. You may have slightly less densely populated within those counties, but this wasn't like say, far Northern California, where it's very rural or very sparsely populated.

Brian: Right, that's right.

Judy: Correct.

Kathleen: Thank you. Good. Let's see.

Brian: Maybe one more?

Kathleen: Yeah. What percentage of the palliative care services were delivered via telehealth? I recognize this was pre-COVID. But do we know anything about virtual versus video versus in-person versus phone versus hybrid?

Brian: In terms of the time of the pandemic, all of these folks enrolled before the pandemic really hit furiously in March of 2020. But their ensuing and subsequent utilization and claims from after that would reflect shifts in telehealth and whatnot. Kathleen, I don't know if you or Judy know better than I do, the extent to which care pivoted to virtual means.

Kathleen: Yeah, in terms of the structure's pre-pandemic, there were requirements about proportion of contacts that could happen telephonically versus in-person for some of the plans. But I think that, along with everybody else, in the pre-pandemic times, the overwhelming majority of care was delivered in-person.

There's lots and lots of questions, and we'll – just to let folks know that I think we've gotten to most of them, but for the ones that we didn't get to or where the questions are beyond the scope of these data, we are combining questions from all three webinars, and we'll be releasing responses to them after the series is over. So, even if we didn't address your question, it is not lost. We saw it and we appreciate it.

Brian: We're ignoring you only temporarily. And we will get back – please, please hold. We will get back to you. So, let's pull back from intensive quantification of fiscal impact and step back to the bigger question of the attempt to standardize the payment model through these standards, which again, is something that's part of this consensus standards package, that's not part of SB1004 Medicaid requirements or dictates.

So, the standards recognize that one way to save time for payers and providers about what needed to be negotiated was to set forth some principles about what makes sense for home-based palliative care reimbursement mechanisms. So, here's what the standards say, “Enrolled palliative care members will continue to be eligible for existing services, as appropriated under the health plan. So, palliative care is concurrent with everything else and it's not a tradeoff, the way that US hospice benefit is.

Community-based palliative care has demonstrated cost effectiveness, often by shifting sight of care to home and ambulatory settings, as opposed to inpatient care. It is recommended that outpatient palliative care payment models emphasize value-based reimbursement. Value-based payment should consider the following principles: process by which payers and providers align the needs and acuity of the patient and the services that are covered. Per enrolled member, per month case rate, to cover all community-based palliative care services and providers included in the care team was recommended, possibly tiered, but not necessarily.

And consider payment incentives for quality and utilization management. So, you can read further about these. If you want to go back or revisit the webinar that Kathleen and Judy did last week, to talk a little bit more about what's in the standard around the payment model. Again, not telling people how much to pay, tell the providers or the payers how much to pay providers, or not telling the providers how much to ask for. But setting forth some principles for payment models that make sense, given the inputs

that are necessary and the outputs have to be expected.

So, here's a couple of variations that came out in the real world of payers and providers tweaking those standards, going a little bit beyond that. So, at least one payer had formal tiers of service, with different payment amounts based on acuity, versus a single payment amount, assuming that the distribution of acuity and neither the patients would, on average, be covered by the single payment amount, and not require a tier. So, not forbidden, but almost mentioned by the standards as something that could be done, a tiered approach.

Similarly, at least one payer utilized supplemental payments, in addition to the per enrolled member, per month case rate for high utilizers. So, a couple of mechanisms here, that are not bad forms of operational variation, where payers and providers can adjust their approach for the patients who need a lot more service. So, here are some quotes from payer experiences to questions that were posed about the payment model and amounts. So, the use of a case rate was universally endorsed by representatives among the payers. Monthly case rates, where we have occasional exceptions, which will pay an extra fee for service charges for extraordinarily intense services. But otherwise, monthly case rates work.

