

# Washington Palliative Care Reimbursement Project Summary Report

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March 2023



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## Introduction

Washington has joined a growing number of states that are undertaking substantive initiatives to increase the accessibility and quality of palliative care for seriously ill patients. According to an August 2022 report from the National Academy of State Health Policy<sup>1</sup>, 18 states had taken 24 legislative actions to support and expand palliative care. These initiatives reflect an accelerating evolution in palliative care from its roots in end-of-life hospice care to its current role in patient-centered, community-based care to improve the quality of life of seriously ill patients.

The evolution of the palliative care policy discussion has been driven primarily by the National Consensus Project for Quality Palliative Care and its foundational *Clinical Practice Guidelines for Quality Palliative Care*<sup>2</sup>, originally published in 2004 and now in its 4th edition. In 2006, the National Quality Forum published *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*<sup>3</sup>, setting forth goals, general principles, and a framework for 38 preferred practices. In Washington, the Dr. Robert Bree Collaborative relied extensively on the Guidelines and Framework to inform its report and recommendations on palliative care<sup>4</sup> in 2019. The product of a diverse workgroup of Washington-based practitioners, payers and health care professionals, the Bree Collaborative Palliative Care report and recommendations provide the foundation for the Center's recommendations.

## Background

In November 2022, the Washington State Legislature passed ESSB 5693<sup>5</sup>, directing the Health Care Authority (HCA) to “design a standard payment methodology for a palliative care benefit for the state Medicaid program and the Employee and Retiree Benefits program.”

HCA engaged the Center for Evidence-based Policy to assist with the development of palliative care benefit and payment methodologies pursuant to ESSB 5693. The Center conducted a policy review, stakeholder interviews, a gap analysis, and a concluding listening session with stakeholders. This report sets forth the Center's key findings, guiding principles and recommendations. Supporting documentation is included in the appendices, including a list of stakeholders who provided practical insights, lessons and advice to the Center and HCA.

## Key Findings

Washington is confronting a number of challenges to the provision of palliative care services by providers, and access to available care by patients in need. The following findings describe the issues commonly cited regarding palliative care in the state:

- There are variations in the way HCA's contracted managed care and Employee and Retiree Benefit (ERB) plans operationalize a palliative care benefit. As a result, it is unclear what specific benefits are available to patients and who is eligible to receive them.
- Payers rely heavily on fee-for-service arrangements that do not adequately support the recommended service delivery model for palliative care that is centered on care provided by an interdisciplinary team. Existing fee structures do not allow for the billing of all services provided by interdisciplinary team members.
- The state Medicaid palliative care benefit and payment methodology for children (age 20 years and younger) are appropriately designed and do not need to be included in the

payment reform effort. In addition, ERB plans pay for pediatric palliative care using fee-for-service reimbursement. Consequently, the focus of the recommendations in this report are specific to the adult Medicaid and ERB palliative care benefit.

- Barriers exist, beyond payment policy, that prevent patient access to palliative care services. While alternative payment methodologies may support addressing the following issues indirectly, additional policies and strategies may be needed:
  - Palliative care carries a stigma by patients and providers who incorrectly perceive the benefit as a decision to “give up” on curative treatments.
  - Providers and plans report concerns about workforce supply and capacity to meet growing demand for palliative care services.

### Guiding Principles

Based on these findings, the Center developed the following set of principles to guide the development of policy recommendations and a proposed payment model for adult palliative care. These principles are closely aligned with existing policies set forth by the Health Care Authority for the provision of Apple Health’s pediatric palliative care benefit<sup>6</sup>.

- Policies and payment models are validated based on sound medical evidence and practice.
- End-of-life prognosis is not required for patient eligibility.
- Policies and models apply to adult patients aged 21 and older. Existing pediatric palliative care policies and payment models are not impacted or altered.
- Palliative care is available to patients with complex medical needs that require care management across multiple health conditions, and coordination of medical services.
- Palliative care is available to patients with medical conditions that exceed the abilities and capacities of family members and caregivers to assist and support the patient.
- Palliative care is available to patients with medical crises; life-limiting medical conditions impacting cognitive, social and physical functioning; and therapeutic goals focused on quality-of-life, comfort and family stability.
- Eligibility is reassessed at least every 6 months, and preferably on a quarterly basis.

### Summary Recommendations

The Center’s recommendations are derived from four primary sources of national research and consensus-building about palliative care policies, practices and payment methodologies. The four cornerstones include:

- (1) *Clinical Practice Guidelines for Quality Palliative Care*<sup>2</sup> published by the National Consensus Project for Quality Palliative Care,
- (2) *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*<sup>3</sup> published by the National Quality Forum,

(3) *Payment Reforms to Improve Care for Patients with Serious Illness (PACSSI)*<sup>7</sup> published by the American Academy of Hospice and Palliative Medicine, and

(4) *Palliative Care*<sup>4</sup> published by the Robert Bree Collaborative.

Additional contributions were provided by the Washington Rural Palliative Care Initiative of the Washington Department of Health<sup>8</sup>, the California Department of Health Care Services<sup>9</sup>, and the Hawaii Department of Human Services<sup>10,11</sup>. In addition, the Center engaged palliative care practitioners, payers, and other stakeholders in Washington to inform the development of the following draft set of recommendations.

### Hybrid Payment Model

The Center recommends adoption of a hybrid payment model consisting of traditional Fee for Service (FFS) components and Alternative Payment Model (APM) structures based on the “PACSSI” model. Such an approach was proposed by the Bree Collaborative in 2019 and is responsive to a diverse set of business models used by palliative care providers in Washington.

The recommended model aligns with policies that have been (1) adopted by California, (2) are under development by Hawaii, and (3) are the primary focus of recent palliative care payment reform analysis by the Centers for Medicare and Medicaid Services. A complete description and analysis of the recommended model follows this summary.

### Covered Services

The Center recommends a palliative care benefit that includes the following covered services. These benefits were endorsed by the Bree Collaborative<sup>4</sup>, consistent with guidelines adopted by the National Consensus Project for Quality Palliative Care<sup>2</sup>:

- Initial assessment
- Goals of care conversation(s)
- Advance care planning
- Assessment of cognitive impairment
- Assessment and management of functional needs
- Assessment and management of symptoms and medical care
- Pharmacy management
- Caregiver support, if needed
- Assessment and management of behavioral health and psychosocial needs related to serious illness
- Spiritual care needs
- Ongoing management

### Eligibility Criteria

The Center recommends a set of eligibility criteria for access to a palliative care benefit consistent with criteria used in the PACSSI payment model and referenced in the 2019 Bree Collaborative report. The criteria consist of the following components:

- The patient must have at least one serious illness or a combination three chronic conditions selected from specific lists of qualifying illnesses and conditions.

- The functional status of the patient must indicate significant functional limitations and the need for assistance with one or more activities of daily living that may also include reliance on durable medical equipment.
- The patient has a recent history of unscheduled health care utilization.

The PACSSI criteria satisfies the guiding principles, fully integrates with the recommended hybrid payment model, and can be made sufficiently detailed to support stratification of eligible patients into two tiers based on severity and complexity of needs. HCA may refine these criteria to accurately target the palliative care benefit to patients in need, and balance demand for services with supply of service providers and available financial resources. Appendices G and H provide more information about eligibility criteria including lists of serious illness and chronic conditions used by the PACSSI model, and a comparison of criteria used or under consideration by California, Hawaii and the Washington Rural Palliative Care Initiative.

## Payment Model Analysis and Development

The Center recommendation of a hybrid payment model for adult palliative care marries traditional Fee for Service (FFS) components and Alternative Payment Model (APM) structures based on the industry-endorsed “PACSSI” model. The recommended hybrid model is the result of a five-step development process that includes (1) establishing criteria that address stakeholder feedback and basic model development principles, (2) evaluating high-level payment model options using the criteria, (3) selecting a model, (4) refining model design elements, and (5) further refining the model with stakeholder feedback.



A detailed description of the process and its products follows, beginning with an introduction to the alternative payment methodology used to refine existing fee for service payment methods.

## Alternative Payment Methodology

### Background

Alternative payment methodologies (APM) are provider reimbursement strategies that move away from the standard fee-for-service model by introducing elements that create greater financial flexibility for providers while simultaneously increasing accountability for patient outcomes. These two factors—flexibility and accountability—are necessarily coupled in APMs because payment that is not fully dependent on volume of services provided carries a perverse incentive to underserve patients. Accountability for outcomes creates more balanced incentives because it is difficult to achieve good patient outcomes unless the patient is getting the services they need. APMs drive efficiency by creating the financial incentive to provide only the services necessary to achieve the desired outcomes. This is an important concept when evaluating options for palliative care payment models.

The traditional fee-for-service model rewards volume of services rendered regardless of the outcome achieved and offers little financial flexibility for providers to operate efficient and sustainable business models that can deliver the desired quality outcomes. The lack of financial flexibility has driven a national push to advance alternative payment methodologies. In response, the Health Care Payment Learning & Action Network (HCP-LAN) developed an alternative payment methodology framework that creates a continuum of alternative payment methodologies from a baseline of fee-for-service (Category 1) all the way up to financial arrangements where the provider is at risk for total cost of care and accountable for outcomes (Category 4).<sup>12</sup> This framework serves as a useful foundation for thinking through different APM options. While there are numerous options for APMs within this HCP-LAN framework, the specific model best suited to any situation will vary based on factors such as providers' ability to take on financial risk, the scope of services in question, and the payer and provider's tolerance for operational complexity.

#### *Alternative Payment Methodology Criteria*

To evaluate potential high-level model options, the Center utilized the criteria listed below. The criteria reflect a combination of generally applicable payment model development principles and criteria that address feedback provided by stakeholders.

- Benefits and eligibility are clearly defined.
- The payment model supports an interdisciplinary team service delivery approach.
- There is sufficient funding for sustainable business models for both providers and payers while supporting access to care for the population that can benefit from palliative care services.
- There is accountability for delivering high quality care and avoiding unnecessary services.
- Financial accountability limited to scope of providers' control.
- Model is operational feasible.
- Model supports delivery of care to population with differing care needs.
- Model supports providers with different business models and resources constraints.

#### *Evaluation of High-level Options*

The state and stakeholders identified a potential high-level model through the Bree Collaborative process. The 2019 Bree Collaborative recommendation<sup>4</sup> for a palliative care payment model was aligned with the Patient and Caregiver Support for Serious Illness (PACSSI) model<sup>7</sup>. Recognizing that it may take time to implement a more robust alternative payment methodology, the Bree Collaborative included recommendations for a fee-for-service based model.

The Center's evaluation of high-level payment model options includes the Bree Collaborative recommendation, and other models including those found in the HCP-LAN APM Framework. Specifically, the Center evaluated fee-for-service models with quality incentives, case rate models, capitation models, and fixed price contracting.

### Bree Collaborative Recommendation Summary

The Bree Collaborative recommendation focused on three model design elements – covered benefits, payment mechanism, and eligibility criteria.

