

Designing and Implementing Community-Based Palliative Care

A Guide for Payers

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Designing and Implementing Community-Based Palliative Care: A Guide for Payers

Authors

Torrie Fields, MPH: Strategic Advisor, Coalition to Transform Advanced Care

Mollie Gurian, JD, MPH: Principal Investigator & Director, Hospice, Palliative, and Home Health Policy, LeadingAge

Amy Abdnor, JD: Co-Investigator & Health Care Manager, Complex Care, Arnold Ventures

Anna Kytonen, MPH

Acknowledgments



Contributors

Gary Bacher, JD, MBA: Co-Investigator & Chief Strategy and Legal Officer, Capital Caring Health

Helene Starks, PhD, MPH: Associate Professor, Bioethics and Humanities University of Washington

Anna Acosta, MSc, PhD(c): Organizational Development Consultant, University of Washington

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INTRODUCTION AND BACKGROUND

In 2010 and 2011, health insurance companies across the country began developing pilots for Palliative Care Services. Through these pilots, case managers realized that the patient population needs defined services rather than solely telephonic support and advance care planning. Implementing community-based palliative care (CBPC) became a priority. These community-based palliative care initiatives began strategically with the expectation and understanding that it would grow to be system-wide and within all product lines, or lines of business. To assist in initiating these programs in California, health plans and various provider partners utilized planning and implementation grants from the California Health Care Foundation to implement pilots in 2016. Later, the same health insurance companies, through system partnerships, piloted palliative care with a Accountable Care Organizations (ACO). These pilots enabled health plans and partners to incorporate the CBPC model within a delegated risk arrangement and create clinical workflows that originated with primary care providers and health system case managers. Eventually, in California, it led to statewide adoption of community-based palliative care services through SB1004, requiring the provision of these services by all managed Medicaid health plans.

Payers concurrently rolled-out a state-wide expansion of CBPC, the approach of which will be further informed and discussed throughout this toolkit.

Outcomes

The aforementioned health insurance companies, through the creation of the California Advanced Illness Collaborative (CAIC), developed a balanced scorecard to report how their community-based palliative care programs aligned with company goals and the Triple Aim in Healthcare, incorporating Utilization, Clinical Quality, and Satisfaction/Experience measures. These also included a measure demonstrating goal-concordance, in line with the goals of members who have a completed advance health care planning document or other demonstration of discussion about goals for care.

Utilization of Serious Illness Management Services

More than 3,000 members – as well as their families and caregivers – received community-based palliative care services through CAIC-affiliated health insurance companies specific health plans to date, nearly double the number at the implementation of SB1004 in 2017.

Patient and Family Satisfaction

Community-based palliative care programs received an average patient and family satisfaction score of 95%

Goal Concordant Care

A 2012 study found 70% of Californians would prefer to remain in their homes; however, only 32% of all Californians passed away at home. This is similar to the national average, according to a poll conducted by the Cambia Health Foundation in 2011.

Conversely, 90% of the health insurance companies' members enrolled in palliative care who have passed away did so in accordance with their wishes to be in their homes at the end of life

Increased Benefit Utilization

Members referred to palliative care were more than twice as likely to utilize their hospice benefits when compared to the national average

What is the Payer Toolkit?

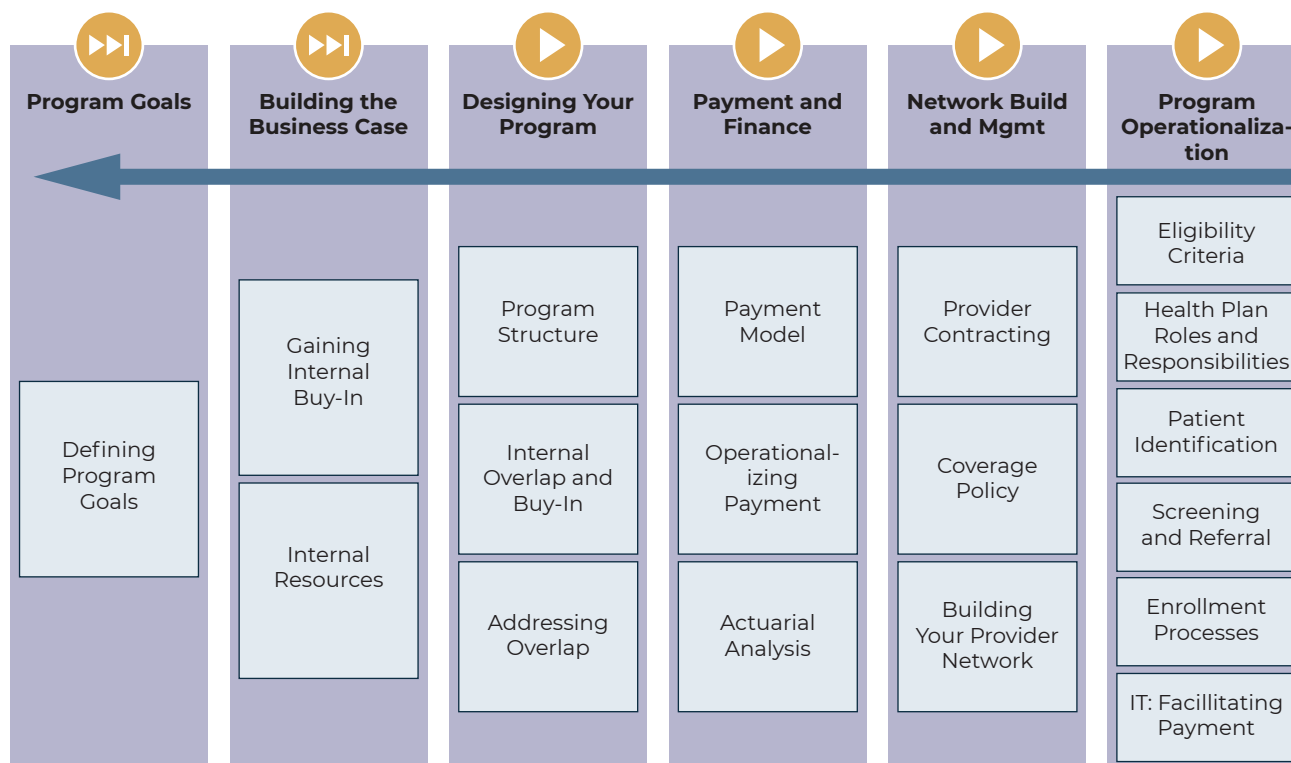
Intent

The focus of this toolkit is on the decisions, questions, and considerations that go into designing and implementing a community-based palliative care program from a payer's perspective. The information presented in this toolkit is based on the valuable insights and lessons learned from a health insurance company's experience, which ultimately led from a pilot to an operational state-wide program.

Content

The process for developing a program is iterative. It requires input and assistance from multiple departments throughout an organization, as well as external partners and stakeholders, including patients and families. The various phases undertaken throughout community-based palliative care design and implementation have been used to organize this toolkit. Insights into such a journey are included where applicable throughout the toolkit to provide valuable examples and illustrations.

ROADMAP FOR SUCCESS: HEALTH PLANS



PROGRAM GOALS

Defining Program Goals

Before developing a more detailed outline of the design for a community-based palliative care program, the goals of the program should be defined and agreed upon. These goals are often based on feedback received from the leadership team as part of the buy-in process, and generally are intended to align with/assist with making broader organizational impact.

When setting program goals, it may help to first ask the following question: “what do we want to or expect to achieve?” A program is shaped by its measurements, so as an initial step, you will need to identify categories of measures that matter, and to whom. With these categories in place, such as affordability or customer experience, then identify the individual measures and keep in mind how each measure will be used. For example, will the measure be used operationally to assess quality improvement of the program, or will it be used to measure organizational change?

An important point to consider here is who is being measured – in other words, are you measuring only your enrolled population or the serious illness population more broadly? For benchmarking or evaluation purposes, and in order to assess your program’s overall effectiveness, measures must be collected for an entire population of those who would benefit from the intervention, not only those enrolled. It is important to think ahead and collaborate with your evaluation and analytics team, or a consultant, to set your program up in a way that will allow you to compare results to a control group.

The next step is to identify whether it is feasible to collect and utilize each measure. This process may end up being iterative, as you may first select certain measures and then find that implementation may not be feasible. On the other hand, if you select a measure that is difficult to collect through administrative claims, you may be able to set additional contractual requirements for provider reporting. For example, if you want to evaluate whether people enrolled had a change in their pain scores, you will need to collaborate with the provider to report this information in an agreed-upon format and on a regular time frame. After careful consideration of measurement categories, individual measures, and measurement feasibility, you are ready to collect baseline data and, subsequently, set appropriate and reasonable targets for your program. Note that the objective of identifying measures is not to drive them to the extremes (i.e. Setting a target of 0% inpatient utilization for people enrolled in palliative care or 100% completion of advance care planning documents). Rather, measure selection helps to create a structure so that appropriate and reasonable quality benchmarks can be met, and improvement can be observed.

Program Goals Checklist

- Identify and select overall measurement categories
- Select program / department level measures aligned with categories
- Determine implementation feasibility
- Collect baseline data
- Set appropriate and reasonable targets for your program

Board of Directors

High-level goals are often set by a board of directors or group of executive-level stakeholders, which ties into overall measurement categories. For reporting purposes, there are four commonly used categories by payers: (1) [Affordability/Cost](#); (2) [Customer Experience](#); (3) [Brand Loyalty/ Likeability](#); and (4) [Quality](#). These categories align with the Triple Aim in healthcare, reflecting on cost, clinical quality, patient and provider satisfaction.

These outcome measures should be measured at an organizational-level (as opposed to by line of business or product) and collected at an annual cadence. The following table provides examples of these four categories.

Measurement Level: Board of Directors

Anything reported to the Board of Directors or to executive-level leadership within a health plan should be evidence-based and designed to show measurable improvement. Additionally, in order to gain program buy-in and ease in implementation, these measures should be similar to what the board members are accustomed to seeing within other clinical programs or initiatives. For example, measuring a decrease in total cost of care is a measure plans already track overall and within other clinical initiatives. By adding this as a measurement, you are simply utilizing an existing measure and looking to evaluate the effectiveness of the intervention designed for a subset of the population receiving those services. Net promoter scores are another measure that health plans already have in some form, and thus easily utilized for your own program.

Being likeable is all about brand – how strong is your position in the marketplace? In the community covered by these services, do you have a good reputation? Tracking likeability through media placements or community surveys, through an internal communications team or a public relations firm, assesses how the public feels about the health plan, and through additional targeted monitoring, your program. Additionally, well-placed media advertisements or sponsorships can help with program visibility. This is especially important for palliative care, as it not a well-known service covered by health insurance. Consider setting up these measurement strategies in the beginning to monitor your program and gather feedback to refine them over time.

Category	Measure	Process or Outcome	Cadence	Measurement Plan
Affordability	% decrease in total cost of care (in last 6 months of life)	Outcome	Annually (quarterly at most for cascading stakeholders)	Benchmarked COHC trend with a control population or pre-post with enrolled population
Customer Experience	Likelihood to recommend / net promoter score	Outcome	Annually (quarterly at most for cascading stakeholders)	Surveys post-death – 6 weeks post death mailing or phone call
Brand Loyalty/ Likeability	Media placements, community survey	Outcome	Annually	Work with external affairs and communications team to determine best tools
Quality	Place of death (% in hospital) – from Dartmouth Atlas EOL Trend Report	Outcome	Annually	Pull from claims data, but dependent upon having death data (limitation)

Program / Department Level

Measures at the program or department level should align with the high-level categories selected by the Board of Directors (BOD) or other executive stakeholders. As granularity increases, additional process-level measures can be added. In other words, in order to test operations, you need to see if you can execute and receive indicators of directional results. From a program perspective, this means looking at a variety of outcome and process measures for the purpose of forecasting. If executive leadership wants to lower the total cost of care, they may reduce unnecessary utilization – which thus becomes the program-level affordability measure. The specific factors of emergency room utilization, inpatient days, and skilled-nursing facility days all contribute to reducing the overall total cost of care for people with serious illness. Measures at this level should be tracked by line of business or product type (Medicare, Medicaid, Commercial – sometimes HMO/PPO). Although timing may vary, generally the more granular the measure, the shorter the measurement reporting period so that you can show directional improvement in performance on 60-90-day intervals.

The table below demonstrates program / department level measures for each of the four measurement categories. A complete version of this table with additional information can be found in the Appendix.

Quality measures should be specific and relevant to the population being measured, evidence-based, and measurable. Feasibility in measurement can be an ongoing issue due to lack of necessary data. For example, payers often start by choosing place of death as their quality measure. They move toward opting to use HEDIS / CAHPS measures instead, as these better align to the Medicare Star Rating System.

Measurement Level: Program / Department

Category	Measure	Process or Outcome	Cadence	Measurement Plan
Affordability	ER Utilization (# of visits)	Outcome	Quarterly	Pull from claims data.
Customer Experience	Patient Satisfaction Survey Scores (Likert Scale)	Outcome	Quarterly	Practice-level reporting or plan chooses to send surveys for all provider programs.
Trusted Advisor / Likeability	Engagement rate for overall program	Process	Monthly	Identify overall population of people plan sees as appropriate or eligible for the services offered.
Quality	Home Health / Home Care Utilization	Outcome	Quarterly	Want to see this improve appropriately. Track by type of service for Community-based palliative care.

Tracking / Quality Improvement

Consider the following questions:

- How is the intervention going?
- Where do we need to spend time improving?
- Am I on track to achieving overall goals that I committed to for my organization?
- Do we need to revise expectations? If so, by how much?

Additional Considerations

Only Measure Once

If something is measured upstream, it does not need to be measured again for lower-level stakeholders. Begin with the measures you will need to capture for the highest vantage point (50,000-foot level) and then work to break down measurement and reporting into more granular sub-analyses from there. If data are captured appropriately and at the right time, meaningful benchmarking and reporting can be implemented.

Balanced Scorecard

Ideally, you always want to aim toward having a balanced scorecard approach to selecting key performance indicators. For example, if one goal is a decrease in unnecessary inpatient utilization, then another goal should be to see an increase in community-based services such as home health and outpatient office visits. You will want to have an equal number of quality and patient experience measures to balance out cost and utilization measures to ensure high quality care is being provided most efficiently and with the highest value.

Medicare Advantage Stars Rating Impacts

Work with your MA quality team to identify and track members who may be identified as benefiting most from a palliative care intervention on the organization's reporting suite. Because quality is a built-in component to how Medicare Advantage plans are paid, the organization will have a dashboard that tracks high need, high cost members and will have selected measures relating to in home care, care for older adults, and others where those with serious illness would be most impacted. Additional guidance can be found in Appendix A.

