***The Case for Palliative Care***

**The Hospice Council of West Virginia supports improving access to palliative care for patients with serious illness. A value-based payment model that reimburses providers for interdisciplinary palliative care would improve access to and the sustainability of West Virginia’s community palliative care programs that are managed by community hospices. Legislation might be needed to implement reimbursement for interdisciplinary palliative care in West Virginia’s Medicaid program.**

Here are some key points to consider:

* Research conducted by the National Academy of State Health Policy demonstrates the value of palliative care for state Medicaid programs.
* West Virginia Medicaid currently does not reimburse for interdisciplinary palliative care.
* Requiring coverage and reimbursement for defined palliative care benefits in West Virginia Medicaid would greatly benefit West Virginians with serious illness and reduce costs or at least be cost-neutral.
* Palliative care services differ from hospice because they may be provided concurrent with curative care and are not dependent on a terminal prognosis. The primary reason for this differentiation is due to the way Medicare’s hospice benefit was designed in the 1980s. However, in practice, the continuum of care from palliative to hospice should be a seamless and comprehensive benefit with hospice as the highest level of palliative care.
* Private payers and the Centers for Medicare and Medicaid Services now recognize that palliative care is needed earlier, so many states are working to add a palliative care benefit in Medicaid. Doing so can allow patients to remain at home in many cases, prevent unnecessary hospitalizations, and result in earlier and smoother transitions to hospice care.
* Palliative care, including hospice, is a board-certification specialty in medicine.
* Palliative care services and hospice services have been differentiated based on what Medicare is willing to pay for end-of-life care, limiting hospice benefits to six months or less. However, palliative care is needed earlier than that.
* Palliative care is provided by an interdisciplinary team with hospice and palliative care certification or special training.

Cost and quality are major concerns in the provision of health care. On both counts, increased use of palliative care offers advantages for West Virginians: improved quality of care at lower costs.

***What is palliative care?***

Palliative care is specialized medical care for people living with serious illnesses, such as cancer, heart failure, kidney failure, and advanced neurologic disorders. The focus of palliative care is on relieving the symptoms of illness and the stress of coping with it. The goal is to improve the quality of life for the patient and the patient’s family while holding down the costs of care.

Palliative care is provided by a team that includes physicians, nurses, social workers and other specialists who are trained to address a patient’s medical, psychosocial and spiritual needs.

***How is palliative care different from hospice care?***

Both palliative care and hospice care involve managing pain and symptoms of serious illness and providing both physical and emotional support. However, hospice care depends on a patient’s prognosis, while palliative care is not limited by the prognosis. Hospice care is for individuals believed to be in their final six months of life, while palliative care has no such restriction. Unlike hospice care, palliative care can be offered along with curative treatment.

***How does palliative care improve quality of care for patients?***

A foundational principle behind palliative care is that better care outcomes occur in supportive environments. That generally means providing care outside of hospital settings, such as an individual’s home, although palliative care is not limited to home-based delivery.

Highmark Blue Shield, which operates in several states, including West Virginia, has offered palliative care through its Enhanced Community Care Management (ECCM), which is a non-billable Medicare Advantage service. Based on experience with thousands of high-risk Highmark members, the company has found that ECCM has made the total cost of care more efficient while receiving more than 90 percent patient satisfaction.

In California, the Palo Alto Medical Foundation Palliative Care Services provides care to patients with advanced illnesses in a range of settings, including private residences and skilled nursing facilities. For home-based care in particular, the organization in 2015 reported very high satisfaction rates among patients. After 90 days of home-based palliative care, 93 percent reported being “very satisfied.” That compared to 81 percent satisfaction reported by patients receiving usual care in other settings. The study also found that mean distress scores for anxiety, appetite, depression, dyspnea, nausea, pain, weakness and well-being all improved in patients’ first 10 weeks of enrollment in home-based palliative care.

***What is the evidence that palliative care can save costs?***

The National Academy for State Health Policy (NASHP) released a study on October 6, 2022, that found that effective administration of a Medicaid palliative care benefit for individuals who are the highest users of services could produce cost avoidance savings that range from $231 per member per month to $1,165 per member per month. It also found that the potential return on investment could range from $0.80 to $2.60 for every $1.00 spent on palliative care. The study also found that, at a minimum, implementation of palliative care for all Medicaid users in a state would be cost neutral overall while improving the quality of care for the members, as well as their families.

According to a May 19, 2019, presentation to the West Virginia Legislature by Dr. Emily Jaffe, executive vice president and medical director of Highmark Health, about 5 percent of Medicare beneficiaries account for about one-third of total Medicare expenditures. Palliative care could divert services for many members of that population from hospitals, which are the most expensive setting for care, to less costly settings, such as the individuals’ homes.

