NHPCO
National Hospice and Palliative Care Organization

NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE

Community-Based Palliative Care Demonstration Model

Overview

The National Hospice & Palliative Care Organization (NHPCO) and the National Coalition for Hospice and Palliative Care (Coalition) urge Congress to support the Centers for Medicare and Medicaid Innovation's (CMMI) fast-track development of a Community-Based Palliative Care (CBPC) Demonstration for people with serious illness, to provide essential interdisciplinary care, in their home. There is a significant evidence base to support the need for a CMMI supported community-based palliative care effort that would lead to improved quality and cost outcomes for beneficiaries experiencing serious illness. This is especially important for seriously ill patients with comorbidities who are at higher risk when battling conditions such as COVID-19.

NHPCO and the Coalition have drafted a framework for a community-based palliative care model aimed at improving patient outcomes and experience of care and reducing unnecessary or unwanted – and often expensive – emergency department visits and hospitalizations for high-risk patients. Additionally, this model will address social determinants of health to improve outcomes for those living in under-resourced areas.

Hospices and community-based palliative care programs in addition to other qualified providers such as home health agencies or specialized group practices, working in partnership with patients' broader healthcare teams, are uniquely positioned to deliver this model of care. Their longstanding expertise in advance care planning, pain and symptom management, enhanced telehealth services, interdisciplinary care, psychological, social and spiritual support, care coordination, and co-management with other medical providers make these organizations ideal entities to deliver this model of care in support of people and families dealing with serious illness at home.

Community-Based Palliative Care Demonstration Model Design Details

- **Proactive identification of high-risk beneficiaries**
- **Comprehensive assessment of symptoms and stressors impacting quality-of-life**
- **Expert management of symptoms and stressors by an interdisciplinary care team[1]**
- **Patient and caregiver education and support, explaining what to expect, clarifying goals and values, supporting shared decision-making and advance care planning**
- **Aide services to meet personal care needs**
- **Care plan coordination across all providers and community services**
- **Ongoing support of patients and families including telehealth with 24/7 access**
- **Accountability for patient experience, quality of care, and cost**
- **Innovative payment mechanisms that fully support care delivery**

Cost Impact

NHPCO has partnered with NORC to determine the projected enrollment and calculated baseline of utilization and cost of care for our proposed Community-Based Palliative Care Model. This analysis was conducted using the Medicare Fee-for-Service (FFS) claims data, derived from The Centers for Medicare & Medicaid Services (CMS) Limited Data Sets (LDS) to produce and estimate the number of potential Medicare FFS beneficiaries eligible, their cost utilization and what the potential savings impact could be if this model is implemented. Based on preliminary results and a conservative sample of enrollees, NORC found that this model can produce hundreds of millions of dollars in savings to the Medicare program.

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[1] National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp

Differences between current CMMI Models and the Proposed Community-Based Palliative Care Demo				
	Primary Care First/Seriously Ill Population (PCF/SIP)	**MCCM**	**Impact from COVID-19**	**Proposed Community-Based Palliative Care Demo**
Provider Eligibility	PCF/SIP is limited to 26 regions	No geographic restriction, although current participation is not nationwide.	COVID-19 hot spots are nationwide, some of the worst are in places where PCF/SIP is not offered.	No geographic limitations – offered nationwide.
	Interdisciplinary care team	Interdisciplinary care team	When a patient is diagnosed with a serious illness, like COVID-19, decline can progress rapidly. There is enormous value in having a certified hospice and palliative care team member already involved in the care plan.	Interdisciplinary care team **with a minimum of one team member certified in hospice & palliative care.**
	Providers must contract with health care partners for transition of patients	Providers are not required to contract with partners because beneficiaries must meet the six-month prognosis requirement	SIP providers will need to return patients to the same dysfunctional care system (i.e., lack of 24/7 access, lack of IDT, lack of palliative care capacity) that made them SIP eligible in the first place, resulting in fragmented care.	Six-month prognosis requirement is eliminated. Providers must identify other healthcare professionals (i.e. PCP and specialists) for co-management and collaboration. Providers applying for participation in the model would be responsible for this ongoing communication and coordination.
Patient Eligibility	No single practice has provided more than half of their E&M visits in the last 12 months	Must be living in a traditional home (no institutional care)	Patients with serious illness often have consistent providers but still experience gaps in 24/7 access, IDT care, expert symptom management, and skilled shared decision-making support.	This is a co-management model. The CBPC team would align with PCPs and Specialists for their seriously ill population. (The CBPC team could also assist patients without a PCP to get connected with one, where available).
	2 or more ED visits or observation stays in the last 12 months (as an alternative factor to the E&M factor above)	Have had at least one hospital encounter within the 12 months prior to model enrollment	Care interventions wait for evidence of ED and hospital utilization for management of chronic conditions and misses prevention opportunities.	This is a proactive model. CBPC team will work with PCP and Specialists to identify at risk population prior to use of ED for decompensation.
	Had a DME claim for transfer equipment or hospital bed	Have had three office visits for any reason with any Medicare participating provider within the 12 months prior to model enrollment	DME screen can weed out far too many patients who are seriously ill but have not yet progressed in their functional impairment to needing this DME.[2]	**Proactive model** with goal to identify serious ill individuals the PCP **anticipates** may to start using the ED for **decompensation** and provide support in the home.
Services	**Planned care and Population Health** capabilities enable practices to meet the preventive and chronic care needs of the entire patient population. Primary Care First practices must set goals and continuously improve upon key outcome measures.	As prescribed by the Medicare Hospice benefit	SIP is a transition to primary care model, while what we propose is an "added layer of support" that provides palliative care services to high need patients. Emphasis on certain screenings and preventive care that may be unnecessary and potentially harmful, such as exposing beneficiaries to low value diagnostic testing and risky institutional settings unnecessarily.	**Individualized Care Plan** If a beneficiary already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A beneficiary's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.
Payment	PBPM, initial CA visit, flat visit fee, quality bonus	$400 PBPM Fee (the fee is pro-rated to $200 PBPM for services provided for less than 15 days in a calendar month)	Existing waivers do not yet provide adequate payment for interdisciplinary services delivered where patients live. Programs billing Part B and supporting interdisciplinary teams often operate at a negative margin.	PBPM, with a tiered payment structure

[2] https://www.ajmc.com/view/gauging-the-experiences-of--the-seriously-ill-in-california-analyzing-serious-illness-beyond-medicare-feeforservice