Risk Adjustment Factor (RAF)

Benchmark your RAF against that of the eligible palliative care population. Ideally, with any high-quality palliative care or serious illness management program, you will see that providers will become more accurate in their diagnosis coding and documentation of the stage of a member's illness. This should increase the overall risk score for the population under management. If this is not the case, consider requiring a documentation and coding workshop for holding a contract with the plan. Set appropriate targets for risk score adjustment.

TIP: To balance utilization and quality, you will want to know how care is shifting from place to place – rationing is not the goal.

PART TWO

BUILDING THE BUSINESS CASE

Gaining Internal Buy-in

What are your program goals when you are contemplating offering a community-based palliative care program? How does this fit into the overall goals of your organization? To make the case for offering a community-based palliative care program, there are several questions to contemplate in this early process of gaining and developing program buy-in, including:

- Who is the **executive champion** that will oversee the implementation of this program and be an advocate for it throughout implementation?
- Who will be the **palliative care team lead** to drive the project? What is the best background or experience for this type of position (i.e., does this person have a clinical background, a business development background, or something else)?
- Where within the health plan **infrastructure** will this program sit? Is there a department that is “strong” within your organization whose goals align with palliative care and could “own” it?
- What **resources** will be necessary for the program to be successful? Who will support the palliative care team lead and what additional personnel resources will be needed? How will the implementation of the program be budgeted?

Leadership

Role of the Executive Champion

The executive champion can help to influence whether palliative care is an organizational priority early in the process of building a program, or a project within a project. Some organizations may already have pressure from an important client, but for others, executive level buy-in is necessary. The strength of support from your executive champion may influence the resources, both financial and personnel, that are devoted to your project and thus the scope of your ability to design and implement the program.

To launch a community-based palliative care program, a stakeholder at the executive level needs to buy-into the project. The most common executive champions include the Chief Executive Officer and the Chief Medical Officer. Having the support of an executive champion ensures that others at your plan know that palliative care has the support of the leadership team, and that an executive is underscoring that this program is different from others already being offered. Additionally, the executive champion can help ensure that the right person, or people, developing the palliative care program are present at key meetings, are properly situated within the organization, and are gaining buy-in from other key leaders within your organization in order to facilitate a smooth rollout and prompt troubleshooting when necessary.

Identifying the Palliative Care Team Lead

The palliative care “champion” or “team lead” is the person responsible for building and operationalizing the palliative care program. This person also serves as the subject matter expert on palliative care. In many organizations, the palliative care team lead has a clinical background, either as a medical director or a nurse.

When hiring for this position, consider whether you are looking for clinical expertise first and foremost, or whether you are looking for someone with more experience in health plan operations (who may have more experience navigating the actuarial, legal, and/or network development phases of the program design). The background of the chosen palliative care team lead will dictate which business units are likely to be more responsive. For example, clinical staff within a health plan may be more receptive to an individual that has a clinical background or formal clinical experience.

Sample job descriptions for this position can be found in the Appendix B.

Internal Resources

Initially, your program may not have its own staff or resources outside of the program lead. You may find yourself sharing resources, including the time of other internal stakeholders (i.e. legal, contracting, etc.). The following sections outline some high-level tactics in building out your own set of resources, including how to select and hire a palliative care program team, choosing a staffing model, and some early budget considerations.

Staffing

Interdisciplinary Team

Designing a palliative care program requires an interdisciplinary team and a dedicated program lead of at least 1 FTE. Your team should ideally include individuals with the following levels of expertise:

1. Clinical
2. Lean management
3. Change management
4. Communication and stakeholder management
5. Payment and policy experience within a payer

Experience vs. Expertise

At times, you may find more success hiring people who can speak the language of the stakeholder and learn the palliative care program piece on the job. For example, say you interview a potential team member who has experience with the health plan’s employer group customers – in sales, account management, and community events. If these employer groups are important external stakeholders for your program, hiring someone with expertise of that skill set is more critical than hiring someone with pre-existing knowledge of palliative care. Another example might be having a team member who

is experienced and comfortable with internal communications. This individual can successfully engage with other internal teams (i.e. information technology) and act as an ambassador to internally drive your new program's success. Consider working with your internal communications team to develop and supplement a Frequently Asked Questions resource so that internal and external stakeholders have a shared understanding of program operations and expectations.

Staffing Model

The “hub and spoke” model is a popular choice when implementing a palliative care program. The “hub” is the palliative care team, and the “spokes” are the internal and external stakeholders, all of whom need to be bought into the operating model and the program itself. The members of the palliative care team will be skills translators – they understand the work of both internal and external stakeholders to whom they are trying to communicate about the program. This enables internal work to be augmented to support others. The use of a hub and spoke approach to implementing a palliative care program can decrease the number of FTE needed dedicated specifically to palliative care and can increase efficiencies across the enterprise. However, this model can only be used most effectively if the stakeholders at each spoke have a clear understanding of their roles and find value in contributing to the program's operational goals.



Hub and Spoke ⁱ	
Benefits	Risks
Consistency across operations	Congestion at hubs
Increased efficiencies	Overextension of spokes
Enhanced quality	Staff dissatisfaction at spokes
Enhanced market coverage	Transportation/Communication disruptions
Improved agility	

Budget

Becoming your own cost center

By receiving your own cost center from the finance department, you control your budget. This means that you can utilize this money however works best for the program, whether it is hiring staff, developing a marketing campaign, or financing training opportunities for external referral sources. Depending on the structure of your organization, it may also be a mechanism for you to buy the time of other internal staff (i.e., a project manager; contracting manager, IT) that could be helpful in jump-starting your program.

However, requesting a new a cost center triggers certain responsibilities, such as delivering savings or other metrics of success. As a new program, it is important to consider whether delivering on these responsibilities is immediately feasible, or if that is a decision to be revisited later.

Case Study: California's Accountable Care Organization Market

The California market is a more mature Accountable Care Organization (ACO) market than many other places around the country. Thus, it is common that health plans have dedicated resources and teams for managing these kinds of at-risk contracts. Initially, many health plans' community-based palliative care programs were folded into the ACO team with funding coming from that budget. This decision was made because the goals of palliative care aligned with the operational and quality goals for the ACOs partnering with the insurance company and program implementation could mirror that of other ACO-based quality initiatives.

Health insurance companies in California had four specific goals they were working toward over a 3-year ACO contract period or budget cycle, and CBPC was an initiative that could drive their ACOs toward those goals. The initial focus of external buy-in efforts were often ACOs. Palliative care resources were utilized evaluating the readiness of their ACOs for a community-based palliative care partner, identifying those partners, and executing contracts.

The timing for including the palliative care program as part of the goals for the ACO team was ideal. The ACO team was in the planning phase of their next three-year contract cycle and had just finished a cycle for shared savings which had exceeded targets. It was a perfect moment to put in place mandates for palliative care initiatives into new contracts – the team was looking for new opportunities after a financially favorable time and had the resources to support the palliative care team goals. On the other hand, the case management team, which would have been another potential “home” from which to launch the program, was not in a planning phase. They had just completed implementation of a larger transformation project that involved staff reorganization and program redesign.

Additionally, given that the SB1004 managed care plan operating framework was to make a network model for delivering palliative care, a desire for the payment for the program to be value-based, and that palliative care champions are not always clinicians, ACO teams make sense as a starting place for developing palliative care programs in greater detail and provide access to and support by key clinical ACO leaders.

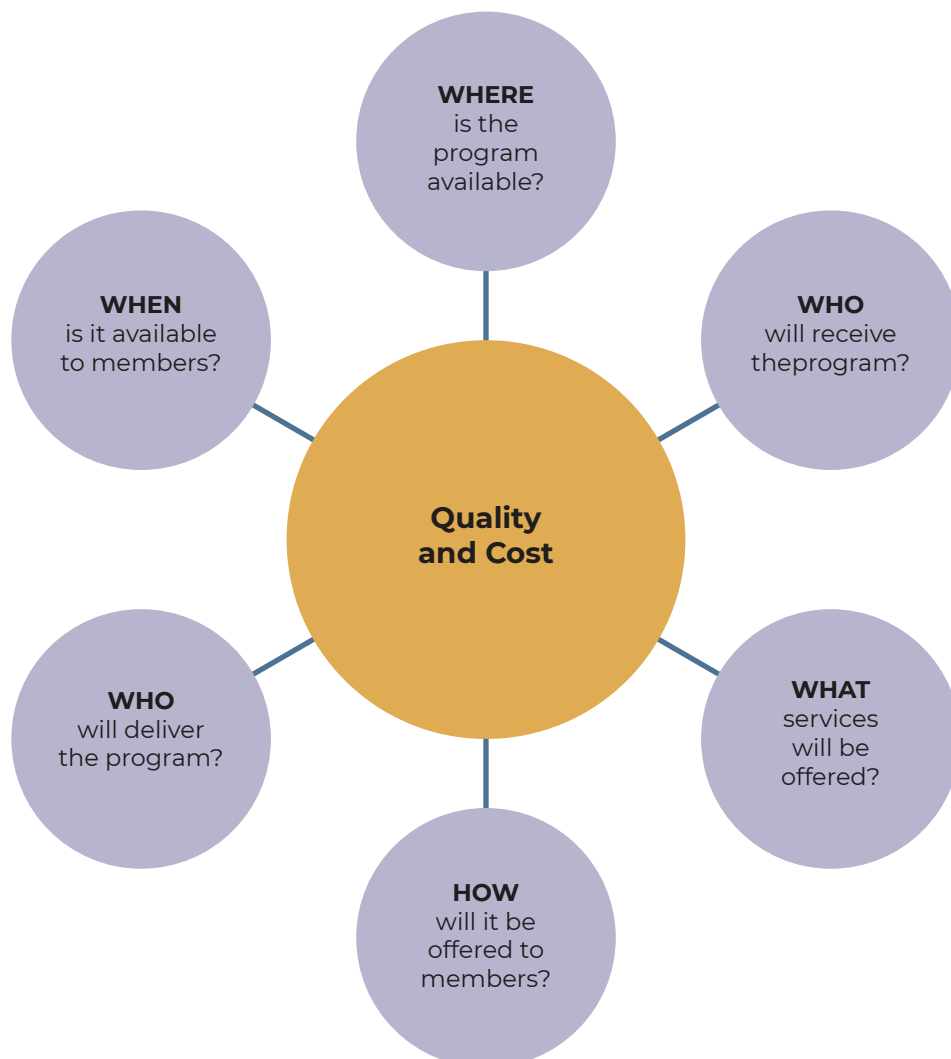
DESIGNING YOUR PROGRAM

Program Structure

The first step is to begin outlining a program that can achieve the previously selected goals at a level that permits and encourages stakeholder engagement. While most people are familiar with many of the core tenants of palliative care, fewer are aware of palliative care as a specialty and its role in the broader health care sector. The following design assists in creating a common internal language and understanding. You can then build upon this framework to make increasingly granular decisions about how the program operates.

The following components make up the essential design decisions at this phase of program design.

These decisions feed into all other decisions that eventually must be made both as it relates to estimating the impact and operationalizing the program.



Defining the Population

The core skill sets that coincide with palliative care are applicable to a broad array of populations and conditions (i.e., goal setting, interdisciplinary team, etc.). It is sometimes beneficial to limit your program to a specific focus, such as a focus on individuals with a “serious illness,” thereby leveraging existing literature to assist with identifying diagnoses most associated with this definition. The next question to answer is how far “upstream” to target individuals with one of the diagnoses associated with serious illness. Focusing on individuals diagnosed with a serious illness AND anticipated to be in the last year of life coincides with the hypothesis that a population closer to death is more likely to benefit from a more supportive, home-based model. Care coordination in the last year of life can be poor, with patients receiving care that may not be aligned with their goals; this results in increased spending and unnecessary utilizationⁱⁱ. Sending clinicians into the home can be a relatively expensive model, thus, focusing on a population that has a greater opportunity for savings or impact is attractive, especially early-on in the establishment of a CBPC program.

Included Services

Selecting the types of services to be included in your CBPC program is a strategic decision that should be made early on as part of the business case development process. There are several resources, including the National Consensus Project Clinical Practice Guidelines for Community-Based Palliative Care, 4th edition, certification and accreditation bodies for CBPC by The Joint Commission, ACHC, and CHAP, that serve as helpful guides in identifying these types of services, and how these services should be deployed. In developing initial model agreements with CBPC provider practices, one health insurance company utilized the National Consensus Project Clinical Practice Guidelines as a basis for the “Services” section. This allowed it to hold providers accountable for services rendered based on the clinical expectations of their medical specialty, making it easier for the practices to buy-in to what they needed to provide to ensure patients and families receive the highest quality care. Utilization of these guidelines and the certifications for community-based palliative care through the accreditation bodies that govern the credentialing for their other service lines (home care, home health, and hospice) also reduced administrative burden and oversight for the plan and streamlined the onboarding of new providers who had already achieved this level of certification. The insurance company worked closely with each accrediting body to develop training workshops for new providers to understand the requirements for certification for CBPC and, in turn, for contracting with it.

Below is a high-level list of covered services that may be appropriate to include in your CBPC program. More information about how these services may overlap with other programs and how to integrate with existing coverage are outlined in other sections of this toolkit. Note: Palliative care is a longitudinal service. A patient remains enrolled in palliative care during admission to and discharge from any facilities where he/she seeks care.

- Comprehensive in-home, palliative care needs assessment
- Development of care plan aligned with patient's goals
- Assigned nurse case manager to coordinate medical care
- Community-based palliative care visits – either in person or via videoconferencing
- Medication management and reconciliation
- Psychosocial support for mental, emotional, social, and spiritual well-being
- 24/7 telephonic support
- Caregiver support
- Assistance with transitions across care settings

Care Delivery

After identifying the desired standards and services for your CBPC program, the next step is to deploy a corresponding model. An interdisciplinary care team (IDT) includes clinicians, social workers, and faith-based support, like hospice. A traditional fee-for-service model does not incentivize the most effective use of the IDT or going into the home, and therefore a more appropriate model would be a case-rate or other type of bundled payment. This allows participating providers to be paid a case-rate or bundle for each member that enrolls in the program. How to determine the correct payment amount and how to operationalize that payment can be discussed in future phases; however, knowing the ideal payment methodology as part of the initial outline process is helpful to assist stakeholders in understanding how the program may impact them.

Geography and Lines of Business

There are several different factors to weigh when deciding which lines of business would be best to initially make CBPC available.

Potential enrollee penetration rate

The number of members that may be generally eligible for CBPC services varies by lines of business and the population covered within the product. There is likely more significant market penetration for CBPC in the Medicare population; however, it may be easier to implement a CBPC program in a commercial benefit package. Alternatively, it may be harder to attract network providers if there is expected to be relatively few members that enroll in the program.