#### Benefit

The recommendation describes a suite of services delivered by an interdisciplinary care team. The services include the following:

- An initial assessment
- Goals of care conversation(s)
- Advance care planning
- Assessment of cognitive impairment
- Assessment and management of functional needs
- Assessment and management of symptoms and medical care
- Pharmacy management
- Caregiver support, if needed
- Assessment and management of behavioral health and psychosocial needs related to serious illness
- Spiritual care needs
- Other, as needed
- Ongoing management
- Define excluded services (e.g., hospitalizations for unrelated diagnoses)

#### Payment Mechanism

As previously noted, two payment models were recommended - fee-for-service and a PACSSI-based APM.

Under fee-for-service, the payment mechanism is per-service compensation. Changes to status quo that would support palliative care under the fee-for-service option include reimbursement for nonclinical interdisciplinary team members (including those without prescribing ability), reimbursement for care coordination or goals of care discussion without the patient and changing the hospice benefit to reimburse for palliative care.

Under the Bree recommended APM, there are three payment mechanisms. These include a larger upfront payment for the initial intake visit, a per-participant-per-month (PPPM) payment, and a smaller per in-person payment.

#### Eligibility

The Bree recommendation flagged the need to define the patient population eligible for the benefit and provided examples of approaches such as the PACSSI, the Washington State Rural Palliative Care Initiative Palliative Care Screening Tool<sup>8</sup>, and California Senate Bill 1004<sup>9</sup>.

#### Bree Recommendation Evaluation

The recommended APM leverages a hybrid payment model with both a volume-based component and fixed-payment component. This general design is effective in balancing accountability for delivering services while providing the financial flexibility to ensure an interdisciplinary team can be compensated for all of the services rendered. To fully address the APM criteria, additional model refinement would be required. The ability of the Bree recommended models to address the payment model criteria is summarized in Table 1 below.

It is possible that not all palliative care providers operate under business models that are well supported by the fixed-payment component of the model. If the PACSSI-based APM is implemented, the fee-for-service model should also be implemented – not just as a short-term transition, but as a permanent companion model. This would also facilitate future APM financial performance analysis as it would allow for a fee-for-service cost comparison.

Lastly, the APM has the risk of becoming administratively burdensome depending on how specific model elements are designed. Areas of concern are highlighted in the remaining sections of report where applicable.

Table 1: Bree Collaborative Recommendations Ability to Meet APM Criteria

Criteria	Fee-for-service	APM
Benefit and Eligibility Defined	Yes	Yes
Supports Interdisciplinary Team	No	Yes
Financially Sustainable	Conditional	Conditional
Accountability for Efficient and Effective Care	No	Conditional
Appropriate Scope of Risk	Yes	Yes
Operational Feasibility	Yes	Conditional
Accommodates Provider Diversity	Yes	Conditional

*Additional Alternative Payment*

While the Bree Collaborative recommendations create a general framework capable of addressing both the current system payment challenges and the payment model criteria, it is important to consider additional options before advancing a model to the next stage of refinement. Four additional general types of models were assessed using the same criteria as the Bree Collaborative recommendation. Models evaluated include fee-for-service with incentives, case rates, population-level capitation, and fixed price contracting. In all cases, material weaknesses related to financial sustainability were identified.

For example, fee-for-service with quality incentives doesn't address the fact that some interdisciplinary team members provide services that are not compensable under the Medicaid benefit. On the other end of the HCP-LAN APM Framework, population-level capitation would introduce (potentially significant) financial risk to both providers and payers related to the number of service utilizers in the population and the service needs of that population. This is unnecessary financial risk to introduce in a payment model. A summary of the models' ability to address the model criteria is shown in Table 2 below and a full discussion is included in Appendix D: Review of Alternative Payment Model Options.

Table 2: Additional APM Options' Ability to Meet APM Criteria

Criteria	Fee-for-service w/ Incentives	Case Rate	Population-level Capitation	Fixed-price Contracting
Benefit and Eligibility Defined	Yes	Yes	Yes	Yes
Supports Interdisciplinary Team	Conditional	Yes	Yes	Yes
Financially Sustainable	No	No	No	No 
Accountability for Efficient and Effective Care	Yes	Conditional	Yes	Conditional
Appropriate Scope of Risk	Yes	Yes	No	Yes
Operational Feasibility	Yes	No	No	Yes
Accommodates Provider Diversity	Yes	Conditional	No	No

*Recommended Model Selection*

While all models have pros and cons, the alternative model options evaluated all have material weaknesses that make them less viable than the Bree Collaborative recommendations. The Center recommends proceeding with both Bree Collaborative recommendations - the updated fee-for-service model and the PACSSI-based APM.

**Model Design Element Refinement**

To advance the Bree Collaborative recommendations towards implementation, additional policy refinement is required in multiple domains. The domains and specific policy recommendations are described below.

*Scope of services or covered benefits and payment mechanisms*

A clearly defined palliative care benefit with delineation between payment mechanisms for different services is required for implementation.

*Fee-for-service*

The list below identifies services that would be included in the fee-for-service benefit, with all services paid on a per-rendered-services basis. Services not listed would be paid outside of the palliative care benefit using the status quo reimbursement methodologies as applicable.

- Qualified health care professional services (MD, DP, NP, etc.) (CPT, HCPCS)
  - Evaluation and management office visits
  - Transitional care management, chronic care management
  - Advance care planning (including when provided by a registered nurse)
  - End of life counseling
  - Home and community interdisciplinary care team consult
  - Inpatient and outpatient interdisciplinary care team consult

- Other licensed professional services (revenue code)
  - Registered nurse
  - Physical therapy
  - Occupational therapy
  - Speech therapy
  - Case management
- Other available services (procedure code)
  - Social work

#### Alternative Payment Methodology

The recommended benefit and payment mechanism for the APM include:

- Initiation: larger upfront evaluation fee
  - Professional: advanced care planning, palliative care assessment and consult, new patient
  - Non-professional: multidisciplinary plan of care
- Ongoing: hybrid payment structure
  - Qualified health care professional services (as shown above): standard billing
  - Other services: Per Participant Per Month (PPPM) fee and smaller per-visit fee
    - Implementing a plan of care
    - Reassessment of ongoing needs (functional, symptoms, behavioral health and psychosocial)
    - Symptom management
    - Care coordination
    - Spiritual care and chaplain services
    - 24/7 telephonic palliative care access
    - Targeted behavioral health services

Examples of specific services not included in APM that would remain available through the same mechanisms as status quo include the following:

- |                                      |                           |
|--------------------------------------|---------------------------|
| • Curative or disease modifying care | • Pharmacy                |
| • Hospitalizations, post-acute care  | • Oxygen                  |
| • Behavioral health                  | • Other billable services |
| • Durable medical equipment          |                           |

The PACSSI model includes the ability to implement payment tiers based on whether a patient is classified as “moderate complexity” or “high complexity”. Payment tiers have the key advantage of aligning payment level with patient resource need. The Center recommends including two tiers of payments in the model design.

### *Quality Incentives*

In addition to the volume-based component of the APM, quality incentives could be used to promote appropriate levels of patient contact and a focus on outcomes. As previously mentioned, the AAHPM has recommended numerous palliative care quality measures to the Department of Health and Human Services<sup>13</sup> (See Appendix F for a list of these quality measures). These measures could be evaluated for inclusion in the Medicaid and ERB payment model.

Provider-level quality measurement can be administratively burdensome, and statistics can be unreliable at a provide or payer-specific level due to low volume with certain payers or low provider panel size. The Center recommends a phased implementation of the APM that includes an initial phase without quality measure incentives, and a potential second phase with quality measure incentives once patient volume for APM participation can be evaluated and operational challenges for quality measurement can be addressed (data collection, analysis, and dissemination).

### *Reevaluation Frequency*

The Bree Collaborative recommendation did not include guidance on the frequency of patient reevaluation to determine patient eligibility and payment level. A recent study comparing two different PACSSI models, the standard PACSSI (which uses an assessment every six months to inform payment level) model and PACSSI-F, found that using the PACSSI-F model (which uses a monthly reassessment of functional status to inform payment level) results in a notable difference in total model costs without significant differences in sustainability of the model for providers.<sup>14</sup> The study found that 28.6% of the population in palliative care experienced sufficient changes in functional status over time to warrant reduced payment levels for the subpopulation. This suggests both the need for a tiered model and for periodic reevaluation to maintain alignment between payment level and level of patient service needs.

The Center recommends no less frequent reassessment of functional status than quarterly, with the ability and expectation to assess more frequently if there are noticeable changes in functional status independent of formal assessment.

### *Payment Trigger*

The payment trigger is the qualifying event that initiates the PPPM each month. The Center recommends the payment trigger would be the first billable visit from a member of the interdisciplinary team each month as this serves as an indication of ongoing receipt of services.

### *Partial Month Initiation Policy*

Because patients could become eligible at any point in the month, the state requires a partial month PPPM policy. The Center recommends that newly eligible members can receive a full PPPM, regardless of when the initial trigger event occurs. To avoid overcompensation, rate setting will have to factor in an assumed rate of partial month PPPMs based on historical data.

### *Minimum Engagement Standards*

The proposed APM does have a volume-based component, but absent accountability for quality measures initially (or even with them), guardrails to ensure appropriate level of patient contact for the PPPM may be appropriate. Data analysis on historical utilization patterns could be used to inform minimum engagement standards. The Center recommends that future policy development include setting minimum engagement standards and that these standards are informed analysis of historical utilization patterns. Note this does not replace assessed level of need; palliative care providers are expected to provide the level of service the patient needs above and beyond a weekly contact.

### *Payment Amount*

Determining the level of tiered payments will require data analysis and stakeholder engagement. While the Center is not in a position to make a recommendation on the policy, it will be important to adhere to standard rate development principles such as adequately covering provider costs, evaluating variation across providers, and implementing solutions for outlier scenarios such as rural provider resource challenges.

### *Eligible Patients*

The Bree Collaborative recommendation referenced eligibility criteria used in other states, the PACSSI model, and a Washington-specific rural palliative care assessment. As previously mentioned, the PACSSI model is the industry endorsed model. PACSSI is also best aligned with the identified guiding principles and payment methodology criteria. The PACSSI model has the additional inherent advantage of stratifying the population into two tiers, which directly supports the Center's payment model recommendations.

Based on these considerations, the Center recommends the PACSSI model for determining patient eligibility. The Center further recommends that HCA refine and define the PACSSI criteria to accurately target the palliative care benefit to patients in need, and balance demand for services with supply of service providers and available financial resources.

Refer to Appendix G for detailed recommendations and considerations related to patient eligibility.

### *Eligible Providers*

Provider eligibility will not be limited other than requiring a scope of services appropriate for the licensure or level of training of the rendering provider.

### *Service Location*

Both models are designed to be agnostic to the service location. Services should be provided in a manner preferred by and most clinically appropriate for the patient.

## **Additional Considerations**

### *Fiscal implications*

Several factors will impact whether there will be a fiscal impact. The level rates are set at will be a primary driver. Changes in utilization will be another driver. With changes in utilization, there is both a direct and indirect impact. The direct impact will be the cost of services provided that would not have been provided prior to the change in methodology. The indirect impact would be

any change in utilization of services other than palliative care that occurred as a result of accessing palliative care services. While the direct effect will increase costs, there is some evidence that the indirect effect will put downward pressure on costs.

