At-A-Glance

Community Models for Concurrent Disease Treatment and Hospice/Palliative Care

Years of research have confirmed that the provision of interdisciplinary palliative services, when delivered concurrently with curative treatments for serious illness, significantly improves quality of life, reduces symptom distress, reduces caregiver burden, improves cost-effectiveness, and may prolong life.

There has been a great deal of innovation bringing comprehensive, interdisciplinary palliative services to patients who are actively pursuing curative treatments – whether through hospice at the end of life or through palliative care delivered earlier in the disease trajectory. This paper highlights nine of these “concurrent” models, serving a variety of patient populations. Through this summary, we hope to inform the modernization of benefits for all people living with serious illness.

Two Types of Models

Past models of concurrent care can be categorized in one of two ways. The first is when disease-directed/ curative care moves "downstream" into hospice, and the population served has a short prognosis. The second is when comprehensive palliative care moves "upstream" to care for patients during active disease-directed/curative treatment, whether or not they are eligible for the hospice benefit.

For purposes of this document, we will refer to the previous models as either "**downstream curative care**" or "**upstream palliative care**."

- Please note that the selection of models is not exhaustive. Where multiple iterations of a similar model exist – such as the Concurrent Care for Children section of the Affordable Care Act, which requires state Medicaid programs to pay for both curative treatment and hospice services for children under the age of 21 who qualify – we have used a certain state or payer as the example.
- Please also note that for purposes of this document, we use the umbrella term “palliative care,” with hospice care as the provision of palliative care services to patients eligible for the Medicare Hospice Benefit.

DOWNSTREAM CURATIVE CARE MODELS

Concurrent Model Elements (Downstream Curative)

Model	Eligible Population	Providers Eligible to Deliver Palliative Care; Team Composition	Palliative Care Services Included	Type of Payment Model Used and Timeframe (if any)
Medicare Care Choices Model	Medicare beneficiaries eligible for the existing hospice benefit with these dx's: advanced cancer, COPD, heart failure, HIV/AIDS	Medicare-certified hospice agencies Teams comprising physician, nursing, social work, and chaplain	All Medicare hospice services for routine home care and respite levels of care Only those services that could not billed separately under A, B, D. 24/7 services required	Monthly per-patient-per month No time limitations
ACA Concurrent Hospice and Curative Care for Children (example from Michigan guidance)	Children less than 21 who qualify for hospice per Medicaid manual	Hospices licensed in the state Must coordinate with the pediatric subspecialist	Hospice and subspecialist must differentiate curative from palliative in the care plan. State guidance suggests hospice services include narcotics, analgesics, anti-emetics, previous tube feeding continuation, antibiotics, oxygen, wheelchairs, spiritual support, and psycho-social support	Hospice and curative care are billed separately Hospice paid as usual
Transitional Care under Medicare Hospice Carve-in Model	MA enrollees eligible for the existing hospice benefit; may be targeted to specific conditions at the MA plan's discretion. Enrollee must elect the hospice benefit	Medicare-certified hospice agencies, in-network with the MA plan In addition, non-hospice providers eligible to deliver the relevant curative care (eg, chemotherapy, dialysis, transfusions) in coordination with the hospice agency	All Medicare hospice services for all levels of care 24/7 services often required	MA plan receives hospice capitation. In turn, MA plan negotiates payments with hospice and non-hospice providers Some MA plans limit concurrence to 30, 60, or 90 days; others put no time limit

Model	Eligible Population	Providers Eligible to Deliver Palliative Care; Team Composition	Palliative Care Services Included	Type of Payment Model Used and Timeframe (if any)
Aetna Compassionate Care Program	Employer-sponsored enrollees Clinician referral, utilization review of admissions, and claims algorithm based on diagnoses and medications	In addition to in-network hospice agencies, patients receive: specialized telephonic care management (anticipatory guidance, decision-making support and help accessing a range of services)	Expanded hospice by: - Prognosis of 12 months - Continuation of curative services - No LOS or maximum dollar limits - Addition of 15 days/year of respite benefits	No changes to hospice payment arrangements
Better Kidney Act Congressional Proposal	Medicare A/B beneficiaries receiving dialysis from a participating facility	IDT led by Nephrologist, includes the Dialysis team, and can include a hospice team	Education on palliative care and hospice care If elect hospice, all Medicare hospice services for all levels of care, while care is coordinated by the Dialysis IDT (and patient continues to receive dialysis)	Dialysis team expected to be eligible for performance-based financial incentives. No information on hospice payment model or timeframe