Timing

Some lines of business, for example Medicare Advantage, require plans to submit bids or materials that include the benefits and services covered—it may be necessary to include the CBPC program as part of these submissions; the timing of when these bids can be updated is a consideration. Submission timelines vary by line of business and can impact when and in which business lines.

Existing provider contracting structures and any risk-based arrangements

There may be existing contracts with providers that can be leveraged in order to build the network (see provider contracting section); however, this may not be the case in every line of business. There may also be barriers for providers that you would be interested in having in your network to provide HPBC due to state licensure requirements, which will be important considerations (see building a provider network section).

The number of lines of business

Do you offer the program in one line of business or multiple (if it is an option)? There may be challenges with operating the program in more than one line of business, including managing the requirements of multiple stakeholders. Sometimes, various lines of business can operate on different systems, resulting in additional work on the operational side to ensure the program is effectively built into every line of business.

Ease of incorporation into the lines of business

For some lines of business, it is easy to cover CBPC, but for others it is more challenging. For example, you may not have the explicit authority to cover palliative care in the Medicare market and would need to determine whether your plan believes you have the authority to do so. Otherwise, the need for a waiver should be explored with the assistance of legal counsel.

The importance of volume

Volume, or adequate enrollment in the program, is attractive for provider partners delivering HPBC. Without enough volume, the administrative costs of the program can be significant, and it is challenging to get the attention of both providers offering the service and referring providers. Additionally, creating significant requirements for only one line of business, an ACO, for example, is challenging to manage and as a result could impact the likelihood of the ACO making sufficient investments to build and sustain the model. These two points are essential in effective CBPC delivery. Without the support of these key stakeholders, and without adequate enrollment in the CBPC program, it will be difficult to meet quality or savings goals.

A Note about Commercial Products

Fewer people are likely to have a serious illness in commercial products, therefore offering CBPC only for fully insured PPO products naturally results in fewer people enrolling in the program. Additionally, health systems may lack accountability under a PPO because they are not at-risk and therefore do not have a motivation to refer to CBPC. However, from a health plan's perspective, the PPO commercial line of business is easier to implement CBPC, for the purposes of a pilot, because it has fewer statutory and regulatory limitations around adding benefits and services. The health plan is also fully at-risk for these products, so it does not have to contemplate how to incorporate CBPC into its delegated financial arrangements (a challenge we address in the provider network) or gain approval from self-funded employers.

After their first year, many participating CAIC health plans expanded their pilots to all lines of fully insured business (i.e. Medicare Advantage, individual, and group markets) through risk-bearing independent physician associations or medical groups. These groups often had one preferred CBPC provider. The expansion provided them with a larger pool of eligible members, given that the geography and number of provider participants was initially small.

After seeing initial results, health plan leadership wanted programs to be state-wide, based on a requests from large employer groups and other factors. Ultimately, the plans opted to offer CBPC in all lines of business when it expanded to state-wide availability, offering the program to all members except those who are enrolled in a federal employee plan or where the insurance company acts as Third Party Administrator only.

Internal Overlap and Buy-in

The next phase in designing your program is to begin to better understand how CBPC will impact various internal departments and solicit their feedback and buy-in on the program. To accomplish this, the first step is to hold interviews with key internal department leaders. These interviews serve two purposes:

(1) to gain the buy-in of these key stakeholders early-on in the development of the program, and (2) to better understand the potential overlap and considerations with engaging each department. This step presents an ideal opportunity to seek feedback from your program's executive champion, who can assist with identifying who within the company should be interviewed and what questions to ask.

Who: Departments to meet with include:

A key insight for a payer's palliative care team is who in the company needs to be "bought in" to the program and when to engage critical departments.

A palliative care champion should seek buy-in and commitment from:

- **Clinical services leads, including representation from case management and utilization management.**

Sample personnel: Head of clinical services or head of case management and head of utilization management. It is also important to engage leaders that are involved in quality initiatives if that is a separate team.

- **Contracting**

Sample personnel: Vice President of Contracting with a particular focus on provider contracts. It is also important to engage the individuals that oversee the management of vendors, including those responsible for contracting and managing various clinical coverage contracts.

- **Legal/Regulatory**

Sample personnel: A provider focused legal team member and a state or federal regulatory expert

- **Actuarial and/or Strategic Finance**

Sample personnel: VP level, with a particular focus on cost of health care savings and value-based payment methodologies

- **Information Technology**

Sample Personnel: senior project manager who understands IT and business requirement development

What: Sample key interview questions

1. What are your department's goals? What is the time horizon for these goals?
2. What are your responsibilities?
3. How is the program/department evaluated?
4. Has your department undergone any significant changes recently? If so, what/how?
5. What resources do you use to accomplish your goals and responsibilities?
6. What are the technology systems being utilized? What assessment tools are built into these platforms? How is information stored on the various platforms?
7. How is the department structured?
8. How are deliverables shown and to whom?
9. Is there anyone else that I should meet with?

Keep communicating

Getting these types of leaders within the organization engaged early will help smooth out operationalization of your program. Once they are engaged, the importance of the hub and spoke model described in the previous section becomes paramount in order to ensure communication between the palliative care team and the rest of the organization.

Meet with each group on multiple occasions. The first meeting may mostly involve listening to the various stakeholders and documenting their responses. CBPC is usually introduced at a high-level during these meetings, meaning there is rarely enough time during this conversation to provide a detailed overview of the program. Follow-up meetings are used to explain the proposed CBPC program design and begin to think about the potential impact of the program on each of the stakeholders' daily responsibilities.

Consider all opinions

It is important to remember that the stakeholders being interviewed come to these discussions with their own objectives and challenges. For example, imagine a department has recently undergone a significant reorganization and there is change fatigue within the department (this is discovered during the interview process). Rather than view this as a stopping point, take these unique circumstances and incorporate them into your design and operational plan, aligning your timeline with that of the department's so that they can tell you are incorporating their unique needs into your plan. The call-out box below provides a more detailed description of this experience and the lessons learned.

Detailed Case Study

Interview Experience with the Case Management Team

Palliative care team leads identified the following points from interviews with case management that underscored key themes that need to be carried over into the palliative care program design.

1. Who the interviewee is and their past relationship to serious illness programs.

Many case management leaders have had experience with palliative care or specialty case management. The approach to serious illness care can run through the case management department so that the program is the underlying frame for thinking about serious illness care within that department. Aforementioned and detailed here, key employer accounts can ask a health insurance company to create a serious illness program within the scope of the existing management fee – this request can trigger the hiring of the palliative care team lead. This request can come in response to a case management or other program which fails due to low engagement, leaving case managers frustrated. It is critical for the palliative care lead to find out -- Why did it fail?

2. Serious illness conversations. Case management teams often find that they are not able to engage patients to talk about serious illness in a productive way. There is often no or limited serious illness communication training amongst the staff; for example, serious illness care is often talked about with an end-of-life frame, with POLST documents sent to patients in lieu of having conversations. Payers often mine data to try to identify appropriate patients for serious illness programs, but are often more specific than sensitive, with the result being that the targets are more appropriate for hospice rather than palliative care or advance care planning and needed considerable hands-on care.

3. Existing programs to consider. Existing programs like complex case management and/or disease management programs are already being run through medical management departments. This includes what populations are being served and how they relate to the definition of serious illness being adopted by the palliative care program.

4. Separation by line of business. Case management also must separate the NCQA or other more regulated Case Management programs from other case management services. Any new program being built that needs to utilize case management should abide by the rules of an accrediting body's required services and procedures.

5. Accreditation. Through a conversation about how case management implements procedures to enroll patients and get case referrals, the rules about NCQA accreditation come up repeatedly. Maintaining NCQA or other accreditation is a top priority for the department, so understanding NCQA or other rules and where they would apply to a palliative care program would be a critical aspect of a successful collaboration.

As a result of the conversations with the case management department, the following program development points can emerge for a palliative care team. The palliative care team should:

- Develop tools that would help the case managers to assess patients for palliative care services;
- Provide case managers with further serious illness communication training in order to help distinguish between palliative care and hospice, as well as to enhance their skills in talking to patients and families and referring them to appropriate services;
- Develop specific criteria and tools for patient identification to assist case managers in targeting appropriate patients for the eventual palliative care program (and to distinguish these patients from other existing case management or other programs).

Addressing Overlap

Throughout this input process, several key areas of overlap are likely to be discovered. While each health plan will be different, this section provides a detailed overview of three overlapping areas that were found to be informative for other health plans. These areas include:

1. Delegated financial arrangements
2. Care management
3. Vendors/Clinical programs

Delegated Financial Arrangements

An important initial overlap consideration is how to incorporate an CBPC program into existing arrangements in such a way that will incentivize your ACO partners to encourage palliative care utilization. Important questions to answer as part of this assessment process specific to these arrangements include:

- What are the underlying delegated financial contracts by line of business (for example, commercial PPO, commercial HMO, Medicare Advantage HMO, Medicaid etc.)? If the delegated arrangements vary by line of business, it is important to understand the specific arrangements under each line of business.
- What is the ACO at risk for under its delegated financial arrangement? This is the key component to understanding who is at risk for inpatient stays and professional services.

Once the answers to these questions are understood, then determine which entity should hold the risk, or pay for, for the CBPC program.

The hypothesis based on a review of literature for a specific health insurance company was that the program would reduce avoidable inpatient and emergency department utilization. Thus, the entity that was at risk for those services was also the most likely to benefit from the implementation of a CBPC program. The result of this analysis was four different risk arrangements for CBPC.

Risk Arrangement	Definition	Financial Delegation for Palliative Care
Health Plan Risk	Health plan has financial responsibility for inpatient stays and emergency department utilization.	Health plan
Shared Risk Arrangement	Health plan and ACO share in the risk for professional and/or inpatient and ED utilization (e.g., 50:50 risk)	Health plan
Delegated Global Risk	ACO has a capitated arrangement and has the majority of the responsibility for all professional and facility services (> 80% of risk is held at the ACO level)	ACO
Dual Delegated Risk Model	A Medical Group is financially at-risk for professional services while a Hospital is at risk for services provided at their facility including both inpatient and ED utilization	Hospital

Division of Financial Responsibility

In a value based or ACO relationship, part of the contract will specify who is responsible or will be taking financial risk for the services being provided. This part of the contract is called the division of financial responsibility, or DOFR. An important consideration when it comes to palliative care is that only formal benefits can legally be part of DOFR. Palliative care is often not a formal benefit; therefore it would not show up as a DOFR line item. On the other hand, a DOFR can help with understanding the business case for palliative care, specifically in looking at where potential or estimating savings will accrue and can support conversations between the health plan and ACO partner about who should reimburse for such services. From a health plan perspective, it is recommended to align payment for community-based palliative care with whatever entity holds financial risk for inpatient, emergency department, and skilled nursing utilization.

Shared Risk

Most financial arrangements involve shared risk. Understanding the financial delegation will assist your team in how to engage ACOs as well as understanding the financial incentives that the program will create and where savings will accrue.

Additional Payments

Despite financial delegation, it may be necessary to pay for CBPC outside of the amounts that are being paid to its delegated risk arrangements. There are several reasons for this, including that all the ACO contracts will need to be amended to account for the CBPC program (i.e. it will re-open ACO contract negotiations), creating the opportunity to incentivize your partners to use CBPC. By paying for the program outside of the capitated rate, it effectively provides the ACOs with a “bonus” for referring to the program. Referrals ultimately reduce utilization that is already accounted for in capitation, but the increased CBPC utilization does not cost the ACO anything. Additionally, this strategy may be deployed temporarily to get stakeholders more comfortable with leveraging the CBPC program and seeing the benefits of making palliative care available to its patients more broadly.

Other areas of ACO overlap to consider and address include:

ACO Contracting

A palliative care contract can be designed as an amendment added to contracts between a payer and palliative care providers (usually hospice or home health agencies). For PPO contracts and shared risk ACOs, palliative care risk is delegated to the health plan, which means the health plan is taking on the risk of the program, but shared risk ACOs could still reap most of the rewards if the program were to be successful. For global risk ACOs, they will ultimately have to take on the risk for reimbursing for the palliative care program. The health plan taking on the palliative care risk for the first few years of the program in order to gain experience on an ACO population provides a glide path for this responsibility.

Provider Relations/ACO Clinical Programs

Implementing a palliative care program requires a lot of education both within a health plan and with external stakeholders. If you already have staff supporting your ACOs from a clinical and programmatic standpoint, consider inserting education about palliative care and your specific program into already existing meetings. For example, an ongoing care management meeting or Joint Operating Committee meeting occurring within an ACO partnership. Your palliative care team can participate in this established meeting and highlight the goals of the program and address concerns directly. Some ACOs will already have a complex care management service that they feel serves the function of the palliative care program. Other groups have no knowledge of palliative care at all. Your program's palliative care team must be able to work with all these variations by navigating the existing infrastructure and creating tools to address these differences.

Direct incentives

Utilizing direct incentives is another method to encourage providers within the ACO to refer to palliative care, as well as to support the roll out of the palliative care program within an ACO. The following table highlights potential payment methods for your ACO partners to support the delivery transformation required by adding a palliative care program:

Strategy	Training	Member Identification	Implementation Support
Tactic	Clinical training both in palliative care principles and in advanced care planning from reputable sources	Prospective member identification via a claims-based or clinical algorithm	Provide upfront funding to support implementation by partner ACOs.
Examples	Advance Care Planning design support through Common Practice Office hours with experienced palliative care clinicians Center to Advance Palliative Care (CAPC) organizational membership Access to in-person training by Vital Talk to enhance communication skills Customized case manager training in advance care planning through CSU Shiley Institute for Palliative Care.	Using health plan analytics resources to develop target lists of potentially eligible members for the ACO or partnering community-based palliative care provider Collaborating with ACO to fund a vendor to support identification and outreach of eligible members Reimbursing for an analyst within the health system to develop an algorithm for identifying patients	Providing support for a case management team to supplement the work of contracted palliative care providers Paying for a dedicated palliative care coordinator for the ACO Paying for a palliative care nurse practitioner to be situated within a partner facility in order to facilitate appropriate referral and discharge planning

Additional Clarity Around Risk-Sharing Arrangements

Health plans commonly delegate risk to an ACO or other provider-led entity. The health plan will pay the ACO or provider organization a set rate based on the number of members that are attributed to it, oftentimes referred to as a capitated amount. In turn, the ACO or provider organization must manage the cost of the individuals within that amount and is “at risk” if costs exceed the capitation rate. With the implementation of a community-based palliative care program for certain lines of business, a determination will have to be made as to whether the CBPC services fall into the responsibility of the ACO or provider group under their capitation or fall outside of their responsibility.