A meta-analysis of the effect of palliative care services on hospitalized adults with serious illness found an average reduction of \$3,237 per admission when receiving palliative care. The greatest savings occurred for those with cancer and for individuals with four or more comorbidities.<sup>15</sup> A National Academy for State Health Policy sponsored actuarial analysis of three states estimated a potential return on investment from palliative care services of between 0.5 and 2.6.<sup>16</sup> The degree to which cost savings manifest will depend on the how closely the eligibility and service model in Washington resembles the populations and services provided in the studies. Lastly, barriers to care such as workforce constraints and stigma will mute both the direct and indirect effects. Eligibility policy will have an effect on the magnitude of these effects as well.

#### *Managed Care Plan Discretion vs. Operational Alignment*

HCA will have to decide what level of prescriptiveness to use when delegating responsibility for implementation to contracted payers. This decision will have to consider both regulatory constraints on the state's ability to mandate payment, but also the value of payer and provider flexibility. It may be advantageous to have sufficient flexibility to negotiate some aspects of the model with providers under unique constraints (rural, for example) rather than adhering to a rigid model. The downside of that flexibility is the risk of fragmented operational-level implementation that could be a burden to providers and inefficient at the plan level.

Standardization of billing-related processes is recommended. This includes alignment on which codes are billed for which services, and under which circumstances. A stakeholder process that includes payers could be used to determine the most appropriate billing and coding strategy for the benefit. Additional information on codes that could be used for the starting point of the stakeholder process are provided in Appendix E.

#### *Regulatory Authority*

Codifying payment methodologies in legislation is not advised, particularly with new methodologies; there may be a need to course correct more quickly than the full legislative process can accommodate. Additionally, the aforementioned flexibility could be eliminated completely if methodological detail is codified.

#### *Operational Complexity*

There are different ways to implement the model. Some are more operationally complex than others. The general tradeoff will be between level of trust in provider billing and utilization management and oversight. A process to evaluate the appropriate balance of oversight and resulting operational complexity is necessary to inform implementation timelines. The state will need to collaborate with downstream payers to come to an agreement on operational strategy, which includes creating aligned billing and reimbursement practices.

#### *Review of Program Integrity Constraints Regarding Self-Referral*

The AAHPM letter to CMS<sup>18</sup> indicated the need for a waiver of some program integrity requirements related to referral to services and related conflict of interests. The state may have similar regulations that will need to be updated to remediate a conflict with the payment model.

### *National Academy for State Health Policy (NASHP)*

The state was awarded the opportunity to participate in a palliative care technical assistance program through NASHP. This opportunity includes access to actual and data analysis to further inform the model development and implementation. Several key areas of exploration would be particularly useful for the state under this technical assistance opportunity; these include the following:

- Data informed eligibility policy refinement: the state can evaluate the potential fiscal impact under different eligibility criteria scenarios to inform where a more limited eligibility threshold is appropriate.
- Data informed tiering: the state can explore whether there are different utilization patterns for patients with specific characteristics that could be used to tier rates, starting with characteristics aligned with the PACSSI-based tiering characteristics.
- Pricing strategy: the actuary can recommend rate setting strategies that produce rates aligned with the proposed policies such as the partial month payments, continued coverage during inpatient hospitalization, etc.
- Data informed provider identification: the state can identify which providers have sufficient volume, across the combined state payers, to potentially participate in the APM.
- Evaluation of palliative care utilization by children covered under the ERB to determine if transition to a similar payment model as utilized by Apple Health would be beneficial.

### **Conclusion**

The Center's recommendation for a hybrid payment model for palliative care is based on careful consideration of the alternative APM structures, models used or under development by other states, and findings and recommendations of the Bree Collaborative. A hybrid payment model based on the industry-endorsed PACSSI recommendation aligns with a common set of payment model development principles, and provides comprehensive solutions to the set of concerns identified by Washington stakeholders. The model's hybrid structure of FFS and APM components addresses palliative care payment issues that impact a diverse set of business models used by palliative care providers in Washington. The Center's recommendation comes with detailed guidance regarding specific components and elements of the model that remain to be addressed to fully implement a hybrid payment model for palliative care.

## Appendix A: Stakeholder Contributors

The Center extends its appreciation and gratitude to the following individuals who provided their knowledge, insights, experiences, energies, passion and time to the Palliative Care Reimbursement Project.

Organization	Participant	Individual & Team Interviews	Medicaid & ERB Plan Interviews	Listening Session
Amerigroup Washington	Hailey Slattum, MSN, FNP-C, Team Lead PNW/SW		X	
	Kelli Gershon, FNP-BC, ACHPN, Clinical Director Aspire/CareMore		X	
	Penny Mckee, Nurse Medical Management Lead		X	
	Shawn Akavan, MD, Chief Medical Director	X	X	
	Simeon Kwan, DO, Associate Regional Medical Officer, Aspire		X	
Centene	Lokesh Popli, MD, MBA, CHCQM, Medical Director	X		
	Usha Sankrithi, MD, MPH, Senior Medical Director, Coordinated Care of WA	X		
Chaplaincy Health Care	Zoe Diaz, Director of Standards and Compliance			X
CommonSpirit Health	David Brunelle, MD, Pediatric Hospice Care Physician			X
Community Health Plan of Washington	LuAnn Lawton Chen, MD, MHA, FAAFP, Senior Medical Director	X	X	
	Shanna Widener, RN, MBA, Senior Director, Care Management		X	
	Terry Lee, MD, Senior Behavioral Health Medical Director	X		
EvergreenHealth	Hope Wechkin, MD, Medical Director, Hospice and Palliative Care	X		X

Organization	Participant	Individual & Team Interviews	Medicaid & ERB Plan Interviews	Listening Session
	Kathy Katzenberger, DNP, Hospice Manager			X
Family Home Care and Hospice (MN)	Donna Goodwin, MN, Former Chief Clinical Officer	X		
Heartlinks Hospice and Palliative Care	Shelby Moore, MPA, CFRE, Executive Director			X
Home Care Association of Washington	Donna Goodwin, MN, Clinical Director	X		
Horizon Hospice and Palliative Care	Marsha Flowers, RN, Palliative Care Manager			X
Humana	Richard Smith, MD, Regional VP of Health Services	X		
Jefferson Healthcare, Hospice Foundation	Deborah Kaldahl, Home Health and Hospice Practice Manager			X
King County, Central Employee Services	Michele Ritala, MPA, Benefits Plan Manager	X		X
Molina Healthcare of Washington	Collin Elane, RN, Vice President, Healthcare Services		X	
	Frances Gough, MD, Chief Medical Officer	X	X	
	Jenna Strully, MD, MBA, Sr. Medical Director, Clinical Policy & Services	X	X	
	Krista Edmundson, Manager, Government Contracts		X	
	Laurie McCraney, RN, MBA, Director, Healthcare Services, Utilization Management (Inpatient Review & Behavioral Health)		X	
	Sasha Waring, MD, Senior Behavioral Health Medical Director	X		
Office of Rural Health, Washington DOH	Pat Justis, MA, Executive Director	X		X
Okanogan Palliative Care Team	Raleigh Bowden, MD, Director	X		X
PeaceHealth	Brandi Clisby, Medical Assistant and Referral Coordinator			X
	Debbie Slyter, RN, Assistant Nurse Manager	X		X

Organization	Participant	Individual & Team Interviews	Medicaid & ERB Plan Interviews	Listening Session
	Karlyn Stankye, Quality Facilitator			X
	Katie Smoucha, RN, Palliative Care RN			X
Premera Blue Cross	Christine Reynoso, MD, MMM, FACP, SFHM, Medical Director of Utilization Management and Medical Policy		X	
	Josephine Young, MD, MPH, MBA, Medical Director, Commercial Markets	X		
	Kathy Peters, BSHS, RN, CCM, Senior Manager of Clinical Programs and Case Management		X	
Providence	Gregg Vandekieft, MD, MA, Palliative Care Physician			X
Regence	Audrey Joyce, RN, BSN, CCM, UMP Clinical Program Manager		X	
	Dan Meltzer, MD, MPH, FACEP, Executive Medical Director (Idaho)		X	
	Darcie Teats, RN, BSN, Clinical Transformation Advisor/Palliative Care		X	
	Jenifer Curry, Program Director, Provider Clinical Transformation		X	
	Jim Polo, MD, MBA, CPE, FACHE, Executive Medical Director (Washington)		X	
	Julie Lindberg, LMSW, Vice President of Clinical Services	X		

Organization	Participant	Individual & Team Interviews	Medicaid & ERB Plan Interviews	Listening Session
	Lori Fleming, Director, HCA Strategic Account		X	
	Nicole Saint Clair, MD, FACOG, Executive Medical Director	X		
Seattle Children's Hospital	Anne Anderson, RN, CHPPN, Nurse Coordinator, Palliative Care Program			X
United Healthcare Community Plan	Linda Keenan, PhD, MPA, BSN, RN-BC, NMCC, Chief Nursing Officer		X	
	Marci Brand, RN, CCM, Associate Director of Medical Clinical Operations		X	
	Petra Eichelsdoerfer, ND, MS, Pharmacist Account Manager	X		
University of Washington Medical Center	Erin Kross, MD, Director, Cambia Palliative Care Center of Excellence			X
	Jim Fausto, MD, Assoc. Chief, Palliative Care	X		X
Washington DSHS	Kelli Emans, Integration Manager, Health Homes	X		
Washington Hospice & Palliative Care Organization	Barbara Hansen, MA, RN, Executive Director	X		X
	Leslie Emerick, MPA, Public Policy Director	X		X
Western Washington University	Marie Eaton, Ph.D., Director, Palliative Care Institute			X
Affiliation Not Identified	Sarah Wilson			X
Washington Health Care Authority	Christopher Chen, MD, MBA, Medical Director, Clinical Quality and Care Transformation	X		X
	Cynde Rivers, RN, MN, CEN, Occupational Nurse Consultant, Clinical Quality and Care Transformation	X		X

Organization	Participant	Individual & Team Interviews	Medicaid & ERB Plan Interviews	Listening Session
	Jamie Teuteberg, MS, Health and Aging Policy Fellow and Life Stages Manager	X		
	John Partin, Manager, Benefit Strategy & Design Section, ERB Division			X
	Josh Morse, MPH, Health Services Section Manager & HTA Program Director, Clinical Quality and Care Transformation	X		X
	Karla Cowan, MSN, RN, Occupational Nurse Consultant, CQCT, ERB & Quality Management Team			X
	Nicole Bishop, Health Home Contract Manager, HCA	X		
	Pedro Garcia, MPA, UMP Contract Analyst, ERB Division			X
	Shawna Lang, MHA, Section Manager, PEB Portfolio, ERB Division			X
	Sophie Miller, MD, MPH, Medical Officer, CQCT			X
	Thao Nguyen, Medical Assistance Program Specialist, MPD			X
	Tonja Nichols, RN, CQCT, Medical-Dental Services			X

## Appendix B: Palliative Care Opportunity Analysis

### Introduction

The purpose of this analysis is to summarize key opportunities to improve access and quality of palliative care service delivery as identified through research and stakeholder engagement to-date. The analysis was completed at the outset of the project and was used to guide development of recommendations included in the main body of this report.