It is common knowledge that Medicaid members with serious illnesses increasingly use high levels of costly emergency department and inpatient services as they near the end of their lives. Thus, diverting much of that care to settings outside of hospitals would bring costs down. Likewise, reducing the number of days patients spend in nursing homes also could reduce costs.

One study found that seriously ill patients who received home-based palliative care had lower rates of visits to emergency departments and hospital admissions and were more likely to die at home. Patients who received palliative care had health care costs that were 33 percent lower than those incurred by patients who received the usual, non-palliative care. Another study found significant reductions in the number of hospitalizations and reduced hospital costs for patients given home-based palliative care compared to those who received usual care. Yet another study found that patients who received home-based palliative care or hospice care had significantly lower odds of hospital readmission. In general, studies have found that palliative care reduces hospitalizations and emergency department visits.

Reducing costs through increased use of palliative care is also consistent with findings in a 2014 paper available through the National Library of Medicine that reviewed 46 papers from around the world that examined the cost-effectiveness of palliative care. That review found that, although the studies varied widely in characteristics and quality, the results showed “consistent patterns” that palliative care tends to be less costly than alternatives. In most cases, the review found, “the difference in cost is statistically significant.”

***What are the trends toward palliative care across the country?***

Palliative care is included in some insurance programs offered by private companies, such as ECCM offered by Highmark Blue Shield as a Medicare Advantage Service. In her May 10, 2019, presentation to the West Virginia Legislature, Dr. Emily Jaffe, executive vice president and medical director for Highmark Health, Inc., said Highmark was working to provide incentives for primary care physicians, specialists, health care delivery partners and payers to develop alternative payment models hat drive quality, are member-centric, and help members achieve their goal of home-based services, whenever possible. The company also was using robust data collection, tracking and sharing to demonstrate the value and effects of palliative care programs.

Several states have expressed interest in adding palliative care as a covered benefit in their Medicaid programs. So far, no state Medicaid program offers comprehensive palliative care as a stand-alone benefit. However, California is now requiring coverage of community palliative care by managed care organizations that contract with the state. In addition, both Maine and Hawaii have passed legislation to add palliative care as a covered Medicaid benefit. Those states are in the process of defining the benefit. The Hospice Council of West Virginia believes the approach taken by Maine, another rural state, is the best one for West Virginia to consider.

Demonstration models approved by the Centers for Medicare and Medicaid Services are expanding hospice benefits to include reimbursement for palliative care.

Many managed care organizations are including palliative care services in their hospice benefits.

***Why should West Virginia seek to increase the use of palliative care?***

West Virginia could potentially see more benefits from increased use of palliative care than other states because of its demographics of having an older and sicker population than most other states. In 2021, West Virginia’s median age of 42.8 years was four years higher than the national average. (The median age actually declined from prior years but that was attributed to higher mortality among older residents because of deaths resulting from COVID-19.) More than 27 percent of West Virginia residents were aged 60 or older, and that was more than five percentage points higher than the national average.

Even when accounting for the state’s older population, West Virginia experiences higher rates of various morbidities and higher mortality rates. According to the Centers for Disease Control and Prevention, West Virginia has the second highest mortality rate in the country, and it ranks among those states with the highest rates of heart disease, cancer and diabetes. Contributing to West Virginians’ poor health outcomes are such behavioral factors as high rates of tobacco use, relatively little physical activity during leisure time and high rates of opioid use and overdoses.

Thus, any form of care, such as palliative care, that reduces costs and improves quality of care can have more effect in a state like West Virginia with a higher rate of health care problems.

***What should be done next?***

Insurers and health care providers should be encouraged to increase their use of palliative care. One of the state’s major insurers, Highmark, is doing that already. Such a movement also should be encouraged through public policy and legislation.

***What type of legislation should be considered?***

The Hospice Council of West Virginia supports passage of a bill that would direct the Department of Health and Human Resources to provide reimbursement for palliative care in the Medicaid program by applying for a waiver or a State Plan Amendment to permit reimbursement for such care. While palliative care could be expected to reduce costs, the legislation could specify that the benefits should be delivered in at least a cost-neutral manner to ensure that palliative care would not be more costly for the program.

Currently, physicians, advance practice registered nurses and physician assistants are providing palliative care, but registered nurses and other professionals, whose services are needed to support patients and their families, have no way to bill for those services. For the sake of quality and the sake of cost control, West Virginia’s Medicaid program should implement reimbursement for the full range of interdisciplinary palliative care.