Based on conversations with providers and payers, it was found that one of four general approaches to contracting for CBPC in the instance that an ACO or provider-led organization was taking risk existed – these are depicted in the figure below and further explained.

Shared Risk ACO / Health Plan Scenario

Under this model, the health plan contracts directly with the CBPC provider. The CBPC provider may or may not have a contract with the ACO. The health plan reduces the ACO's capitation rate by the amount necessary to pay the CBPC provider and pays the CBPC provider for its services. Both the health plan and ACO share in savings generated by community-based palliative care.

ACO Risk Scenario

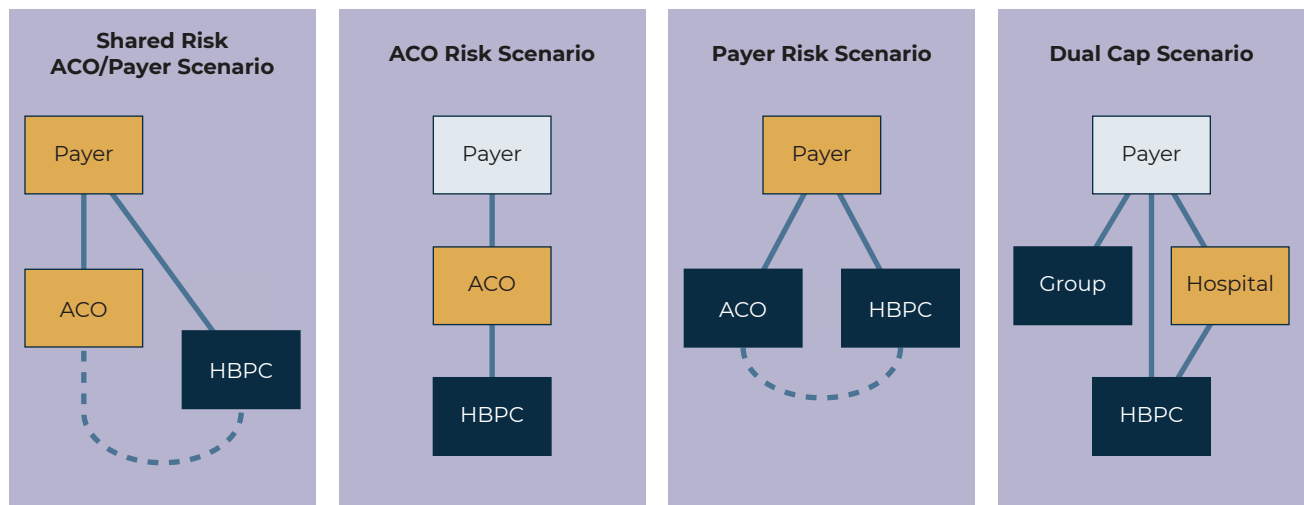
The ACO contracts with a CBPC provider directly. The ACO then accrues any savings. Depending on the arrangement between the ACO and the payer, the payer may also accrue savings, as applicable.

Health Plan Risk Scenario

The health plan contracts directly with the CBPC provider. Unlike the shared risk model, the ACO's capitation rate is not reduced by the cost of providing CBPC, so the ACO does not share in any savings generated.

Dual Capitation Scenario

Certain health plans may have some arrangements where the health plan is contracting for CBPC through a hospital. The health plan pays for the services but allows the hospital to keep some of the savings generated from the CBPC program.



KEY Financial Responsibility No shared savings/losses for HBPC

Care Management

As a new service, palliative care can be difficult to add to a triage or referral mechanism developed by health plans to identify the best program to help improve the healthcare of their members, as the population of people with serious illness requiring additional support are often identified for other care coordination or disease-directed programs. Before developing a palliative care offering, payers should consider the overlap with other programs offered to individuals who will be potentially targeted for a palliative care intervention.

One natural overlap between current health plan offerings for people with serious illness and the services provided by a palliative care program is the complex or chronic case management services offered by telephonic or in-home case managers. These programs focus primarily on improving management of or adherence to protocols for a chronic or complex disease, such as chronic kidney disease (CKD), coronary artery disease (CAD), or chronic obstructive pulmonary disease (COPD). Because the targeted conditions for case management intervention can overlap with the identification criteria for CBPC, it is important to collaborate with case management and utilization management leadership to determine the best ways to prioritize the suite of services that are available for these members.

First, consider whether your plan would like to require case management as a **core function** of a CBPC team or if you would like to assign an **internal case manager** to oversee the case while a member is receiving CBPC. Most CBPC teams are equipped with nursing and social work case managers skilled in coordinating care and identifying community resources for their patients under care. However, they will need assistance with expedited authorizations, benefit coverage determinations, and connection to other programs and services the health plan may offer for their members with serious illness. Should you require a case manager as part of CBPC services, ensure that you work with your provider partners to determine how to best coordinate for services or expedited authorizations, as they will be critical to successfully achieving the outcomes you have identified for your program.

Identify all available services

To make the best use of clinical resources available for people with serious illness and reduce patient abrasion through outreach from multiple programs competing for patients, it is useful to identify all services currently available within the health plan and ACO for the diagnosis categories covered by your CBPC program. By identifying these services by condition category and line of business, this will allow your plan to identify where in the triage mechanism for referral to CBPC may occur.

Create a hierarchy

One approach is to work with internal utilization management and case management departments to identify internal programs targeting members with the same disease criteria and then create a hierarchy for identification and referral, matching patient acuity with the richness of services provided. For example, if a member was identified as eligible for CBPC, they would not be considered eligible for telephonic case

management unless the member declined a palliative care offering first. This ensures that outreach coordinators know which program to offer a member while performing a telephonic assessment as well as all the other offerings available to them, in a prioritized order, based on the estimated impact of the service being offered. This triage protocol also serves as a roadmap for creating trigger tools for complex case managers and health coaches who already had open cases with members, giving them greater confidence in referring actively managed cases to CBPC services in the community.

Develop a training plan

Consider developing a training plan for the internal clinical staff that manages cases with serious illness so that staff members understand where CBPC fits into the overall care continuum for members with whom they may be working.

External Vendors / Clinical Programs

For health plans, high risk/high need individuals are often targeted for the multiple programs and services, as they require aggressive management and resources to improve their quality of life and reduce unnecessary utilization in higher levels of care. Similar to coordinating with internal case management, it is critical to ensure that you inventory the programs and services you may offer through vendors to members with serious illness, in particular those who have overlapping identification and targeting criteria with your CBPC program, to develop a plan to ensure members are not targeted for duplicative services and handoffs between programs work as smoothly as possible.

Develop standards and expectations

Like case management, external vendors, such as those providing home-based primary care, social work visits, in-home assessments for risk adjustment, and behavioral health case management, can be a source of referral for CBPC providers but also can cause undue patient abrasion if not educated about the CBPC and requirements or expectations for coordination. Work with your internal teams that manage these vendor-based programs to develop standard operating procedures, expectations, and coordination protocols between the services they provide and those provided by CBPC.

As new vendors are onboarded, it is critical to revise these expectations and have a plan for the prioritization of programs and hierarchy for outreach and engagement. By determining expectations upfront and as soon as new vendors are introduced to the health plan population, the plan can more effectively allocate resources to each service and create meaningful expectations around expected or anticipated engagement rates for each program.

Case Study

In 2018, a health insurance company entered a collaborative relationship with a home-based primary care vendor serving members with multiple chronic conditions across several lines of business within the health plan. To develop the best path forward for implementation, the insurance company engaged both clinical leadership and analytics teams to determine the size of the overlap between the population targeted for the CBPC vendor's intervention and those previously targeted for CBPC. This analysis demonstrated a sizeable overlap in the target population, with greater overlap in the Medicare and Medicaid populations.

Once the overlap was identified, the insurance company's palliative care team and the team managing vendor-based programs, in collaboration with clinical leadership, developed protocols to add the vendor to their triage pathways already developed for internal case management and the previously existing vendor-based programs already working with the insurance company.

In addition, the insurance company worked closely with internal and external communications teams to develop messaging that incorporated the health plan's entire suite of home-based services available to members across the care continuum. This helped internal clinical staff and community partners understand that while both programs had overlapping eligibility criteria and services appeared similar, the plan had clear criteria and expectations for which services to refer to first for each individual member identified and how to resolve circumstances where members were enrolled in both programs at the same time, based on clinical need, program capability, and contractual requirements. By setting expectations with external vendors during a pilot and then again at the launch of a full-scale program, this allows the health plan to have the most flexibility in deploying programs and services for their members at highest risk of decline and control over the management of resources available.

PART FOUR

PAYMENT AND FINANCE

Payment Models

When selecting a payment model for your community-based palliative care program, it is important to consider which model aligns most appropriately with the overall goals of your program. The following list is by no means exhaustive but offers several points of consideration for payment model selection.

Alternative Payment Model

To move away from the transaction, fee-for-service model of healthcare delivery, consider selecting an alternative payment model (APM) for your CBPC program. Although there are many APMs available to choose from, a bundled case rate is often preferable for these types of services.

Actuarially Sound

An actuarially sound payment model considers that the reimbursement for the services rendered are enough to cover the services expected to be provided under the contract, account for the acuity of the population, geography where services are provided, and account for any market pressures or medical trend inflation.

Marketable

Your selected payment model should be marketable in terms of contracting terms, flexibility, and regional adaptability. Account for the ease of negotiation in contracting by collaborating with contracting managers who are responsible to negotiating these contracts.

Flexibility

A good payment model allows for some level of variation, as certain regional factors are not translatable or appropriate to every region. In this realm, allow for rate negotiation but with pre-set guardrails or corridors. Consider a strategy adding in sliding escalators for years past the pilot period based on meeting certain enrollment or utilization reductions targets.

Evidence-Based

Examine available publications and case-studies for evidence to support the appropriateness of your payment model. There are several existing publications on this subject related to community or community-based palliative care. These can be found in Appendix C.

Common Alternative Payment Arrangements

The following table provides a brief overview of five commonly used alternative payment arrangements. It is adapted from the Center to Advance Palliative Care's Payment Primerⁱⁱⁱ materials and includes additional considerations for payers.

Payment Arrangement	Description	Additional Considerations
Enhanced Fee-for-Service	In an enhanced fee-for-service payment arrangement, the health plan pays the provider under traditional fee-for-service rules but with a rate paid higher than standard fee-for-service rates, accounting for the acuity of the population and the additional administrative costs to provide care that are not reimbursable by fee-for-service billing.	This arrangement allows health plans to easily demonstrate savings attributed to the inclusion of palliative care services. It is also often the fastest way to initially reimburse the cost of services. ^{iv}
Care Management or Care Coordination Fee	Under this arrangement, the provider is paid a per-patient fee for activities supporting information-sharing and patient-decision making. This fee is paid either monthly or via fee-for-service. This arrangement encourages assessment and having conversations with family, as funds are available to support the time and effort involved in these activities.	A potential risk for the provider is they may be unable to cover all the non-billable expenses involved in patient and family communications. Payers should ensure that the care coordination fee covers all expected administrative costs not covered by Fee-for-Service billing. Newly released payment model guidelines from the Centers for Medicare and Medicaid Innovation (CMMI) can be a starting point to determine base fees and set of services covered by a care coordination fee.
Bundled Payments	With bundled payments for defined episodes of care, the provider bears almost full financial responsibility for costs for defined patients over a limited episode (i.e. 90 days). This is a hybrid approach between FFS and capitation that helps to better isolate conditions and treatments in which palliative care is appropriate. This is beneficial to patients, enabling greater flexibility in meeting patient needs, and is likely to yield the greatest potential for cost savings. ^v	Bundled payments often need additional claims configuration groupers to bundle codes and services together and adjudicate payment properly. Determine if your plan has the appropriate internal configuration software to develop a bundle.
Case Rate	In a case rate arrangement, the provider agrees to deliver a defined set of services to a defined population for a fixed price. It is sometimes referred to as partial capitation, as the price is fixed for only a defined set of services.	This arrangement is desirable to payers for the following reasons: (1) having a lack of experience in payment for palliative care services can make it difficult to predict the claims experience in an FFS arrangement; (2) no need to set up CPT codes for claims payments in the payer system; and (3) supports the management of care on behalf of the provider across the continuum of care. ^{vi}
Full or Global Capitation	In this payment arrangement, the provider is paid prospectively and bears near-full financial responsibility for the needs of a population. This arrangement offers providers the greatest amount of freedom to direct both billable and non-billable services. However, by engaging in this arrangement, the provider also accepts both upside and downside risk, and is responsible for the significant infrastructure and investment required before assuming significant financial risk.	This is a risky option for initial palliative care programs, as member enrollment for any given palliative care provider can be too low to offset the cost of taking on full risk for a seriously ill patient. Do not consider entering into such an arrangement with a provider without proven experience demonstrating the provider's ability to engage and enroll patients into their program, has a sustainable census, and can effectively manage the population to meet cost and utilization targets.

Quality vs. Quantity

Fee-for-service (FFS) is a payment system “in which a provider bills and is paid for each individual encounter, service, or procedure performed” (CAPC Payment Glossary). Under this model, providers are less likely to refer to palliative care because they are paid for the quantity rather than the quality of services performed. In short, there is little to no incentive to refer patients to palliative care, even when the need exists.

A case rate, or per enrolled member per month, is the most prevalent alternative payment model used by private payers in the palliative care space. A per-enrolled member per month case rate is a payment model in which, each month, a fixed amount per patient is paid to a provider for a set of defined services. The per member per month is a typical payment under capitation as it ties payment to accountability, focusing on the outcomes for a population rather than a quantity of services (CAPC Payment Glossary). The case rate payment for palliative care services can be layered in as a subset of the overall capitation (or PMPM) that an ACO receives, as it would only cover the services for those enrolled in palliative care and not simply anyone identified as eligible for the services.

This model has various strategic advantages for a community-based palliative care program, such as often requiring 24/7 availability for patients, maximizing operational efficiencies such as telehealth, and emphasizing the need to stratify a patient population to manage service delivery within a fixed payment (CAPC Accelerator).

Operationalizing Payment

As you develop your program, there are largely one of two ways other health plans have opted to address paying for their palliative care programs.

1. **Claims-based billing:** a claim is submitted for each member being serviced in the program. This is largely done electronically but can also be done through paper claims; or
 - a. *Automated Adjudication* (Claims processed automatically through claims adjudication software)
 - b. *Manual Processing* (Manual review and payment approval by medical claim examiners)
2. **Roster billing:** simplified billing process falling outside of the standard claims configuration process that allows the provider to submit one invoice with a list of all the members enrolled in their program. Providers are paid through a check issued by the health plan with little ability to automatically track and evaluate total cost of health care for the population enrolled in palliative care.