### Opportunity Analysis Framework

The palliative care opportunity analysis evaluates 4 domains that are critical for ensuring patients that could benefit from palliative care services can access them if they so choose. These domains include the following:

- Services
- Eligibility
- Providers (Care Team)
- Payment Mechanisms

The analysis provides a summary of relevant context and specific opportunities identified by stakeholders, the Bree Collaborative report, state billing manuals and benefit descriptions, and additional research. Billing guides and fee schedules were used a proxy for covered benefits as plan-specific implementations may vary.

### Services

The efficacy of a palliative care benefit is contingent on having an appropriate suite of available services and having clear and transparent coverage standards for the services. Potential opportunities were identified for both aspects of benefit coverage.

### Transparent Coverage Standards

Multiple stakeholders indicated that lack of clarity around what services are covered for palliative care is a barrier for both provision and referral to services; however, this is limited to the adult palliative care benefit. The children's palliative care benefit is clearly defined in the Medicaid program's Hospice Billing Guide and ERB reimburses pediatric palliative care via FFS.<sup>6</sup>

Opportunity: Similar to the children's benefit, the adult benefit should be clearly articulated in billing guidelines. Additionally, there is potential benefit in doing so separately from the hospice billing manual given the stigma associated hospice.

### Covered Services

The Bree Collaborative Palliative Care Report<sup>4</sup>, issued in 2019, defined a set of palliative care services informed by the National Consensus Project for Quality Palliative Care<sup>2</sup>. The services include the following:

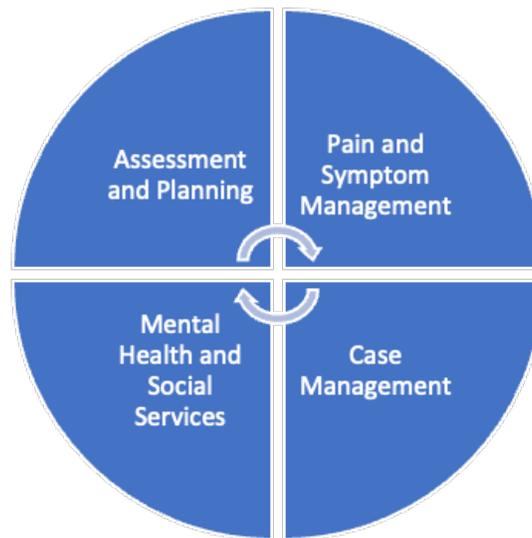
- Initial assessment
- Goals of care conversation(s)
- Advance care planning
- Assessment of cognitive impairment
- Assessment and management of functional needs
- Assessment and management of symptoms/medical care
- Pharmacy management

- Caregiver support, if needed
- Assessment and management of behavioral health/psychosocial needs related to serious illness
- Spiritual care needs
- Ongoing management

### Categories of Service

For the purposes of the opportunity analysis, the services above were categorized for analysis according to the four categories shown in Figure 1 below.

Figure 1: Palliative Care Categories of Service



### Assessment and Planning Findings

The scope of services that fall under Assessment and Planning are generally compensable under the Medicaid program and are likely compensable under the public employee benefit plans via standard Evaluation & Management codes used by qualified health professionals. While stakeholders did not generally indicate challenges with service coverage for assessment and planning services, they did emphasize the need for members of the interdisciplinary care team to be able to bill for assessment and planning activities.

Examples of Medicaid compensable codes that are likely used for palliative care assessment include the following:

- Advance care planning: 99497, 99498
- Plan of care/Palliative care assessment and consultation inpatient: 99251-99255
- Plan of care/Palliative care assessment and consultation outpatient: 99341-99350

Opportunity: Because not all members of the interdisciplinary care team can bill Evaluation & Management codes, this is a potential opportunity that could be addressed via an alternative payment methodology.

### *Pain and Symptom Management Findings*

Pharmacy, durable medical equipment, and other clinical services associated with pain and symptom management are generally compensable under both programs as they are included in standard benefit packages. Stakeholders noted no challenges in accessing pharmacy and DME but did strongly emphasize the need to be able to provide some services via telehealth and the need to have a 24/7 call line. Additionally, stakeholders noted that it can be difficult for registered nurses to provide services in home unless the patient is already receiving home health services.

Due to the pandemic, telehealth is more broadly compensable than it has been in the past. Numerous compensable telehealth codes could be used to support palliative care services when rendered by a qualifying provider.<sup>17</sup>

Opportunity: For the palliative care benefit to be effective, registered nurses need to be able to be compensated for services provided in the home setting even when a patient is not authorized for home health benefits.

### *Mental Health and Social Services Findings*

Behavioral health services such as psychotherapy are available as part of the standard benefit package for both programs. Social services were recently added to the home health benefit in the Medicaid program. It is unclear if social services are covered under the public employee benefit program. No indication of coverage of spiritual services was found for either program.

Opportunity: Social and spiritual services need to be available as part of an evidence-based palliative care benefit, even for patients that are not receiving home health services. These services should be included as discrete compensable services where possible or addressed in an alternative payment methodology.

### *Case Management Findings*

Case management services provided by a registered nurse are fundamental to a palliative care benefit. While the Medicaid program does have compensable codes for RN case management, it is unclear when/how these codes can be used. Additionally, the care coordination aspect of the palliative care is potentially duplicative with other efforts that exist in the managed care program, or as part of other specialized programs a member may participate in.

Opportunity: Additional research (described in later sections) is required to determine if a benefit coverage gap exists related to case management.

Opportunity: The state has actively worked to catalog care coordination programs/efforts and that work should be examined for intersections with any potential future palliative care payment model proposals.

### *Eligibility*

As noted in early sections, the children's palliative care benefit is clearly defined in the Medicaid program, including the eligibility criteria. For adults, there is no standardized definition for eligibility. Anecdotally, stakeholders indicated that one ERB plan authorizes adult palliative care benefits based on physician referral. Options for eligibility criteria were discussed in depth in the Bree Collaborative report and include elements of disease burden and functional status. Other states have included social needs as part of the eligibility criteria, too.

Opportunity: Clearly defining eligibility standards for adults should be a top priority for improving the palliative care benefit.

### *Providers*

Stakeholders were clear that workforce limitations are an active barrier to access for palliative care services. There are a number of contributing factors, but some anecdotes were provided suggesting that the lack of ability for some members of the interdisciplinary team to be compensated and general low compensation are contributing factors. One stakeholder described palliative care reimbursement as covering approximately 30% of the costs of providing palliative care services in a hospital setting. In this example, the palliative care team continued to be utilized because palliative care services were driving down overall costs enough to offset the loss incurred by the palliative care team.

Absent data analysis of service need based on clear eligibility criteria and a source of information on the palliative care workforce, it is difficult to ascertain the magnitude of the gap between existing provider resources and needed resources under a well-functioning palliative care benefit. The pandemic's impact on the health care workforce cannot be understated. Even with higher levels of reimbursement and greater financial flexibility, it may be a longer-term opportunity to increase workforce capacity in this area.

Opportunity: The Center does not plan to provide recommendations related to level of reimbursement but does anticipate that modifications to the payment mechanisms can ensure that services rendered by the interdisciplinary team are compensable.

### *Payment Mechanism*

While needing to be validated with plans, palliative care is likely compensated via fee-for-service. The primary consequence of this payment mechanism is that members of the interdisciplinary team may not be able to receive compensation for the services rendered and providers have less financial flexibility/stability. Coupled with the other challenges noted in prior sections that impact compensation, this is likely having a negative impact on access to palliative care services.

Opportunity: The Center will be proposing payment methodologies that offer financial flexibility and ensure services provided by the interdisciplinary team are compensable.

### *Summary and Next Steps*

Multiple opportunities exist to improve access to palliative care services for those in need. The most critical elements to address are to clearly define the benefits and eligibility standards for adults and to offer payment methodologies that ensure palliative care can be provided in the home setting, using telehealth when appropriate, and provided by an interdisciplinary team.

The Center will be providing recommendations for eligibility standards and payment models that address the opportunities identified. To ensure solutions are robust, the Center recommends additional interviews with the health plans and benefit administrators for the programs prior to proposing options for payment models.

## Appendix C: Review of Selected Reimbursement Models

This review focuses on best practices for palliative care and notable reimbursement models currently used or under development by California, Hawaii, and Medicare. The Center’s research includes a review of existing Center MED reports addressing palliative and hospice care, and a limited review of literature on palliative care models and reimbursement, including the 2019 Bree Collaborative recommendations for palliative care.

### Key Questions

1. What best practices are currently being used by Medicaid agencies and/or ERB plans to provide and/or reimburse the costs of providing palliative care services?
2. What specific palliative care reimbursement models are currently in use? Are there examples of reimbursement models that incorporate such elements as per member per month payments (PMPM), bundled payments, and fee-for-service (FFS) components?
3. What practices and reimbursement models are currently being used or developed by California, Hawaii, and Medicare?
4. Are there any MED reports in the Center’s Clearinghouse that address the provision of palliative care services and associated reimbursement models? If so, please provide references and a summary of findings.
5. Are there any notable palliative care and reimbursement models found in a brief review of published literature? If so, please provide references and a summary of findings for each model, including a summary of the 2019 recommendations published by the Bree Collaborative.

### Methods

The Center conducted Internet-based research to compile findings in response to the key questions raised by this report. Where necessary, the Center sought out and collected information from direct sources. The Center also conducted a search of MED Clearinghouse reports on palliative and hospice care.

In addition to the “document review” that comprises the substance of this report, the Center is in the process of conducting interviews of content experts within HCA and at partnering organizations and associations. Findings from those interviews can be found in Appendix I: Stakeholder Contributions.

### Key Findings

The Internet search produced an abundance of organizations, information, and resources to guide the development of palliative care policies and service delivery strategies. The following 3 organizations are particularly noteworthy given the extent to which they informed the development of palliative care policies and practices by public health care agencies and insurers. Taken together, they represent foundational cornerstones for the development, implementation, promotion and adoption of national policies and practices for quality palliative care.

- National Coalition for Hospice and Palliative Care (NCHPC)
- National Quality Forum (NQF)

- National Academy for State Health Policy (NASHP)

The following findings are largely derived from the work of these 3 organizations, along with observations of efforts underway by the states of California and Hawaii, federal rules set forth for Medicare, and guidance from the Bree Collaborative. A search of the MED clearinghouse did not produce any relevant reports or studies regarding palliative care reimbursement methods or models.