Alignment between their outputs, the cost of palliative care services and outcomes, was a little bit less clear to some of the payers. One plan expressed some concern about that alignment. I do not feel that there is adequate alignment to the case rate and the impact on total cost of care and quality of care. The plan would benefit from a more defined approach, regarding which members are eligible, and a utilization management process to ensure appropriate enrollment and adequate services are provided during enrollment. So, what they're saying is, well, based on this initial experience, we're gonna tighten up our approach a little bit.

One plan did not feel they had enough data yet to evaluate fiscal outcomes. And that was one of the reasons we wanted to do this part of the study, was to help payers and providers to understand what was going on, fiscally. How about the provider experiences regarding the payment model? Case rates were appreciated, but there were concerns about some aspects of it. The reimbursement needs to be more to be a profitable program. Case rate is a better payment model, it varies, and in some instances, it's difficult to provide excellent palliative care services with a lower amount.

Most contracts require care delivery models that exceed reimbursement sustainability. So, the problem of providers feeling like they're not getting enough from payers is a longstanding problem that did not originate with palliative care, but here we see what it looks like in palliative care. So, it's coming together around the need for case rates. But still, there's going to be some disagreement about what is sufficient and what is not sufficient.

So, including standards about payment models in the California consensus standards was intended to promote that the entire team, the full multidisciplinary team would be covered, the cost of all core services would be covered, the incentives would be aligned between payers and providers. And that there would be some minimum acceptance about this, that people could start negotiating the details, instead of arguing about the need for a case rate or the need for services, trying to prevent some unreimbursable effort.

So, what we find is universal approval for the case rates, provider concerns about adequacy of payment, and next and evolving perceptions of return investment for plans. It's not always clear whether the plans expect just to break even or if they want to see reduced overall cost. I'm gonna skip limitations of the demonstration project for now. Not because they're unimportant, but because we're almost out of time. So, just an overall summary before we take final questions and discussions. So, there was the creation of the standards and their publication in 2017. And then, the demonstration project of implementing those and evaluating those, 2018 to 2021.

It's important to recognize that there were both pieces because we didn't want to just create standards and throw them out there. But we wanted to demonstrate what this looked like, implementation and to support the evaluation of those. One of the key things that we have found is that there's kind of an equation that standards plus good implementation choices will help to equal a resulting unwanted variation becoming less, and fewer negative outcomes. It was great to see how willing providers and plans were to participate in this, to share their experiences, to talk with one another in what started off as in-person meetings, and then eventually virtual meetings, and to share data and lessons learned.

The payment model does seem to be acceptable to both payers and providers. Again, except for sometimes, the dollar amount. One thing, a little bit with an eye toward next week's webinar is, could this be done elsewhere in the country? Well, we feel that this

demonstration project showed that a multi-payer, multi-provider, multi-region project, across all three major insurance types is feasible and valuable. So, let's acknowledge that it is, on the East Coast, almost 3:00. Kathleen, any questions and answers? Or just move to the wrap up?

Kathleen: I think we better head to the wrap up and we'll track the remaining questions and include those in our written responses after the series.

Brian: Great. Judy, is this you?

Judy: Thank you, Brian, so much rich information. I think probably some of our listeners will go back and listen to this some more. We really want to thank and acknowledge everyone who participated in the demonstration project, both our payers and our providers, as well as our evaluation team. Next slide. So, just a reminder about next week's webinar, if you're interested in hearing that, go ahead and register for it. It is a separate link from today and we'll be really focusing and drilling down on some of these lessons learned. Next slide.

Just a quick reminder, The Coalition has an annual conference. We will be back in-person in May, we hope that you will join us. It's a great chance for the palliative care community to come together again in-person, after too much time apart. Next slide. We have a regular webinar series that's separate and distinct from the CIIC series. We are filling that out, we've got a lot of great topics coming up. And I encourage you to register and attend those. Next slide.

Thank you for being here today. We will send you the slides, as well as the recording. And there are links to get more information. So, again, thank you for being here today. And please join me in thanking Brian for such a rich presentation, and Kathleen for doing a great job of moderating those questions. Thank you and have a good day. This ends our webinar. Bye-bye.

[End of Audio]

Duration: 61 minutes