The selected approach may change or evolve over time. For example, you may elect to begin a program using roster billing for the purposes of a pilot but build the necessary functionality in your claims system and move to a claims-based approach when implementing the program more broadly.

The best approach is dependent on your implementation priorities. Key questions for making this decision include:

- What is the preference of key stakeholders, both internal (e.g. leadership) and external (e.g. providers)?
- There are varying resource requirements associated with both claims-based billing and roster billing. How easy or difficult will it be to acquire the necessary resource to ensure provider payment?
- How quickly do you want or need to scale the program?
- What are the operational limitations of the existing claims system? Is it capable of supporting the payment model selected today? If not, what changes and resources or workarounds are required in order to ensure it has the necessary functionality?

Key Considerations for Each Approach	
Claims-based Billing	Roster Billing
• Automated process; once it's set up correctly, it requires less resource time • Improves health plan auto-adjudication rate • Can be resource expensive and time consuming to build correctly • Automation allows for the ability to scale more quickly • Likely simpler for program providers, as many are familiar with submitting claims and have automated processes • Claims is a source for other systems for many health plans; the ability to have a flag or claim in the claims system that denotes enrollment in the palliative care program may make pulling reports and any interaction with other systems more simplistic • CMS uses claims-based billing rather than roster billing and likely would if they were to implement a program • Claims systems have varying degrees of capabilities—it will be important that the claims system can support the payment model selected	• Manual process; significant amount of resource time to administer required • Falls outside the claims system, making it more difficult to track spending and utilization on a regular reporting schedule • Requires a level of closeness to the program because of manual review required—it's clear who is in the program at all times • Requires more communication between the providers and health plan on a regular basis—the providers must submit the forms in order to get paid • The enrollees may need to be “flagged” in other systems which requires a process to be built

Additional Payment Considerations

Information Technology

Ensuring that the information technology systems are designed and developed in such a way that enables payment is a challenging but critical task. When implementing a claims-based approach, there are a significant number of tasks and departments within the health plan that must be involved in developing the infrastructure to ensure it works appropriately. One challenge you may face is in relation to ensuring the necessary functionality is in place to ensure timely provider payment using a claims-based approach. If this challenge is not addressed proactively, it may result in staff time spent on fixing problems with the payment process, that would otherwise be dedicated to continuing to build the program. Engage teams working in pre- and post-payment review early in the configuration process to ensure all downstream payment processes have been captured.

Encounter Data

Complete, accurate, and timely encounter data is critical for determining needed changes and improvement in health-related programs. Health plans use encounter data for monitoring and oversight functions including HEDIS reporting, capitation rate development, and for meeting various regulatory requirements. Preferred Provider Groups (PPGs), ACOS, and hospitals with capitated payment arrangements who submit encounter data to a health plan usually must use a plan-specified avenue for encounter data collection.

Line of Business

Payment models generally do not vary by line of business (LOB) unless the services being provided to any particular LOB are more or less rich than any other. Health plans often have different rates for different lines of business, depending on the size of the budget that a line can use to improve healthcare services. Payment models won't change by rate but may change depending on the underlying fee-schedule for that particular line of business. One thing to consider is that Medicaid, Duals, and Special Needs plans often have a high prevalence of beneficiaries with serious mental illness or an increased burden based on social determinants of health^{vii}. These payment models may benefit from the inclusion of a behavioral health interventionist as part of the core palliative care team, while other lines of business may consider using them as an ancillary service.

Network Type

Network type directly impacts the outcomes of a program as well as patient engagement. For example, with contracting, preferred provider organization (PPO) members do not have a requirement for a prior authorization in order to see a specialist, whereas HMO populations do. Consider whether you want a community-based palliative care team to be subject to a prior authorization requirement. Prior authorizations lead to delayed services, especially for palliative care, as receiving a prior authorization often depends on a PCP's understanding of what palliative care is or what services / benefits it provides. Misinformation and lack of knowledge can even lead to blocked services, and not only delay.

The following table lists several pros and cons of removing the prior authorization requirement to receive palliative care services

Pros	Cons
Removes service access barriers, especially when PCPs are unfamiliar with palliative care or have a different definition	Goes against the standard clinical rules for HMO beneficiaries and will require a coding and system change
Allows for plan-based direct outreach to members	Increased potential for fraud, waste, and abuse
Increases patient autonomy	Increased potential for population eligibility to vary from plan
Standardizes program availability between beneficiaries, making it easier for patients and providers	

Out of Pocket Costs

Payment type alone does not change the out-of-pocket rules for beneficiaries. These rules are stated by the member's overall benefit plan and must be revised separately if a plan elects to do so. Because palliative care is considered a medical specialty, services provided by that specialty are subject to a higher, specialty-level copay. This includes services such as palliative care, paid for under alternative payment arrangements, and services such as advance care planning, paid for under fee-for-service billing. Consider removing the member responsibility (co-pay and coinsurance) for palliative care services or re-classing these services as preventative for all clinicians. Anecdotal evidence from major health systems and ACO partners in California has shown that patients and families subject to higher co-pays and coinsurance refuse service services like advance care planning and palliative care at a higher rate, which can impact both the engagement and retention for these types of services. Due to the changes to the Uniformity requirement for Medicare Advantage, Medicare Advantage plans are now able to vary co-pays and coinsurance for high-value services, or those services that improve the quality of life of health status of an individual with a chronic disease.

Actuarial Analysis

For most health plans building a community-based palliative care program, you will be making the case for a program that is new – in other words, you will not have your own claims experience to draw on when making the case to your health plan’s actuarial and finance teams.

Advocates for CBPC within a health plan need to try not only to make the case for the initial implementation of the program, but also for how to sustain the program. When making the business case, you will need to think about the return on investment in terms of net savings to the program.

Over time, consider how the program is going to fit into the year-over-year trends – return-on-investment (ROI) should be considered more broadly than just financial, including impact to quality and consumer satisfaction (and thus ROI might not be in pure savings, but rather in decreased premiums, decreased administrative overhead for case management and increased enrollment).

If you are a medical director or other clinical program manager making the business case to start a CBPC program, this tool will help you think about making your case outside of the “pure numbers.”

Key Concepts in Building the Business Case
Identify opportunities for “site of service” shifts and estimated savings (not expected savings) that will result.
What are the opportunities and challenges regarding revenue?
What are the opportunities for quality score increases?
Where are the opportunities to decrease administrative overhead within the plan?
What are the administrative costs to my health plan to run this program?

Where do I start?

A large proportion of the palliative care business case rests in the potential for reduction in utilization of high cost settings, particularly inpatient settings.

What does the actuarial team do with raw savings numbers?

The actuarial team will be presented with a business case that is not based on their claims data or experience. As a result, they will assume that the savings are not going to accumulate to the same level as “someone else’s” data. Their main questions will be:

- Does this data align with my population – is that my population?
- What is the level of confidence in the savings analysis and that we can achieve the same savings results?

And you should be prepared to answer the following regarding administrative costs:

- How many FTEs will it take to run the program on the health plan side?
- How much will it cost to change internal processes to build the program?
- Overall, what does my plan have to invest in order to get these results?

Utilizing the literature

There is no study to date that differentiates between the impact of CBPC on the total cost of care and what the health plan specific savings are – in other words, none of the papers account for the loss in revenue that a health plan might see due to a CBPC program. The questions related to administrative costs are also unfortunately missing in current palliative care literature. When you are presenting savings from the literature, you should be ready to identify this barrier and present why this program is valuable despite these missing data points.

The team will use actuarial values to discount your anticipated savings. They will not estimate that you will get a full year's worth of savings in year 1 – so neither should you.

What is the loss of revenue?

While a palliative care program may still provide overall savings to a health plan, there is no literature to date on the impact of loss of revenue on the net savings of palliative care programs.

RECOMMENDATION

Analyze your population of members with serious illness utilizing the Dartmouth Atlas methodology for high need, high cost beneficiaries in their last two years of life. Identify when people die in your claims data and perform a retrospective claims analysis; purchase the Social Security death record master file or other access to state or federal vital statistics data for an accurate accounting of those who have died; match your membership with the death data and take the methodology paper that Dartmouth Atlas published and create your own trend report on your own population.

Case Study: a large health insurance company performed this exercise and found that it had over \$90M in facility fees in the last 90 days of life – which represented a sizeable opportunity for palliative care to have an impact.

What else should I point out about the value of palliative care?

Increased value and quality

Creating a community-based palliative care program is not only creating a program that will result in savings via site of service shifts, but you are also creating a program that puts trained clinicians in the home who are experts at staging diagnosis.

Increased diagnostic accuracy

This expertise provides the opportunity to get a more accurate view of patients in their homes. This increased accuracy will not only allow for a potential increase in revenue due to more accurate risk scoring but will allow your health plan to target the right services to the right patients at the right time. By partnering with existing network providers holding expertise in staging diagnoses, this can also eliminate the need for additional parties to be contracted for an in-home assessment for those with serious illness.

Strategy integration

An accurate view of the true population being served will also allow for your program to be a part of your overall health plan strategy regarding how to be sure that appropriate products can be priced based on the severity of the population being served. If an insurance product that includes a CBPC service line is going to impact how sick the population of people in your health plan is, you want your actuarial team to know you understand that they will need to be able to discuss those trends in the context of pricing products across all lines of business. Be sure to be ready to make the case across all lines of business.

Closing the care gap

Someone at your plan is looking at which measures are still “open” on which patients, and a dollar amount is assigned to closing that care gap (look for the person (or persons) producing “care gap” reports, especially as related to HEDIS measures and the Medicare Stars program for Medicare Advantage plans). If you provide your palliative care providers with a care gap report, they will be incentivized to close those gaps. Make the case clinically for what your CBPC providers can do to close those care gaps – for example, if your CBPC providers spend time with what seem like clinically stable patients (i.e. not in immediate symptom crisis), what else are they doing to close care gaps? Are they preventing falls?

Provider Education

Educate your providers on the tools that help you sustain your business case within your health plan. This will prepare them to meet your goals and the goals of patients and families now and into the future.

Exercise: Assessing Scope

It is important to understand the characteristics of the population enrolling in your community-based palliative care services. Consider the following exercise intended to identify the potential scope of beneficiaries that may be eligible to enroll and estimate who might enroll in the future.

To estimate the scope of previously eligible individuals in the program:

- Purchase death records through state or federal vital statistics organizations or vendors in order to have a more complete record of deaths within a member population; otherwise, records may be incomplete as based solely on claims-based deaths (i.e. death in the hospital).
- Narrow down the list of members who died to those with a diagnosis associated with serious illness. Remove members with sudden events that do not coincide with a serious illness (i.e.. motor vehicle accidents, traumatic injuries)
- Run analytics around the identified patient population, including demographics, utilization, sites of service, cost, and site of death (where available) trends.

Based on this analysis, you are better poised to estimate the impact to quality and the potential savings that are achievable for your population based on the literature. Also consider using this experience to develop an algorithm to prospectively identify patients that might be eligible for the program, which may feed into your overall referral strategy.

NETWORK BUILD AND MANAGEMENT

Provider Contracting

Contracting and the associated complexity is somewhat dependent on whether you are opting to introduce your palliative care program as a pilot or as a complete program. Opting for the latter is likely to make the contracting process more significant than it would be otherwise, as program development can require more standardization and automation. When developing a new program that includes an element of payer-provider contracting it is important to have the right people involved in the contracting process from the beginning.

While there is no standard process for developing a model contract, and who needs to be involved may differ based on the structure and maturity of the plan, the following key categories of individuals are considered to be necessary participants and should be included in the ideation phase of contract development.

Who to Include	Tips and Tricks
Business Owner	Director-level and above, with approval authority
Business Driver	Pilot or program manager
Clinical Sponsor	With subject-matter expertise in palliative care or hospice
Contracting Team	Contract developers; contract negotiators
Actuarial and Analytics	For pricing development, evaluation, and reporting
Clinical Coding or Clinical Editing	For review and revision of pre- and post- payment edits applied to specific providers or facility types that would affect claims configuration; For review of codes to be included or excluded as part of the case rate payment; For review of diagnosis codes for member identification
Provider Legal and Regulatory / Compliance	Expertise in state and federal provider licensure, including hospice and home care
Product Development or Market Innovation	Gain buy-in for including the program in your product *Note: this almost needs to be done ahead of the model contract
Communication	Provider-facing and internal communications to ensure messaging is aligned and internal teams understand the services available
Project Management	Expertise in both IT configuration and business operations/multi-stakeholder facilitation and engagement

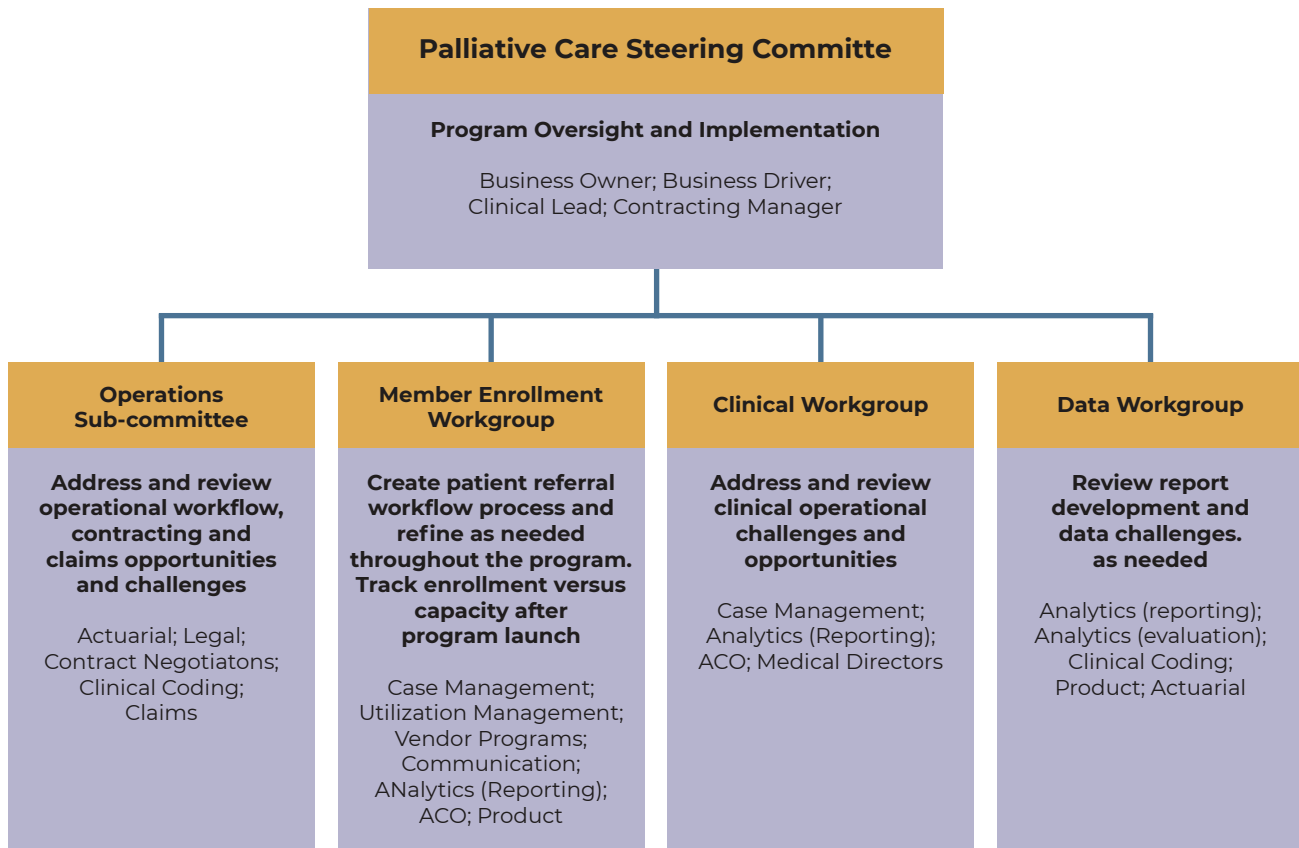
Payment contracts include several different components that should be considered early on and jointly negotiated upon, first inside of the plan and then when collaborating with provider partners. It is important to note that contracting is not simply about developing payment rates or types, but about defining who will do and not do what and protecting both sides from potential situations outside of your control. Each major component of a contract for community-based palliative care should have a subset of the group of stakeholders who will be responsible for either developing or managing that component of the agreement. In addition to the **Business Owner**, **Business Driver**, **Clinical Lead**, and the **Contracting Manager** who develops new model agreements, it is important to include other stakeholders as early as possible in the development of a pilot or program. By including the right stakeholders early, pilots and programs can have a greater chance of operational effectiveness and major revisions can be avoided later.