### National Guidance on Quality Palliative Care

Two foundational works from 2004 and 2006 set forth a national consensus on best practices for providing quality palliative care:

- In 2004, NCHPC published Clinical Practice Guidelines for Quality Palliative Care<sup>18</sup>. The initial publication identified 8 domains and 39 detailed guidelines that comprised quality palliative care.
- Building from the NCHPC Guidelines, NQF published A National Framework and Preferred Practices for Palliative and Hospice Care Quality<sup>19</sup> in 2006. The Framework set forth 6 goals, 15 general principles, a framework consisting of 7 elements. The Framework led to the identification of 38 preferred practices aligned with NCHPC's 8 domains of palliative care, as well as the initial mapping of a system of quality measures.

In 2019, NASHP published Palliative Care: A Primer for State Policymakers<sup>20</sup>. The article aligns closely with the foundation works from NCHPC and NQF, provides insights into the development of model palliative care services, references notable reforms undertaken by states, and includes the following set of "key considerations":

- Review how palliative care is defined by state policies and programs. Develop standards and definitions within state licensing and regulation, paying particular attention to the following 5 structural elements identified by the National Quality Forum:
  - Target services to the highest risk group;
  - Include an interdisciplinary team of providers and social supports;
  - Provide 24/7 access to clinical care;
  - Integrate medical and social supports; and
  - Provide services alongside and independent from curative care.
- Measure the quality of palliative care services.
- Identify populations that can benefit most from palliative care services.
- Leverage continuing medical education requirements to build workforce capacity and increase access.
- Articulate policies and payment to support palliative care.
- Consider incorporating palliative care into public health and public education strategies.

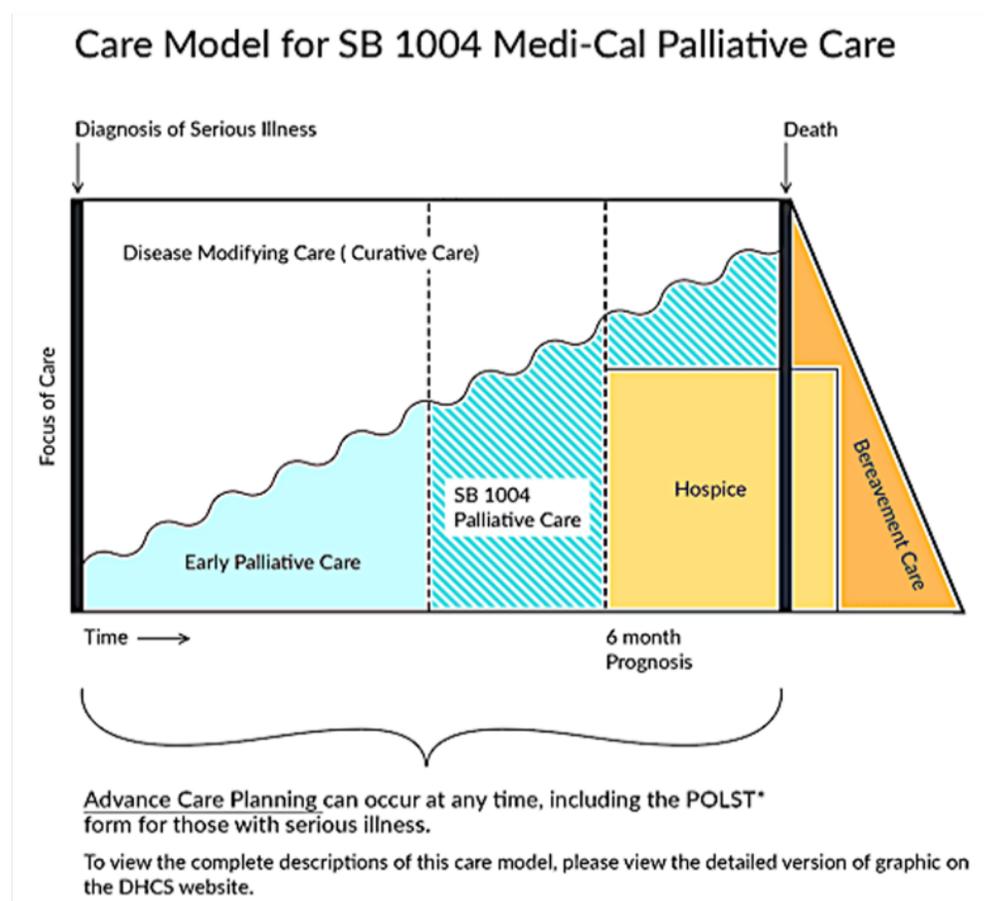
## California

On January 1, 2018, California's Department of Health Care Services (DHCS) began implementing SB 1004, a state initiative to 'establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.'<sup>21</sup>

The legislation places significant responsibilities on managed care plans (MCPs) to increase availability, access, and use of palliative care services as defined by DHCS, and devise payment models to entice participation by palliative care service providers. DHCS, working with a network of community and professional organizations, has developed an extensive inventory of online training and technical assistance materials to help MCPs and providers.<sup>4</sup>

The California model (Figure 1) identifies two phases of palliative care beginning with the onset of serious illness and continuing until transition to hospice care or death. The first phase, called Early Palliative Care, appears to consist of low-level and voluntary services that are not covered by Medi-Cal managed care plans. The second phase, beginning within 1 year of the expected end of life, consists of a minimum of 7 required services, dedicated and trained care teams, and patient eligibility limited to a specific set of life-threatening diseases and medical conditions.

Figure 1



The 7 services include:

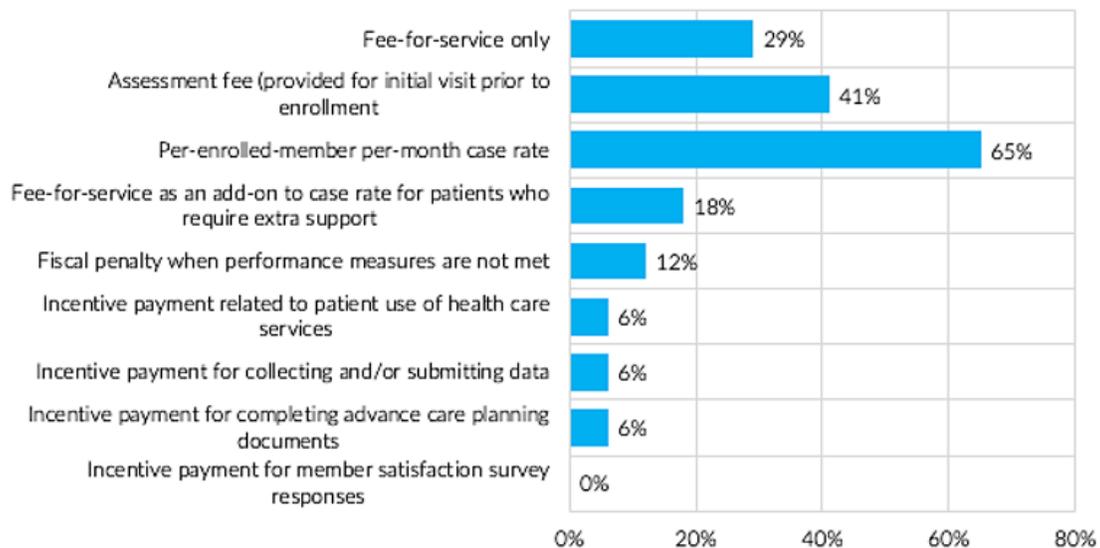
- Advance Care Planning
- Assessment
- Plan of Care
- Palliative Care Team
- Care Coordination
- Pain and Symptom Management
- Mental Health and Medical Social Services

At this time, California has not increased its capitated rates for Medicaid reimbursements to support heightened levels of palliative services, or to carve out a separate bundled payment for palliative care. MCPs are expected to work within existing capitated rates to pay for palliative services and negotiate contracts with providers using a variety of reimbursement models.

As a result, California MCPs have employed a diverse mix of reimbursement models as is illustrated by the results of a March 2021 survey (Figure 2) conducted by California Health Care Foundation. The findings reflect the types of payment models used in contracts involving 19 MCPs and 31 palliative care providers.

Figure 2

Payment Models Employed in MCP Contracts with Palliative Care Providers<sup>22</sup>



## Hawaii

Health care organizations and advocates in Hawaii have been actively promoting palliative care since the 1980s.<sup>23</sup> The high level of policy development, currently underway, has been built on 20 years of public, private and community actions. The Med-QUEST Division (MQD) of the Hawaii Department of Health Services submitted to CMS a State Plan Amendment (SPA<sup>24</sup>) to provide palliative care services in non-hospital settings. The SPA sets forth the following service components:

- The target group includes individuals with serious illnesses. A serious illness is defined as a health condition that carries a high risk of mortality and negatively impacts daily functioning, or quality of life, or excessively strains caregivers. Palliative care is based on the needs of the patient, not on the patient’s prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.
- The community palliative care benefit includes, but is not limited to, the following services:
  1. Care plan development and implementation that is aligned with patient and family goals;
  2. Clinical services provided through an interdisciplinary team;
  3. Comprehensive management; and
  4. Care coordination and communication.
- The reimbursement methodology is based on per member per month case rate(s) and is established by the State. The case rate(s) and billing codes are included in the FFS schedule. Other services may be covered that are billed separately from the case rate(s) such as initial assessments and reassessments.
- Palliative care is provided by healthcare providers that are legally authorized to deliver healthcare services by the State of Hawaii. In addition to the State of Hawaii requirements, the Medicaid agency will establish additional credentials and/or criteria for healthcare providers to provide community palliative care services.

At a palliative care virtual summit in June 2021, MQD presented rolled out the following policy elements that would eventually find their way into the SPA.<sup>11</sup>

- Eligibility is based on three required criteria, including (1) diagnosis of serious illness, (2) decline in physical condition or cognition, or the lack of social support, and (3) evidence of social risk or other factors.
- Required services fall under three basic categories: (1) assessment and planning, (2) clinical services, and (3) care coordination and communication.
- MQD will require data reporting on process and quality measures, including patient satisfaction, clinical quality, and utilization.

### Medicare

Medicare addresses end-of-life care strictly through a hospice benefit that is limited to patients that have a life expectancy of six months or less, and have waived all access to curative or disease modifying care. While Medicare does not provide a separate benefit for palliative services, CMS recognizes a role for such care within hospice, as described in the CMS Medicare Hospice Benefit publication:

“Palliative care is the part of hospice care that focuses on helping people who are terminally ill and their families maintain their quality of life. If you’re terminally ill, palliative care can address your physical, intellectual, emotional, social, and spiritual needs.