Concurrent Model Outcomes and Analysis (Downstream Curative)

Model	Outcomes Reported	Limitations of Model	Other Considerations
Medicare Care Choices Model	14% less Medicare spending 14% fewer ED visits, 28% fewer hospitalizations, and 38% fewer ICU days Earlier enrollment in hospice benefit More days at home (CMMI final report)	Only included a sub-set of serious illness Patients concentrated in a small number of providers Insufficient guidance on what is otherwise covered in Part A, B, D (eg, nursing visits)	

Model	Outcomes Reported	Limitations of Model	Other Considerations
ACA Concurrent Care for Children	Increased hospice LOS and decreased live discharges No impact on ED or acute care (Lindley AJHPC 2021)	Findings analyzed early experience (2011-13), when curative teams may have been less familiar with hospice capabilities	
Transitional Care under Medicare Hospice Carve-in Model	Less than 1% of plan hospice enrollees received Transitional Care No change in hospice utilization (CMMI year 2 report)	Enrollment difficulties -- the requirement to elect hospice first, and then add TCC didn't make sense to patients and families	Both plans and hospices noted a great deal of difficulty in coordinating and clarifying the services, complicated by needing to determine what was related or unrelated to the terminal condition
Aetna Compassionate Care Program	More than doubled hospice enrollment, and increased hospice LOS Significant reductions in acute admissions, LOS Acute days/1000: 1549 vs. 3986 ICU days/1000: 899 vs. 2542 (Spettell JPM 2009)	Commercial population (rather than Medicare) Replicated the impact on utilization in a Medicare Advantage population with just the enhanced care management	Concurrent hospice (and expanded prognosis) impact was not separately studied – results may be due to the specialized care management

UPSTREAM PALLIATIVE CARE MODELS

Concurrent Model Elements (Upstream Palliative)

Model	Eligible Population	Providers Eligible to Deliver Palliative Care; Team Composition	Palliative Care Services Included	Type of Payment Model Used and Timeframe (if any)
Veteran's Administration Comprehensive EoL Care Initiative	Referrals based on clinician opinion (bolstered by VA education)	*Not specified* (If hospice elected, dedicated nurse liaison between treating teams and hospice team)	"Primary palliative care" through goals-of-care discussions Mandatory specialty palliative care consultation teams in all hospitals All hospice services	Budget-based (no payment model)
Elevance Connected Palliative Care (fka Aspire Health)	Runs a proprietary claims algorithm to identify those with a likely prognosis of < 1 year (variables include age, diagnoses, and past utilization)	MD (on-call 24/7) overseeing APP-SW field teams, with RN telephonic support	Symptom management, advance care planning/anticipatory guidance, and 24/7 urgent visits/treat in place ALOS 10 months	Monthly case rate plus shared savings
Proposed Medicaid Benefit, MedQuest Hawai'i	Anticipate combining specific conditions with functional and social needs	Anticipate developing specific credentials and/or criteria for community-based palliative care Notes the need for an interdisciplinary team	Assessment and care planning "Clinical services" Care coordination	Monthly case rate Initial assessments and comprehensive re-assessments billed separately
Proposed Primary Care First Seriously Ill Population (SIP) Option	Claims algorithm based on HCC scores and unplanned hospitalization or certain DME claims, and "a pattern of care fragmentation"	Part B participating providers Nurse care manager and interdisciplinary team Ability to follow-up post-ED visit or hospitalization Ability to find resources for social and functional needs	Comprehensive assessment Management of both primary and palliative needs 24/7 response to clinical needs Short-term stabilization, then transitioning to either primary care or hospice care	Monthly case rate plus quality adjustments First month is set at higher payment to account for assessment time

Concurrent Model Outcomes and Analysis (Upstream Palliative)

Model	Outcomes Reported	Limitations of Model	Other Considerations
Veteran's Administration Comprehensive EoL Care Initiative	Compared to Medicare beneficiaries: - More likely to die on hospice care - Less likely to receive high-intensity care at end-of-life - Earlier access to palliative care consultations - Improved family satisfaction (Sullivan JPM 2022)	VA operations do not rely on billing revenue VA system integrates multiple settings and services, and uses a single EMR	
Elevance Connected Palliative Care (fka Aspire Health)	58% reduction in admissions/1000 (Elevance website) Gross savings of $12,500 per member (2016 CAPC webinar)	Longer-stay patients do not fit well in the model (need more home-based primary care than this)	No peer-reviewed publications or external evaluation of results