What's Included in a Contract

	What it is ^{viii}	Why It's Important ^{viii}	Plan Stakeholders
Eligibility, Enrollment, & Disenrollment	Terms for reporting and documenting when a patient is eligible, enrolled, and disenrolled for palliative care	• Keeps accurate record of enrolled or eligible patients • Impacts quality/cost evaluation	• Analytics (Reporting) • Analytics (Evaluation)
Program Services and Standards	What clinical and administrative services you agree to provide for the payment	• Impacts staffing ratio and scope • Often includes visit requirements	• Clinical Coding • Actuarial • Legal • Communication
Payment Model and Price	Type, method, and amount being reimbursed	• Contribution to budget for staffing, overhead • Impacts quality/cost evaluation	• Actuarial • Legal • Contract Negotiation • Product Development
Term and Termination	How long the overall contract and payment terms will be in effect	• Determines when you are evaluated or negotiate payment changes	• Analytics • Contract Negotiation
Reporting and Performance Measures	What you will need to report, per patient, or overall. Can include quality and/or administrative data	• Takes administrative time and coordination • Must be captured and reported	• Analytics • Clinical Coding
Other Provisions	Any other requirements negotiated between Payer and Provider in order to receive payment	• Can impact administrative overhead	• Analytics • Contract Negotiation • Legal

Developing a Shared Governance Structure

It's not a realistic expectation that every provider will come to the table with the same priorities, questions, or even culture. While each provider has unique strengths and weaknesses, consider the following shared governance structure for throughout the development, contracting, and pilot process.



Additional Considerations

Identify administrative resources

Managing a contract and the services rendered under it takes various administrative resources, both clinical and operational, that should be considered ahead of time. Identify what resources will be needed for data collection, how much time will be spent in contract negotiation meetings, and what additional processes will be required for patient enrollment and disenrollment. By identifying key stakeholders and their roles and responsibilities in planning and executing a pilot, you can prepare for and

anticipate potential operational challenges or responsible parties as challenges arise. Setting up a value-based payment pilot for palliative care can be a complicated process. Over-estimate the amount of time dedicated to documenting and troubleshooting operational processes. Consider partnering with your project management team or hiring a contracted resource to manage workflow and execution.

Begin with evaluation in mind

Setting up a payment contract is about more than just price. When developing a value-based payment contract with a provider, prepare ahead of time to discuss and collaborate on all components of a contract. Determine against what measures you will be evaluating effectiveness of the program (likely already agreed upon internally during the Program Goals phase) and partner with your pilot providers on the best process and outcomes measures to collect. Be prepared to discuss why these measures are feasible and meaningful during contracting discussions. Partner closely with analytics and quality teams to ensure that what matters for program effectiveness can be measured and reported, to internal and external stakeholders, with confidence. Consider beginning with a smaller population that can be easily identified and evaluated to show initial effectiveness before expanding to populations that may be more difficult to measure or where there is less evidence of your chosen intervention's effectiveness.

Partner through transparency

Contracting is not a quick process and it will take ongoing collaboration and problem-solving with provider partners to improve over time. This may not be a surprise for you or your team, but it is best to be transparent with your provider partners, who may otherwise have unrealistic expectations about the length of time the contracting process can take. During the planning phase for your pilot or program, agree on a partnership model and meeting schedule with internal and external stakeholders, including the clinical and operational leads for your provider partners. This will allow all parties to adjust expectations and improve understanding and communication even in advance of an executed contract. Ensure that this meeting cadence persists throughout the pilot period to account for troubleshooting. Communicate to internal and external stakeholders that it may take several iterations of a contract and operating model to determine the best way to work together.

Walk away if needed

Not every payer-provider relationship is going to be appropriate for your program. If the administrative burden is too great or there are other non-negotiable hard-liner items on the table, be prepared to walk away. Remember, contracting is about quality, not quantity or speed. Ensure you have the right expertise at the table, budgeting in subject matter expertise or help from outside resources as necessary.

Coverage Policy

Determining how to incorporate these services into your various lines of business will present some challenges, as it has to other plans that are implementing programs throughout the country. Some of the services themselves and the way in which they are bundled is a new construct for the health care sector. The best comparable examples are medical homes and hospice; however, the emphasis on providing and paying for care in the home is still a differentiator. There is no single reimbursable CBPC service code in Medicare fee-for-service. When serving individuals that are covered by

Medicare fee-for-service today, providers bill a patchwork of evaluation and management codes that do not permit paying for an interdisciplinary team, including social workers and chaplains, and are not typically adequate for running a home-based program that does not lead to considerable losses.

Coverage Policy Considerations

Determining where community-based palliative care fits into the initial stages of designing your program is important because it can impact:

1. How CBPC appears to members;
2. How it is financed or classified for financial reasons;
3. What, if any, changes need to be made to the benefit package;
4. Provider or vendor contracting; and
5. Which existing medical management policies may apply or need to be amended as a result of the addition of HPBC or whether any new policies need to be created.

One thing that must initially be considered for each line of business and product(s) within it is whether the program should be considered as a medical or administrative expense. Other than self-funded plans, most plans are subject to a “medical loss ratio” (MLR) which is a way to evaluate how much of an insurance company’s revenues are spent on medical expenses as compared to administrative expenses and profits. Many markets have either statutory or regulatory requirements for plans to meet an 80 to 85 percent MLR.

$$\text{MLR} = \frac{\text{Health Care Claims for Covered Benefits and Services} + \text{Quality Improvement Expenses}}{\text{Premiums - Taxes, Licensing, and Regulatory Fees}}$$

Most plans look to capture their program as medical expense (or as part of the numerator) in the calculation to help them meet any MLR requirements. Within that, the most common approaches are:

- A new, defined benefit
- An additional service under a benefit that is not palliative care specific
- As a care management program under quality improvement expenses

The approach does not need to be consistent by line of business, and it actually may be required to be different and distinct for each because different statutory and regulatory requirements for adding new benefits and services exist in some markets. In particular, there are requirements for the Medicare Advantage, Medicaid managed care, and ACA-compliant individual and small group markets that may impact your ability to add a formal benefit. This is in large part why several health plans begin their programs in the large employer commercial market where fewer requirements exist; it is easier to test out a new program. To provide an example of the benefit and service considerations, we outline the requirements for Medicare Advantage in the following section.

Additionally, plans may categorize their activities into one or more of these categories. For example, the portion of the CBPC program that includes coverable services would be included as such and any additional services, such as care management, are included as a quality improvement expense. This approach has different ramifications for various markets. Please note that in markets where there are statutory and regulatory requirements, an official legal and an accounting opinion, in some circumstances, may be required to ensure you are complying with all the necessary requirements. Performing this assessment and making these determinations has been a particular pain point for plans implementing CBPC programs.

Highlight on Medicare Advantage Coverage

Overview

The predominant payer of individuals that are most likely eligible for palliative care programs are those that are enrolled in Medicare. While many of the services that may be included in an CBPC program are covered under Medicare, some of the team members and the specific services are not explicitly covered under Medicare.

Medicare Advantage plans though may still opt to provide such programs^{ix}—there are two major ways in which plans could do so:

1. As a medical management program under the standard Medicare benefits (i.e., Part A or B—this could also be done under a supplemental benefit that is not specific to palliative care); or
2. A specific palliative care program supplemental benefit.

There are advantages and disadvantages to both approaches plans wanting to offer a palliative care program under their Medicare Advantage products will need to consider.

Benefit and Services

Medicare Advantage plans must offer Part A and Part B (42. U.S.C. §1395w-22) “original” Medicare benefits^x that are not otherwise excluded from coverage under the Medicare program (see §1862 for exclusions).^{xi} Regulation further defines benefits as those:

“Health care services that are intended to maintain or improve the health status of enrollees, for which the MA organization incurs a cost or liability under an MA plan (not solely an administrative processing cost). Benefits are submitted and approved through the annual bidding process”.^{xii}

In other words, benefits can be thought of as a collection of services.^{xiii} CMS determines coverage and payment for services within a benefit based on whether the service falls within a covered benefit category, the service is not explicitly excluded, and the item or service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury, to improve functioning of a malformed body member or is a covered preventative service.

CMS outlines their coverage determinations through several various mechanisms and Medicare Advantage plans must cover a service if:

- its coverage is consistent with general coverage guidelines included in original Medicare regulations, manuals, and instructions (unless otherwise superseded);
- it is covered by CMS’ national coverage determinations; or
- it is covered through a decision made by the local Medicare Administrative Contractors with jurisdiction in the geographic areas covered by an MA plan.

Through coverage determinations, Medicare places some limitations and/or conditions on certain services. For example, original Medicare places a limit on the number of days that a beneficiary can spend in a skilled nursing facility and under what circumstances. A Medicare Advantage plan may cover the services when the conditions are not met or extend the benefit (e.g., time in a SNF), but CMS requires those changes be considered a supplemental benefit (see next section for a further explanation of supplemental benefits). In situations where there is no coverage guidance, a plan may adopt the coverage policy of another plan in its service area or the plan can make its own coverage determinations but must provide CMS an objective evidence-based rationale for their policy.^{xiv}

While somewhat prescriptive in what can and cannot be covered CMS says, “the requirement that an MA plan provide coverage for all Medicare-covered services is not intended to dictate care delivery approaches for a particular service. MA plans may encourage enrollees to see more cost-effective provider types than would be the typical pattern in original Medicare...”

While palliative care is not an explicitly defined benefit or service, many of the services that are commonly included in a palliative care program are approved services. For example, advance care planning and physician consults. Thus, some plans have interpreted flexibility around delivery approaches to allow them to include a palliative care program in their Medicare Advantage plans. These plans “package” the applicable services together to form their program and use medical management criteria to make it available to their enrollees.

TIP: While benefits and services is an important component when determining how and what to cover under a palliative care program, it's also important to consider any Medicare Advantage requirements associated with the care team members, including any licensure limitations, care settings, and codes.

Supplemental Benefits

Supplemental benefits may provide plans with an additional or alternative opportunity to cover palliative care. Supplemental benefits must be approved by the Secretary through a plan's bid application—to gain approval a benefit must be: (1) not a Medicare Part A or B covered service; (2) primarily health related; and (3) the plan must incur a non-zero medical cost for the provision of the benefit.

Palliative care as a supplemental benefit is currently not common. To date, one of the most significant challenges with offering palliative care as a supplemental benefit is that under previous rules and regulations all supplemental benefits were required to be made available to all enrollees uniformly. Thus, if a plan offered a palliative care program as a supplemental benefit, they could not limit enrollment into the program to only those that met specified criteria. Recent updates to these regulations though would allow for flexibility in these “uniformity” requirements—beginning in 2019 plans can limit the availability of certain benefits to individuals that meet certain medically defined criteria.

While this addresses one of the major hurdles to offering palliative care as a stand-alone benefit, supplemental benefits cannot be a Part A or B covered services. Since many of the services commonly included under a palliative care programs are covered services plans will have to determine how and if they can offer such a benefit. In addition, CBPC is a higher-cost service and would need to be payable under the rebate budget for the plan, which may restrict access to the benefit to a smaller proportion of the population than would be otherwise eligible for palliative care. When creating a benefit for CBPC under Medicare Advantage, plans will need to account for both of these issues.

Building Your Provider Network

During the business case process, identify how you want to scale your program. For example, you may find you want to use a network of providers who are paid via a value-based payment. In order to accomplish this goal, it is first necessary to identify who can be part of your network of palliative care providers.

Key First Questions

- What are the standards for being a contracted palliative care provider? Is there going to be any flexibility or variation in these standards (i.e. depending on geography, line of business, etc.)?
- Where does a plan find palliative care providers?
- How does a plan assess whether providers meet its criteria for delivering care?

Why ACOs first?

In some instances, an ACO's goals may align with the implementation of your palliative care program. For example, both may be trying to engage providers to improve patient and family experience, improve quality of care, reduce total cost of care, or reduce unwanted medical services. If a palliative care program is well-integrated into the practice of medical groups and hospitals participating in an ACO arrangement with your health plan, all contracted entities as well as the patients and caregivers can benefit.^{xv}

Ideally, palliative care will fit into the various tactic areas for achieving short and long-term goals of the ACO programs. If the ACO is focused on ways to reduce inpatient hospitalization, for example, palliative care could fit into the strategy in the following ways – (1) centering the clinical strategy on care management and coordination and developing optimal care in facilities, (2) increasing home care that is focused on the elderly, frail, and seriously ill for whom travel was difficult, and (3) creating and expanding high-risk clinics that focus on providing comprehensive care to those patients with complex needs. Finally, if the development of ACO contracts is an organizational priority, your palliative care program may receive more attention and buy-in if it is helping to achieve the larger ACO goals.