Palliative care supports your independence, access to information, and ability to make choices about your health care.”<sup>25</sup>

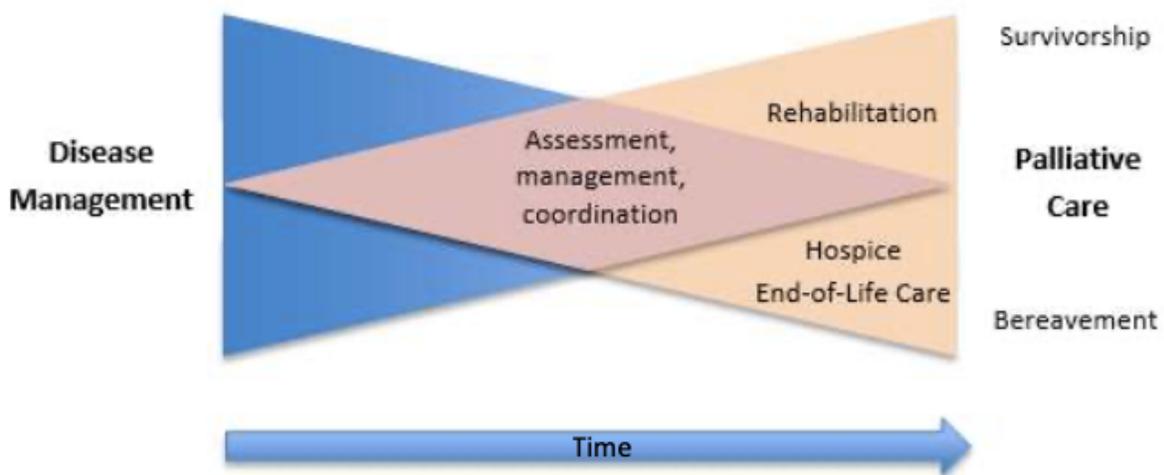
While CMS recognizes a role for palliative care within hospice, providers of these services are limited to reimbursements through Medicare fee-for-service billing codes, and it doesn't appear that CMS provides reimbursements for interdisciplinary care teams through a capitated fee. Medicare coverage for palliative services depends on the patient's insurance plan (Part A, Part B, Medicare Advantage), and the care setting (in or out of hospice). Coverage while in hospice is paid through a two-tiered capitated rate, while coverage outside of hospice is paid through dedicated fees for service and billing codes.

### Bree Collaborative

In 2014, Washington's Bree Collaborative published its End-of-Life Care Report and Recommendations. In 2019, the Collaborative complemented the 2014 report with Palliative Care, a comprehensive report with a complete set of recommendations. Taken together, the reports document the evolving national consensus about patient-focused, community-based palliative care, and provide valuable references to end-of-life and palliative care resources to inform HCA's current policy initiative.

The Collaborative borrowed from the National Consensus Project for Quality Palliative Care for the following definition of palliative care, and adapted the bow-tie figure from Pippa Hawley to describe a model for locating palliative care in the life trajectory of patients:

“Palliative care focuses on expert assessment and management of...symptoms, assessment and support of caregiver needs, and coordination of care [attending] to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness.” Hawley P. The bow tie model of 21st century palliative care. *J Pain Symptom Manage*. 2014;47:e2-e5.



With the broad definition and model in mind, the Collaborative's palliative care workgroup identified a set of focus areas to build common understanding and support for future initiatives:

- “Defining palliative care using the standard definition developed by the National Consensus Project including appropriateness of primary and specialty palliative care.
- Spreading awareness of palliative care.
- Clinical best practice provision of palliative that is:
  - Responsive to local cultural needs,
  - Includes advance care planning as outlined in the 2014 Bree Collaborative End-of-Life Care Report and Recommendations including appropriateness of an advance directive and Physician Orders for Life-Sustaining Treatment (POLST) or similar suitable document, and
  - Incorporates goals of care conversations into the medical record and plan of care.
- Availability of palliative care through revision of benefit structure such as a per participant per month (PPPM) benefit.”

The Collaborative’s recommendations from 2019 are aligned closely but not completely with guidance from the National Consensus Project, and the models developed by California and Hawaii:

- Eligibility is based on three required criteria, including (1) clinical diagnosis of serious illness, (2) functional measures, and (3) health care utilization.
- Required services include multiple levels of assessment, goal-setting and advance care planning, care management, pharmacy management, spiritual care, and caregiver support. The goals, requirements, and methods of providing palliative care change as the needs of patients transition from primary and specialty care settings.
- Reimbursement models increase access to high-quality palliative care through incremental changes within the existing fee-for-service infrastructure or through new value-based models of reimbursement, or combinations of both.
- Embed palliative care within the basic delivery of primary care and build interdisciplinary teams when palliative care moves from primary to specialty care settings. Provide specialized palliative care education and training at all levels of care delivery.

### Policy Review Conclusions

A shared set of principles from NCHPC’s Clinical Practice Guidelines for Quality Palliative Care have informed and influenced the policy and program development work in California, Hawaii and by the Bree Collaborative. These principles look for palliative care policies to be driven by a focus on the patient and family, for care to be delivered by an interdisciplinary team of trained and qualified providers and community support partners, and for services to be provided wherever the patient is located (hospital, nursing facility, assisted living, patient’s home, etc.). In addition, palliative care services are to be coordinated with disease-modifying or curative care. Some palliative care services may be provided without reimbursement at the onset of serious or chronic illness. Reimbursed palliative care often begins when life expectancy is at 12 months, and transitions to hospice when life expectancy is 6 months or less.

The following conclusions derive from an initial survey of studies, reports, articles, guides, toolkits, and other online materials from NCHPC, NQF, NASHP, the states of California and Hawaii, CMS, and the Bree Collaborative.

- Insurers are wrestling with placing palliative care into a comprehensive continuum of health care services, somewhere between primary care, specialty care and hospice. Each of the three general categories of care incorporate aspects of palliative care.
- Without clearly defined and integrated service delivery models across the health care continuum, insurers have been hesitant to build payment models specifically targeting palliative care services.
- None of the palliative care models reviewed (CA, HI, Medicare, Bree) carve out bundled reimbursements to managed care organizations for palliative care. Instead, they propose payment models for MCOs to build into contracts with service providers, within existing Medicaid capitated payments. Medicare expects some palliative services to fall within their bundled reimbursement structure, supplemented by FFS for some services.
- The design of new Medicaid managed care reimbursement models appear to incorporate some or all of the following elements:
  - States set the standards, qualifications and regulations that define palliative care and inform the development of detailed service delivery agreements between payers (MCOs) and palliative care providers.
  - Reimbursement design is dependent on data-driven analysis and modeling of demand for palliative care services, duration of care, costs of care, and avoidance of high-cost care.
  - Initial assessments are reimbursed with one-time fee-for-service, while reassessments are built into defined capitated reimbursements.
  - Sustainable reimbursement design places a premium on minimum enrollment periods once patients qualify for care.
  - A well-defined bundle of palliative services are reimbursed through a capitated payment or case rate paid per patient per month.
  - Reimbursement design may incorporate performance-based bonuses, incentives, and penalties to ensure quality.

## Appendix D: Review of Alternative Payment Model Options

The following section contains additional detail from the review of alternative payment model options.

### Fee-for-service with Incentives

A fee-for-service model with quality incentives is a volume-driven model with financial incentives tied to specific outcomes. Most commonly, performance is monitored over the course of a year, performance is evaluated retrospectively, and financial incentives are applied based on the outcome of the analysis. Financial incentives could either be penalties such as a recoupment (or not earning back a withhold), or there could be additional reimbursement as incentive payments.

#### Potential strengths

- If modifications to fee-for-service are applied as recommended by the Bree Collaborative, some reimbursement gaps could be closed.
- The model reinforces a focus on outcomes.

#### Potential weaknesses

- Gaps in compensability would remain for members of the interdisciplinary team that provide services not coverable by Medicaid or ERB (e.g., chaplaincy)
- While the AAHPM did recommend a suite of metrics that would be useful in monitoring the efficacy of the palliative care benefit (both from patient experience and clinical outcome perspective), operationalizing provider-level quality metrics is resource intensive.
- There is a significant delay between when services are rendered and when financial incentives are incurred due to the performance evaluation process. Providers would be more likely to treat the incentives as a 'nice to have' but not as a source of revenue to support their business model. Importantly, this means the incentives would not be viable for covering the cost of closing revenue gaps inherent in the fee-for-service model.

### Case Rate

Under a case rate model, the provider would receive a single payment to cover all palliative care services a patient needs over the full course of their engagement in services.

#### Potential strengths

- The model affords a high degree of financial flexibility and could be used to ensure all services provided by the interdisciplinary team are compensable.
- There would still be an option to introduce financial incentives for quality and outcomes.

#### Potential weaknesses

- Payment is not changing as the resource needs of the patient change. This can result in over/under payment to providers.
- There is a strong incentive to underserve patients.

## Population-level Capitation

Capitated models pay a fixed monthly amount for an entire population whether the patients use specific services or not. The expectation is that all patients that need services get them and the total funding paid for the population is sufficient to cover the costs of service utilizers.

### Potential strengths

- This model offers the greatest financial flexibility; service compensability for all team members could be addressed.

### Potential weaknesses

- Population-level capitated arrangements are not well suited for specialty care providers, even when the scope of services are limited to the services the specialty providers render. Both the payer and provider are taking on financial risk for differences in utilization assumed in the capitated rate and actual utilization. That is an unnecessary risk for palliative care providers.
- There is a strong perverse incentive to underserve patients with this model.

## Fixed Price Contracting

A fixed-price contract creates a budget under which the provider is expected to deliver a certain level or amount of services.

### Potential strengths

- Financial flexibility is provided to support the entire interdisciplinary team.
- Revenue is highly predictable for providers.

### Potential weaknesses

- The model is most effective when service demand is predictable.
- Both the payer and provider are taking on financial risk for differences in utilization assumed in the fixed contract and actual utilization. That is an unnecessary risk for palliative care providers.
- There is a strong perverse incentive to underserve patients with this model.

## Appendix E: Palliative Care Benefit Coding

HCA will need to collaborate with providers and payers to identify the most appropriate billing codes for both the FFS benefit and for the APM. As part of the gap analysis and the stakeholder interview process, specific codes were identified that could potentially be used to support the recommended palliative care benefit. To assist with the future billing standards development process, these codes and the respective relevant services within the palliative care benefit are shown in the table below. The code list will require further evaluation to determine if they can be used to support the benefit as designed. For example, some services are rendered by a registered nurse and not a physician under the interdisciplinary team model. This could limit which specific codes are allowable under standard coding guidelines.