Incentivizing and Utilizing the ACOs for Eligibility, Referral, and Network Development

Level	Characteristics
Level D	• Placing Advance Directives in the charts is not a routine practice • Documentation of surrogate/medical decision-maker is not usually on file • Your providers may or may not engage in advance care planning or refer to palliative care or hospice
Level C	• You consistently have advance care planning discussions and work with patients to complete their advance directives. You make them part of their chart • You document the surrogate/medical decision-maker consistently and you update the information on a regular basis
Level B	• You perform the functions of Level C above and • Your patients have access to an interdisciplinary inpatient palliative care team (with board-certified clinicians) where you can refer patients • You have a designated internal or external home health/hospice referral network and you can refer families to grief/bereavement services
Level A	• You have all the functions of Level B available and • You have an outpatient/ambulatory palliative care team. • Additionally, you track data to monitor the use and adequate availability of your palliative care, hospice and end-of-life services (data includes referrals to various services, deaths by location, use of life saving interventions, and number of patients using the services)

It may be necessary to provide incentives for ACOs to develop a palliative care program. One such incentive is to create incentives for medical groups on ACO contracts to participate in the development of a palliative care program. As a new program, the palliative care team will have to decide how to operationalize within existing processes to support the ACO program.

This challenge – of how to operationalize the palliative care program *within systems that already exist* – is an ongoing challenge for many payers as their programs grow.

Given the complexity of incorporating palliative care into the routine care patients receive at ACOs, the availability of the technological solutions and level of coordination between ACO partners and acute care facilities, some plans have taken the tactic of defining achievement levels or tiers by which their ACOs can be ranked and initiatives prioritized. These tiers include a glidepath for integrating palliative care services across the continuum and can serve as a roadmap to improving referrals to CBPC and developing shared infrastructure between plans and ACOs when operationalizing palliative care across the continuum of care an ACO would provide.

A Hands-on Approach to Capacity Assessment

Your palliative care team can take a hands-on approach to helping ACOs develop a palliative care program and network. To facilitate prioritization for your team, ask ACOs to complete a capacity assessment or environmental scan (see Appendix D) that helps assess readiness to implement the program. The capacity assessment asks about size and scope of the lives covered by the ACO. It also breaks down the ACO's current relationships and programs in order to assess their readiness for palliative care by asking about the types of providers within the ACO and referral relationships outside of the ACO's structure, including referrals to skilled nursing facilities, in-home assessment providers, home-based primary care, home health, and hospice. For example, it asks oncologists, pulmonologists, and cardiologists to assess how many patients with cancer, congestive heart failure (CHF), or congestive obstructive pulmonary disease (COPD) might be attributed to that ACO and where they may be seeking care most often. By determining the referral environment for people with serious illness, ACOs can assist in identifying the best CBPC provider for them (usually from a home health, hospice, or home-based primary care relationship) and those providers who have a high volume of seriously ill patients who may be welcome receptor sites to refer to CBPC and partner more closely with these providers.

A health insurance company's palliative care team may be less likely to engage quickly if an ACO's population does not contain a substantial subset of patients who might be eligible for palliative care. The capacity assessment can help an insurance company to prioritize which palliative care providers their ACOs are already working with for contracting evaluation.

PROGRAM OPERATIONALIZATION

Eligibility Criteria

Predicting life span is challenging and clinicians have proven to be poor predictors of mortality^{xvi}. Thus, asking clinicians to use the “surprise” question (i.e. would you be surprised if your patient died within one year?), often does not identify the right patients. The ideal eventual state is to not only to identify those individuals who have had poor outcomes and are already in significant physical decline, but to identify people at-risk for such decline and assist them in navigating the system.

In order to identify this population, there are several well-documented proxy measures that are indicators of decline: **(1) diagnosis, (2) functional limitation;** and **(3) utilization patterns.**

The identification of these measures is based on clinician feedback and a review of literature on patient identification.

The following tools were created by a specific health insurance company to identify patients as eligible for their CBPC program. The criteria are outlined below:

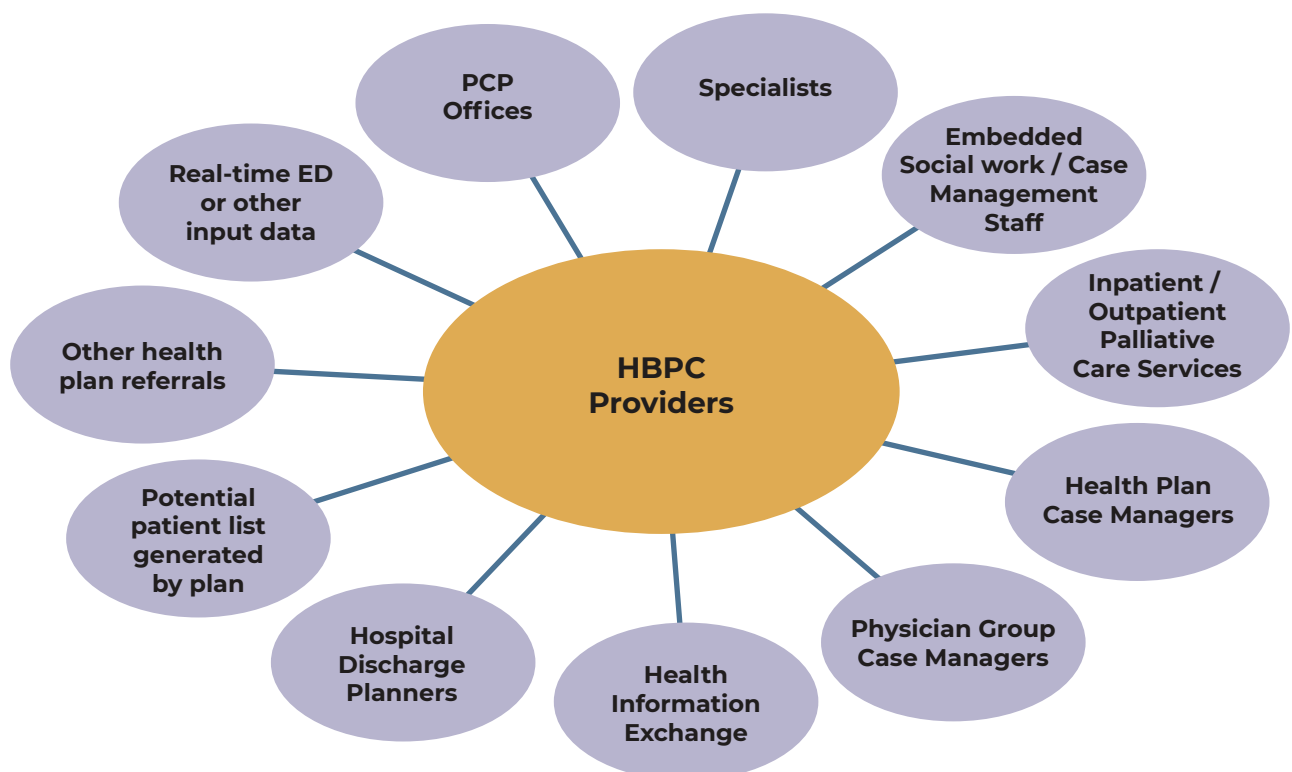
Members are deemed **“Program eligible”** when they meet the criteria outlined in this tool.

Step 1: Chart review (Patient must fulfill all criteria)	
Patient has an advanced disease/disorder/condition that is known to be life-limiting:	□ Stage 3 or 4 cancer: Locally advanced or metastatic cancer; leukemia or lymphoma □ NYHA Class 3 or 4 congestive heart failure □ Chronic obstructive pulmonary disease: Admission for COPD exacerbation, oxygen-dependent state or short of breath at rest, low body mass index or weight loss, poor functional status □ Cerebral vascular accident/stroke: Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia □ Chronic kidney disease (CKD): Signs of uremia (itching, confusion) or edema in a patient not on dialysis, patient on dialysis with poor functional status □ End-stage liver disease (ESLD): Encephalopathy refractory to medications, coagulopathy, renal dysfunction □ Severe dementia: Needs help with ADLs, changes in personality, difficulty eating, recurrent infections, recurrent falls, and/or non-ambulatory □ Other (fill in): _____
The patient meets at least one of four criteria:	□ One or more ER visits within past 12 months □ One or more hospitalizations within past 12 months □ Hospital readmission within past 30 days □ Current clinician referral prompted by: • Uncontrolled symptoms related to underlying disease (e.g., pain, shortness of breath, vomiting) AND/OR • Inadequate home, social, family support
Step 2: Nurse in-person screen (Patient must fulfill all criteria)	
The patient's PPS rating is ≤70%	Click the link to access the Palliative Performance Scale (PPS) tool nccrc.org/files/news/palliative_performance_scale_PPSv2.pdf
The patient meets at least two of six criteria:	□ Decline in function, feeding intolerance, frequent falls, or unintended decline in weight (a.k.a. FTT) □ Complex care requirements: dependent on one or more ADLs, complex home support for ventilator/antibiotics/feedings □ High-risk factors: low health literacy, medication non-adherence, a frequent no-show to outpatient appointments, cognitive impairment □ Would you be surprised if this patient died within one year? □ Patient declined hospice enrollment □ Complex goals of care: conflict among patient/family regarding GOC, patient refusing to engage in GOC/ACP activities
The patient meets ALL criteria:	□ The primary diagnosis explaining the above is NOT solely psychiatric in nature □ The patient is not currently enrolled in hospice

Referral Methods

How can a patient be referred into a community-based palliative care program?

- Self
- Caregiver/Family/Friends
- Case manager
 - Health Plan
 - Physician Group
 - Health System
 - Hospital
- Hospital discharge planner/transition coordinator
- Providers
 - Primary Care
 - Specialty
 - Embedded social workers or case managers from the CBPC in providers' offices
- Inpatient or outpatient palliative care services
- Health Information Exchange
- List of potential patients sent from plan based on claims-based algorithm
- Other plan department referrals (i.e.. pharmacy-based authorizations, surgical or pharmaceutical pre-authorizations, customer service, utilization management, SNF or inpatient rounds)
- Real time ER or other inpatient data (i.e. Admission, Discharge, and Transfer (ADT) feeds)



Decision Point: Health Plan Roles and Responsibilities

A critical decision point in implementing a palliative care program is *how actively you want to be involved in patient identification, referrals, and enrollment*. At one end of the spectrum, you can expect contracted providers to identify all the patients, whether through boots on the ground patient recruitment or through their own clinical mechanisms or algorithms. Alternatively, you as the health plan can develop or purchase an algorithm to identify patients and take on the responsibility of enrolling them or pass the list of potential patients to your contracted providers for them to enroll (a blended approach).

The following chart builds on a provider decision points tool created by the [California Health Care Foundation](#) that was based on health plans' and their provider partners' experiences more broadly throughout California implementing CBPC in the state's Medicaid program.

Delegating Roles and Responsibility			
	Health Plan	Referring Provider	Blended Approach
Overview of Role	Plan creates lists of potentially eligible patients Plan reaches out to list of patients and refers those deemed eligible to the program	Health systems can build a clinical or other trigger into an EHR for a PC referral Review patient panels to see if patients could benefit	Plan creates lists of potentially eligible patients Referring providers review based on eligibility criteria and refer to palliative care provider
Pros	Low labor Scalable Centralizes control and approval of members into program	Eligibility screening completed in advance of referral Patients more likely to follow advice of trusted referral	Most likely to be accurate and comprehensive Facilitates up-front buy-in from medical group leaders and case management staff
Cons	Low engagement rates Can be overinclusive Algorithms can be inaccurate	Under-identifies members based on provider bias Involves provider education and buy-in to program	Labor Intensive High level of buy-in from all stakeholders Dependent on both education and list generation working

Patient Identification

For health plans that opt to assist providers with identification either as an initiative you take on yourself or as part of a blended approach, one of the first steps is to determine how you are going to identify patients. One of the most common health plan approaches is through a claims-based algorithm. Algorithms, once built or purchased, require very low labor costs and are easily scalable as the program grows within a health plan; however, they are challenging develop and oftentimes are inaccurate.

Build or Buy

Several vendors on the market have created algorithms to analyze a health plan's data looking for the right patients for this intervention^{xvii}. Buying an algorithm is less resource intensive with regards to personnel, money, and time than building it from scratch. If a provider or group of providers with whom you are working is already using a certain algorithm, their familiarity with how it works and how to move forward to enrollment based on the data produced may also serve to scale the program faster.

Alternatively, if a plan chooses to build their own algorithm, it can be built based on a plan's own claims data and population. Additionally, the algorithm can be adapted to consider other programs that the plan is running. For example, the algorithm can be built to consider eligibility for other case management programs including those targeted at specific disease states like oncology. It can also be more easily adapted to the plan's own IT systems and palliative care program.

Building an Algorithm

Proactive identification of the seriously ill population is best achieved through a combination of three key variables: diagnosis, functional impairment, and past health services utilization^{xviii}. The source of this information though can vary between claims data-only and claims data in addition to other data sources. The chart below provides an overview of the different options and considerations for each. If you are going to assist with patient identification at all, a decision point is whether you choose to build or buy an algorithm to identify patients.

Overall considerations with algorithms	
Pros	Cons
• Claims-based algorithms are going to be the easiest to develop; in other words, algorithms based on past health services utilization and diagnosis data.	• Claims take time to process therefore there will a lag or delay between an indicative medical event (such as a new prescription, a hospitalization, or an ER visit) and when it shows up in the claims system to feed an algorithm. • Claims are based on the data that is input which also means it only captures information about past health care utilization or about diagnoses that have been captured. Thus, information about functional status, frailty, unrecorded or mischaracterized diagnoses, or other potential palliative indicators. • Miscoded or “dirty” claims that have to be sent back to the biller for reprocessing also impact the accuracy of a claims-based algorithm.
• Adding administrative, clinical and functional data to the algorithm improves its accuracy in identifying the population • Some states have real time emergency room data that is available through a state database. If available, this utilization data would inform an algorithm more quickly than claims data.	• This data is much harder to collect, and may not all be available to a health plan; for example, specific clinical data may only be in an EHR • Even for utilization indicators that signal functional impairment, authorizations may be shared with provider partners in risk arrangements - <i>In some value-based contracts, authorization for DME lies outside of a payer’s purview. DME can be used as an indicator of decline.^{xix}</i>

Clinical Eligibility

Consider designing an eligibility process that can be operationalized in conjunction with your referral process, allowing the utilization of clinical criteria to inform your referral process. One major component of this process is education of your referral sources about the clinical eligibility criteria and how to utilize them. For example, one referral partner might have their own internal criteria for who is eligible for palliative care services – you would work with these partners to figure out how to marry these two sets of clinical criteria. Additionally, consider working through your ACOs to determine how to add palliative care to other workflows around screening for eligibility.