Services	Codes
Advanced Care Planning	99497, 99498
Palliative Care Assessment and Consultation	99251-99255, 99341-99350, 99366, 99368
Plan of Care	99341-99350, 99251-99255
Care Coordination	99490, 99491
Transitional Care Management	99495, 99496
Chronic Care Management	99490, 99439, 99487, 99489, 99491
End of Life Counseling	S0257
Clinical Social Worker	G0155
Home Visit - Psychologist or Social Worker	99510
After Hours Call Line	99441, 99442, 99443, 98966, 98967, 98968
ADL Assistance/Personal Care	99509
Potential code for PPPM	G9987 (currently used by one payer for this purpose)
Physician Services	E&M code set
Other Licensed Professionals	PT, OT, ST, and RN - existing service code sets by service type
Other Symptom and Pain Management (not in benefit)	DME, Oxygen, and Pharmacy billed consistent with status quo
Other Behavioral Health (not in benefit)	Billed consistent with status quo behavioral health benefit

## Appendix F: Quality Measures

In exploring implementation of a standardized palliative care payment model with the Centers for Medicare and Medicaid Services, the AAHPM identifies a number of potential quality measures (shown in the table below). Additional detail and analysis of the measures can be found in the source documentation.<sup>26</sup>

PACSSI Measures	Measure Type
Patient or Caregiver Post-Admission Experience of Care Survey	Patient (or caregiver) reported measure
Post-Death Experience of Care Survey	Patient (family surrogate) reported measure
Hospice CAHPS Post-Death Experience of Care Survey	Patient (family surrogate) reported measure
Completion of a Comprehensive Assessment Soon After Admission	Process
Screening for Physical Symptoms Soon After Admission	Process
Documentation of a Discussion Regarding Emotional Need or Screening for Anxiety and Depression Soon After Admission	Process
Documentation of a Discussion Regarding Spiritual Concerns or Screening with "Do You Have Any Unmet Spiritual Needs?"	Process
Documentation of a Discussion about Advance Care Planning, Including Preferences for Surrogate Decision-maker(s) and Life-sustaining Treatments	Process
Completion of a Structured Assessment of Caregiver Needs and Distress	Process
Percentage of Patients Who Died Receiving Hospice Care	Outcome
Percentage of Patients Who Died and Were Admitted to Hospice for More than 7 days	Outcome
Percentage of Patients Who Died with No Days In ICU During the Last 30 Days of Life	Outcome

## Appendix G: Eligibility Criteria

Similar to the strategy for identifying an appropriate payment model, eligibility determination models were selected by identifying guiding principles, evaluating models against the principles (with input from HCA), recommending a model, and then providing additional detail on the core elements required to operationalize the model.

### Guiding Principles for Eligibility Criteria

When evaluating options for eligibility criteria, the Center considered the following guiding principles, which were informed by HCA and stakeholder feedback. These principles are closely aligned with existing policies set forth by the Health Care Authority for the provision of pediatric palliative care<sup>6</sup>.

- Policies and payment models are validated based on sound medical evidence and practice.
- End-of-life prognosis is not required for patient eligibility.
- Policies and models apply to adult patients aged 21 and older. Existing pediatric palliative care policies and payment models are not impacted or altered.
- Palliative care is available to patients with complex medical needs that require care management across multiple health conditions, and coordination of medical services.
- Palliative care is available to patients with medical conditions that exceed the abilities and capacities of family members and caregivers to assist and support the patient.
- Palliative care is available to patients with medical crises; life-limiting medical conditions impacting cognitive, social and physical functioning; and therapeutic goals focused on quality-of-life, comfort and family stability.
- Eligibility is reassessed at least every 6 months, and preferably on a quarterly basis.

### Recommended Eligibility Model

#### General PACSSI Criteria

The recommended eligibility criteria are based on the industry-endorsed PACSSI model consisting of three components – diagnosis, functional status and health care utilization.



The following conditions are considered for determining eligibility:

- The patient must have at least one serious illness or a combination three chronic conditions selected from specific lists of qualifying illnesses and conditions.
- The function status of the patient must indicate significant functional limitations and the need for assistance with one or more activities of daily living that may also include reliance on durable medical equipment.
- The patient has a recent history of unscheduled health care utilization.

#### *Diagnosis of Serious Illness and/or Chronic Conditions*

The PACSSI recommendations include the following list of serious illnesses and chronic conditions. Additional specifications may be required to provide clear guidance for determining eligibility.

#### *Serious Illnesses*

- Metastatic Cancer - Pancreatic, Gastrointestinal, Lung, Brain, or Hematologic cancers
- Heart Failure with Class III or IV level function under the New York Heart Association Functional Classification
- Heart Failure with a Left Ventricular Assist Device
- Advanced Pulmonary Disease (Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis)
- Advanced Dementia with stage 6 or 7 using the Functional Assessment Staging Tool or  $\geq 2$  ADLs
- Progressive Neurologic Disorder (e.g., Cerebrovascular Accident Parkinson's Disease, Amyotrophic Lateral Sclerosis, Progressive Supranuclear Palsy)
- Hepatic Failure (Cirrhosis)
- End Stage (V) Renal Disease (excluding patients on dialysis)
- Protein-Calorie Malnutrition
- Cachexia
- Hip Fracture (with functional decline)

#### *Chronic Condition Categories (Dartmouth Atlas of Health Care<sup>27</sup>)*

- Malignant Cancer, Leukemia
- Chronic Pulmonary Disease
- Coronary Artery Disease
- Congestive Heart Failure
- Peripheral Vascular Disease
- Severe Chronic Liver Disease
- Diabetes W/End Organ Damage
- Renal Failure
- Dementia

*Functional Status (Activities of daily living or Durable Medicaid Equipment Needs)*

The minimum qualifying functional status differs depending on whether the patient has cancer or not. For individuals without cancer, the minimum eligibility standard is a Palliative Performance Scale (PPS) rating of less than or equal to 60%, one or more Activity of Daily Living (ADL) support need, or an existing order for Durable Medical Equipment (DME). For individuals with cancer, the minimum eligibility standard is a PPS of 70% or less, or an ECOG of greater or equal to two, or one or more ADL support need, or a DME order.

*Palliative Performance Scale (PPS)*

The Palliative Performance Scale is a functional assessment for palliative care recipients that looks at level of ambulation, activity level evidence of disease, self-care, intake, and level of consciousness.<sup>28</sup>

Score	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal / No Disease	Full	Normal	Full
90	Full	Normal / Some Disease	Full	Normal	Full
80	Full	Normal with Effort Some Disease	Full	Normal or Reduced	Full
70	Reduced	Can't do normal job or work / Some Disease	Full	As above	Full
60	Reduced	Can't do hobbies or housework / Significant Disease	Occasional Assistance Needed	As above	Full or Confusion
50	Mainly sit/lie	Can't do any work / Extensive Disease	Considerable Assistance Needed	As above	Full or Confusion
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion
30	Bed Bound	As above	Total Care	Reduced	As above
20	Bed Bound	As above	As above	Minimal	As above
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma
0	Death	-	-	-	--

*Eastern Cooperative Oncology Group (ECOG) Performance Status Scale (ECOG)*

The ECOG Performance Status Scale was specifically developed “to classify a patient according to their functional impairment, compare the effectiveness of therapies, and assess the prognosis of a patient.”<sup>29</sup> The PACSSI model applies the 5-point ECOG scale to cancer patients. The scale consists of the following levels:

- [0] Fully active, able to carry on all pre-disease performance without restriction
- [1] Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
- [2] Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
- [3] Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
- [4] Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.

### *Health Care Utilization*

The PACSSI model considers health care utilization within 12-months preceding assessment, and allows for the waiving of this standard under a specified set of circumstances. The model includes the following separate criteria for each of two tiers of eligibility:

- Tier 1 Moderate Complexity - One significant health care utilization in the past 12 months, which may include an ED visit, observation stay, or inpatient hospitalization.
- Tier 2 – High Complexity - Inpatient hospitalization in the past 12 months, and one of the following: an ED visit, observation stay, or second hospitalization.

### *Additional Considerations*

#### *Frequency of Reassessment*

The PACSSI model includes reevaluation for continued eligibility every 6 months. Note that assessment for changes in functional status are recommended by the Center to be no less frequent than quarterly. Policy would need to be developed to determine if results from more frequent assessment could trigger eligibility loss or if it would only trigger a change in payment tiers and the patient remains eligible for the remainder of the 6-month period.

#### *Eligibility for Rare Diseases*

It is anticipated that many individuals with rare diseases will qualify for palliative care by meeting the serious illness or chronic condition eligibility criteria. It is also recommended that HCA employ an appeals process to make coverage decisions for those with rare diseases that might benefit from palliative care.

#### *Data Analysis to support Model Design*

The PACSSI model provides a structure for building a detailed eligibility policy that supports the Center's recommended hybrid payment model. However, as the Center has seen in the policies developed in California and under development in Hawaii, the detailed components of the PACSSI may be modified and refined to meet the specific state needs. Attachment E contains a listing of the PACSSI definitions of serious illness compared to listings from California and Hawaii.

In the interest of tailoring a national model to the unique requirements of Washington, HCA may consider conducting an analysis of health care utilization patterns to better understand the different populations and their service utilization needs before finalizing the eligibility criteria. Such an analysis will inform decisions on all aspects of eligibility policy including lists of qualifying

serious illnesses and chronic conditions, the severity of diagnosis of qualifying illnesses and conditions, the functional assessment tools to be used, and the levels of qualifying functional impairment, and the extent to which activities of daily living (ADLs) and dependence on durable medical equipment (DMEs) are to be considered.

## Appendix H: Comparative Review of Criteria for Defining Serious Illness

The following table provides a comparison of three sets of criteria for defining “serious illness” as a component for determining eligibility for palliative care services. The PACSSI criteria were proposed by the American Academy of Hospice and Palliative Medicine in 2017, serving as a national model for consideration by states. The California criteria were advanced through the passage of Senate Bill (SB) 1004 in 2014, and the promulgation of regulations by the California Department of Health Care Services in 2018. The Hawaii criteria was presented during a NASHP-hosted webinar in January 2023 by Judy Mohr Peterson, Hawaii Medical Director. Hawaii is preparing its criteria as a component of a State Plan Amendment to establish a Medicaid Palliative Care Benefit for the State of Hawaii.

Serious Illness	PACSSI (Proposal 2017)	California (Regulation - SB-1004, APL 18-020, 2018)	Hawaii (Proposal 2023)
Cancer	Metastatic - Pancreatic, Gastrointestinal, Lung, Brain, or Hematologic cancers	Advanced Cancer: Must meet (a) or (b). (a) The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and (b) The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).	Advanced Cancer (Stage 3 or 4, locally advanced or metastatic cancer; leukemia or lymphoma)

Serious Illness	PACSSI (Proposal 2017)	California (Regulation - SB-1004, APL 18-020, 2018)	Hawaii (Proposal 2023)
Heart Failure	Class III or IV level function under the New York Heart Association (NYHA) Functional Classification, or with a Left Ventricular Assist Device (LVAD)	Congestive Heart Failure (CHF): Must meet (a) and (b). (a) The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and (b) The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.	Congestive Heart Failure (Patient meets New York Heart Association (NYHA) Class III or IV criteria
Pulmonary Disease	Advanced - Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis	Chronic Obstructive Pulmonary Disease: Must meet (a) or (b). (a) The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or (b) The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.	Chronic Obstructive Pulmonary Disease (Diagnosis of COPD)

Serious Illness	PACSSI (Proposal 2017)	California (Regulation - SB-1004, APL 18-020, 2018)	Hawaii (Proposal 2023)
Dementia	Advanced with stage 6 or 7 using the Functional Assessment Staging Tool (FAST) or $\geq 2$ ADLs. (Dementia as the primary illness would be confined to the moderate complexity group, as the rate of decline is often slow, and functional limitations occur significantly earlier in the course of an illness.)	Not included	Alzheimer's Disease and other dementias
Neurologic Disorder	Progressive - e.g. Cerebrovascular Accident (CVA), Parkinson's Disease, Amyotrophic Lateral Sclerosis, Progressive Supranuclear Palsy	Not included	Neurologic Disorders such as motor neuron disease, Parkinson's Disease, Muscular Dystrophy, Multiple Sclerosis, or another progressive neurologic disorder

Serious Illness	PACSSI (Proposal 2017)	California (Regulation - SB-1004, APL 18-020, 2018)	Hawaii (Proposal 2023)
Liver Disease	Hepatic Failure (Cirrhosis)	Liver Disease: Must meet (a) and (b) combined or (c) alone. (a) The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and (b) The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or [alone] (c) The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.11	End-Stage Liver Disease or Cirrhosis
Renal Disease	End Stage (V) excluding patients on dialysis	Not included	Chronic Kidney Disease (Stage III or IV) or End-Stage Renal Disease (ESRD)
Protein-Calorie Malnutrition	No specifications	Not included	Not included
Cachexia	No specifications	Not included	Not included
Hip Fracture	With functional decline	Not included	Not included

## Appendix I: Stakeholder Contributions

The Center worked with HCA to identify stakeholders, both internal to and external of state government, whose input could help inform efforts to design a payment methodology for a palliative care benefit. Between November 1 and November 15, 2022, the Center team conducted interviews with 14 individuals, representing 8 stakeholder organizations and the Health Care Authority. Each individual was provided the following questions in advance of the stakeholder interview:

- As applicable for your organization, to what extent do you already include palliative services in your care or reimbursement model?
- How are patients referred to palliative care services?
- As applicable to your organization, how do you pay for palliative care or how are you reimbursed for palliative care?
- What quality metrics do you think would best capture high quality, effective palliative care?
- What are your pain points and opportunities for improvement with palliative care?

In addition, on October 14, 2022, the Center team participated in an HCA meeting with medical directors of managed care organizations and health plans that contract to cover the agency's Medicaid and employee and retiree benefits program. HCA provided the following questions prior to the medical directors' discussion and asked attendees to please review in advance of the meeting.

- Is your perception that most patients who would benefit from specialty palliative care services are receiving them? If not, what do you think the primary barriers are and have you taken any steps to address them?
- Do you have a pathway within care management to identify those who would benefit from palliative care services and connect them to that care? If so, describe. If not, are there other ways that you support these connections occurring? What are common issues/questions that come up with your care managers regarding palliative care (and hospice)?
- What currently works regarding how you pay for palliative care services? What are the challenging aspects? Do you utilize quality metrics directly related to palliative care?
- What are your pain points and opportunities for improvement with palliative care models? With specific emphasis on these domains: access, quality of care, eligible providers.

## Themes

The Center team summarized notes from the stakeholder interviews and discussed the resulting themes with the HCA team at meetings on October 24, November 9, and November 22, 2022. These themes are organized into following 5 areas - overarching findings, eligibility criteria, patient referral to palliative care services, outcomes measures and reimbursement.

## Overarching Findings

- Several stakeholders shared an explicit request that HCA define the two following core elements of palliative care reimbursement:
  - Eligibility criteria: what patients can receive the benefit?
  - The benefit: what services are covered?
- Stakeholders expressed general support for:
  - the California model but like the notion of divorcing eligibility from estimations of lifespan, such as California's use of 12 months of life expectancy
  - a description of the Hawaii model, specifically the model's accounting for social risk factors
- Stakeholders reported that there is limited capacity for palliative care due to both:
  - Low reimbursement and inability to cover costs for select members of palliative care team (nurse, social work, chaplain)
  - Limited workforce capacity that curtails access to palliative care services
- Even if reimbursement is clarified and/or increased, lack of palliative care workforce and capacity is a rate-limiter for utilization of palliative care services
- Both provider and health plan stakeholders expressed interest in alternative payment models for palliative care (case rate, bundled payment, etc.)
- A few stakeholders observed that hospitals might be reluctant to fully engage in outpatient palliative care as it destroys demand for hospital services
- Washington Rural Palliative Care Initiative is a well-established, well-functioning program, and any reimbursement recommendations should be supportive of it
  - The program's telehealth consult with rural teams is critical for provision of care

## Eligibility Criteria

- Several stakeholders noted that specific eligibility criteria are needed
  - Because there is limited capacity, eligibility criteria would support palliative care providers' efforts to prioritize those with greatest need
  - It is hard for palliative care teams when eligibility criteria fall in the gray zone, as this creates lack of clarity for implementation
- There was some discussion about eligibility for individuals with dementia
  - Strong need cited, but concerns about staging dementia and the duration of services (can be up to 5-10 years)
  - Palliative care could be differential at a certain point in disease progression

### *Patient Referral to Palliative Care Services*

- Established referral relationships are key as outreach by community palliative care providers helps facilitate primary and specialty care referral
- Communication initiatives can counter-act notion that palliative care is simply pre-hospice and reassure patients and providers that care will not be withdrawn
- Most managed care and health plans identify members that might benefit from palliative care and make referrals to their plans' care management resources
  - But patient's existing physician is viewed to be best, trusted source for palliative care referral
- [Washington Rural Health Palliative Care Screening Tool](#) includes a scoring threshold for eligibility that is determined by each provider organization
- Patients and families may not be willing or able to travel for palliative care services so telehealth may be important for rural settings

### *Outcome Measures*

- Stakeholders mentioned the following as possible outcome measures to consider:
  - Reduced ED and inpatient utilization
    - For example, utilization 6 months prior to and 6 months post-palliative care engagement
    - As institutionalized care might decrease, measurement of skilled nursing facility utilization might be worth considering
  - Patient satisfaction
    - Suggestion that patient's perception of communication should improve with engagement of palliative care
  - Portion of patients with advance care planning discussed and documented
  - Mixed feedback about using measures for:
    - A documented POLST
    - Patient's assessment of their own wellbeing

### *Reimbursement*

- Medicaid pediatric palliative care program is well defined in HCA's hospice billing guide, no mention of adult palliative care services
  - Medicaid physician billing guide does not provide guidance for palliative care billing
- Some hospitals are prioritizing inpatient palliative care over outpatient palliative care as it is easier to cover palliative care costs within DRG context

- For outpatient palliative care, informal estimate that 30% of costs are covered via professional service fees and hospital has to decide to offset remainder of costs
- Setting of care is important with a need to prioritize home-based services for those that are home-care eligible
- For King's County:
  - Regence will reimburse 30 palliative care visits per year when conducted by a licensed agency/facility for home health care
  - Primary care provider must file request for palliative care services attesting to severity of illness
- Palliative care programs currently can bill for physician, nurse practitioner and physician assistant in-person visits
  - But have difficulty covering the costs of others on the care team: nurse case management, social work, chaplain
- Okanogan program uses CPT 99215 for great majority of billing
  - Reimbursement is estimated to cover 50% program costs, remainder is offset by grants
- Interest in case rate or a PMPM payment to support case management services (nurse, social work, chaplain, etc.)
- Concern about patients stabilizing, becoming ineligible for palliative care, and then exacerbating
- ERB has a code for transitional care management (TCM), but Medicaid does not and this TCM code could be used to help encourage referrals for palliative care
- Ensure flexibility in reimbursement model for rural providers, with specific provisions to allow telehealth
- 24/7 support for palliative care needs to be defined with some latitude to allow an after-hours nurse call center/support line
- Services that should be covered in the palliative care benefit include:
  - Palliative care assessment including a home safety assessment with a suggested reassessment at 6 months
  - Nursing case management, social work, and spiritual care service
  - Advance directive planning (but do not require a POLST)
- Services that are already covered and do not need to be included in the defined benefit:
  - medication, durable medical equipment, and oxygen

- Outpatient and home care visits by physician, nurse practitioner and physician assistant

On March 13, 2023, the Center conducted a concluding listening session with stakeholders to review the Center's findings and recommendations and capture the following additional insights and considerations for the Health Care Authority.

### Services Included in Benefit

Didn't see chaplaincy in the proposed covered FFS list.

Cover pharmacist reviews for complex medication management

Clarification that RN case management services are included in FFS model. Is it a barrier that no HCPCS code for RN Case management services is available under Part B?

Community health worker reimbursement for navigation

It would be key that the palliative care benefit doesn't preclude mental health services being covered under their basic benefits

### Payment Models

A gap may exist between what is paid for under the FFS in comparison to what it takes to build a team to provide this care. And the FFS model would require "x amount of volume" of visitation to make this feasible.

Mixed preference between no per-visit fee and a relatively small per visit fee. 70% of participants preferred a relatively small per-visit fee.

### Permitted Setting of Care

Would this APM include palliative care delivered in both inpatient and outpatient settings?

For coverage of community-based palliative care, would like it to be inclusive of telemedicine, home, clinic and LTC?

Clarifying provider eligibility to provide and bill for services is essential. Pediatric palliative care only allows hospice providers to provide this care. Recommendation to allow anyone qualified to render the services without additional constraints.

### Patient Eligibility

Big fan of PACSSI, glad it's being highlighted!

Strongly disagree with diagnosis limits to 12 illnesses as it leaves out rare illness.

Dementia coverage is crucial. Patient may not be hospice or home health eligible.

### ERB - Pediatric Palliative Care

Concerned that pediatric patients will have less access to palliative care, as their benefit is only for Medicaid, and the PEBB/SEBB group is a big group that serves the pediatric population as well.

During the listening session, the Center polled participants on their support for major elements of the Center’s policy recommendations. The results of the polling were as follows

Response	Count
<b>Which option best captures your perspective of the FFS model design?</b>	
Some additional billable services are necessary for an effective adult palliative care benefit	12
A significant amount of changes would be required to achieve an effective adult palliative care benefit	2
The adult palliative care benefit defined under this FFS structure is adequate as presented	2
<b>Total</b>	<b>16</b>
<b>For the smaller per visit fee for services that fall under the PPPM, which best represents your perspective?</b>	
The per-visit fee should be relatively small with the majority of compensation coming through the PPPM.	7
There should be no per-visit fee. 100% of the payment should be through the PPPM.	4
<b>Total</b>	<b>11</b>
<b>On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support the proposed benefit and APM approach?</b>	
Scale Level 5	11
Scale Level 4	2
<b>Total</b>	<b>13</b>
<b>On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support the proposed eligibility approach?</b>	
Scale Level 5	5
Scale Level 4	2
Scale Level 3	1
<b>Total</b>	<b>8</b>

## Conclusion

The stakeholder interviews and listening session provided valuable, concrete input regarding services that could be included in a palliative care benefit, reimbursement methods, eligibility criteria, barriers to patient engagement with palliative care, and outcome measures that capture high quality palliative care services. Stakeholders generally expressed support for the model recommendations while offering additional suggestions and recommendations for the Health Care Authority to consider as it moves to refining and implementing a detailed reimbursement model for palliative care.

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## Suggested citation

Stuard S, Thompson N, Mofford S, Vizzini D. Washington Palliative Care Reimbursement Project Final Report. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University; 2023.

## Conflict of interest disclosure

No authors have conflicts of interest to disclose. All authors have completed and submitted the Oregon Health & Science University form for Disclosure of Potential Conflicts of Interest, and none were reported.

## Funding/support

This research was funded by a professional services contract between the Washington State Health Care Authority and the Center for Evidence-based Policy at Oregon Health & Science University.

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## Endnotes

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