Eligibility Screening and In-Person Assessments

In structuring your payment, consider electing a billable code that can be billed by your network of palliative care providers prior to triggering the case rate. The goal behind having this billable code is to allow palliative care providers to perform an initial assessment of the patient and be compensated for their time if the patient does not meet all of the Step 2 criteria for eligibility. The provider will be incentivized to perform the screening and refer the patient to the right program, whether to hospice, another program within your health plan, or to palliative care.

At this point in the process, the case manager has not closed the case on this patient – once the patient is enrolled in palliative care, case management does close the case on that member because he or she is now the responsibility of the palliative care provider's case management. Official enrollment into the program should not occur until after this in-person assessment is completed and the patient consents to care by that provider.

Screening and Referral

Internal Screening and Referral

If you choose to control the flow of patients into your program, a decision point is whether to train your own staff to perform the screening and referral or whether to hire a third-party vendor to perform these functions. Whether using your internal case managers or by using a third-party vendor, you can choose to control who is referred into the program at the health plan level. You can also choose whether enrollment occurs at the health plan level or at the CBPC program level. One consideration in choosing this approach is how you will educate and notify providers that you are offering this wraparound service to their patients, if you are doing the screening and enrollment alone rather than in partnership.

Data for screenings, for a vendor or for your own staff to use, can be drawn from your eligibility criteria, claims data (medical, pharmacy, and hospitalization), and utilization triggers. The vendor can also use triggers from other sources like a state ER database or EHR data that may trigger the need for a screen sooner than claims data can detect.

Training internal case managers and other staff

Regardless of whether you choose to have your internal staff screen lists of patients generated by an algorithm, education of internal resources is still critical in order to generate additional referrals from other plan resources, and also to create buy-in for the program inside your plan. You can utilize CAPC or other case manager training^{xx} to educate internal case managers to empower your internal case management team to understand the difference between hospice and palliative care.

The case management team will also need to distinguish among or how to layer palliative care in with other programs you may have for certain disease states, or to manage complex chronic illness (i.e., an oncology care bundled payment program). Your case managers will also need “triggers” when their own case management function turns off and the case management function at the palliative care team turns on. You can utilize these tools to train other departments within your plan on referrals to the CBPC palliative care program as well.

Training frontline customer service staff is critical so that self-referrals can be appropriately processed. Additionally, training pharmacy staff and those who process authorizations for procedures may be helpful so they can spot high utilizers who may benefit from screening and referral or those with initial diagnosis of a serious illness and are just being authorized for treatment or services (i.e., Chemotherapy or high-risk medications).

Utilizing a vendor to perform screening and referral

Another option for screening and referral is to hire a vendor just to do the screening and enrollment. The key consideration for plans in making this decision is the terms under which the contractor is going to be performing this screen. At times, it may be necessary to bring in an outside vendor to try to increase enrollment into your

program. However, it is imperative that your vendor is experienced with conducting screening and referral calls to patients with serious illness and can introduce palliative care services effectively. Otherwise this may end up slowing down enrollment, which contrasts with the goal of working with a vendor.

Key Considerations around Working with a Vendor
What is the vendor's experience with screening patients with a serious illness for palliative care program?
Have the outreach personnel had training in serious illness communication skills? If not, what are your opportunities to make that part of the contract?
Will the contractor work with you on a script and other materials for screening?
Will you have the opportunity to listen to some of the calls between potential enrollees and the vendor to provide feedback and perform quality improvement?

Utilizing a “Blended” approach

You may choose to build your own algorithm for palliative care patient identification and use it to create a list of potential patients. A “blended” approach then involves providing that list to your referring provider partners for review and referral to CBPC programs.

For example, when working in partnership with an accountable care organization, you can run the algorithm on the patient population for each ACO partner and send a list of potentially eligible patients to the patient's attributed primary care provider (PCP)^{xxi} for screening. The PCPs can screen the list using the “surprise question”, and then refer to the community-based palliative care program if that patient meets the “surprise question” (i.e., “would you be surprised if the patient died in the next year?” criteria for further screening.

In some instances, the “blended” approach of simply handing lists of patients to providers may not yield high enough enrollment. Some providers will refer to the program, while others will not. Thus, consider investing in other interventions to educate referral sources about palliative care so that the referral sources will understand:

1. What is palliative care? How is it different from hospice?
2. How can the program support them? How can it support patients and families?

Some additional tactics to use will be external for the referral community and CBPC providers themselves – others will be internal to your own health plan. Tactics include:

- Pay for staff that are dedicated to these programs
- Investing in training provider community referral sources
- Educational Resources
- Train health plan staff

These are each described in more detail in the following sections.

External Screening and Referral

For some CBPC programs, utilizing the internal or blended referral approach may not be desired or feasible. However, opting for an external approach may come with a certain level of anxiety or feel like a relinquishing of control over the process. In order to ensure success, there are certain tactics you can use when working with external screening and referral sources. Outlined below are the potential interventions, considerations for the business case, and some key takeaways to help you evaluate if utilizing the external approach makes sense for your program.

Invest in Specific Palliative Care Personnel

This tactic is aimed at groups that have a high level of readiness to engage in implementing or engaging with a CBPC program. You can choose to fund very specific personnel – for example, funding a palliative care nurse practitioner position that is permanently in a health system to help with referrals and program management.

Alternatively, you could choose to embed palliative care resources in the leadership teams at independent physician associations or ACOs. If you have risk-based contracts with these types of entities, funding personnel to build and manage a palliative care program as well as to manage referrals at the practice level may be mutually beneficial. It can also be a mechanism to respond to an ask for more reimbursement – providing personnel support for a defined period of time can be a way of paying for startup costs.

Implementing this strategy is expensive (involves paying for staff) and requires a high level of trust between you and the partner you choose to fund since you as the plan will likely not be supervising the position(s) you are funding. If you are counting personnel in your “startup” costs in business planning, it is a decision point of how long before that investment must show a return (or what type of return it has to show). It is also not practical to scale across a large program so you will have to be thoughtful where you invest in personnel.

In-Person Serious Illness Communication Training

Another decision point is whether to fund providers in your community to improve their serious illness communication skills. One such tactic is to fund courses on serious illness communication as an overall investment in the quality of care in your communities. Ideally, it is expected that the training will result in increased referrals into the community-based palliative care program since providers who understand what palliative care is and how to have conversations about serious illness diagnoses are more likely to make appropriate referrals to the CBPC program.

Once again, you will need to make an assessment as to which groups of providers or entities in your community might make sense to fund for this type of training. It can be cost prohibitive for the providers or an ACO leadership team to undertake it on their own accord – a sample cost can be upward of \$500 per course per physician. Consider partnering with a foundation to fund this training. If you have risk-based contractual arrangements, the potential for referrals may be enhanced because the providers should, at a minimum, share in the upside of palliative care – achievement of mutual goals around quality care provision and potential financial savings as a result of that increased quality.

Additionally, you will want to consider what types of providers you target – such as providers who are not already hospice and palliative medicine certified and who may have a high volume of potential palliative care eligible patients. Examples include primary care doctors, hospitalists, oncologists, nephrologists, pulmonologists, and cardiologists.

Some things to consider about this approach are that it is high touch, expensive, and the providers must be motivated to participate since it is in-person and a large time commitment.

Online Serious Illness Communication Training

Paying for membership to the Center to Advance Palliative Care (CAPC) or other training modules and resources is another option to consider. This tactic may be beneficial because it could allow you to reach providers who do not have time to receive in-person training or who do not receive funding (and do not have other sources of funding) to receive in-person serious illness communication training (if in-person training is offered). Online training is also accessible by and targeted to a wider variety of providers and support staff. For example, administrative staff in a provider office can take appropriate modules and be able to help with patient identification and referrals. It is also more scalable; if you have limited dollars to give to an ACO leadership team to help them incentivize participation in the CBPC program, the leadership team can disseminate online training to their many attributed providers as opposed to having to choose a few to attend an in-person training. It is also more repeatable – people can take the trainings multiple times to master these skills.

Despite its many benefits, paying for membership on a large scale can still be expensive and is potentially less effective than in-person training where motivation is higher and there is dedicated attention to the topic.

Summary of Decisions for Screening and Referral

- Do you want to be involved in patient identification?
- Do you want to build or buy an algorithm?
- If you build an algorithm, what data sources will you include?
- How will you incorporate partners who may have data sources you need (i.e. referral sources)?
- Will you provide lists of potentially eligible patients? To whom?
- If you choose to completely control enrollment into your program, how will you work to notify the treating providers that the patient is enrolled?
- What role does case management play in your referral process?
- Will you train your own internal case managers?
- How will your case management interact with the case managers at your palliative care partners? At other provider partners?
- Are you going to use external referral sources? Which? Are you going to provide funding to support training of any of those sources?

Enrollment Processes

Regardless of how the patient ends up enrolled in the palliative care program, you will have to work with your partners to determine how to move the enrolled patient through both your enrollment systems and through the provider (both referring and palliative care) workflow to ensure smooth service. The thread that underlies everything about enrollment is data sharing – how do all of the parties involved in caring for a seriously ill patient inform one another that the patient is enrolled in palliative care so that other inputs to that patient’s care can be activated or deactivated as appropriate?

Enrollment Alerts: How does a palliative care provider let the plan know that a patient is enrolled, especially when a program is small or relatively new?

One option is to utilize a manual system for providers to let them know that a patient has enrolled in the palliative care program. The goal here is to automate the process, but there may be barriers to doing so, mostly revolving around how to get various technical systems to talk to one another. For example, the palliative care provider emails your palliative care team to be put on the palliative care registry. From this registry, you will be able to “tell” all your systems that need to be involved with that patient. The goal is for the patient to be enrolled and tagged automatically by using patients for whom the claim code has been billed as a “tag” to indicate a palliative care patient. This patient will have different authorizations involved for the palliative care program that have to be shared across the company.

Data Sharing: How will you share data between your program and participating providers?

When moving palliative care from a pilot to a program, consider forming a data sharing workgroup with participating program sites (i.e. an ACO) and your internal program personnel. During the pilot, the participating palliative care provider and the participating ACO can form an affiliation agreement and thus work out details around privacy and data sharing. When moving from a pilot or otherwise scaling your program, you will need to work through what data sharing arrangements must be made between referring providers.

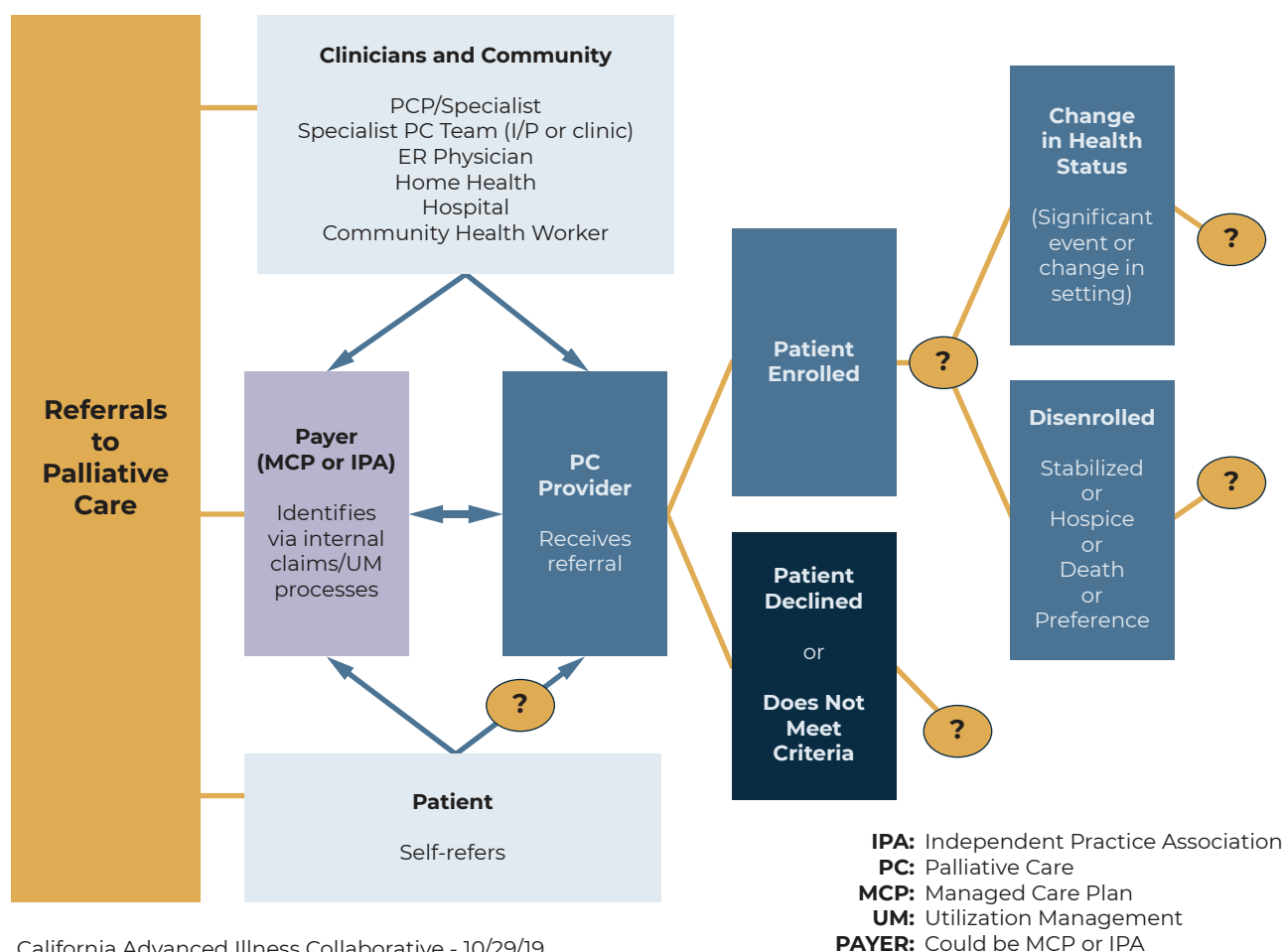
Other Considerations	
Communication	Who else must be alerted that the patient is enrolled (PCP? Case Manager?)
Enrollment Workflow	How does the enrollment workflow look? How do you incorporate the palliative care referral process for your plan into referring providers’ systems and the palliative care providers’ workflows? How can this be accomplished most simply?
Stopping Referrals	When does the plan “let go” of the patient and stop referring to other programs?
Other Program Interactions	How does a patient’s enrollment in palliative care impact other interactions within the health plan?
Disenrollment	What is the disenrollment process including all necessary notifications to ensure a warm handoff?

Referral Workflow^{xxii}

In October 2019, the California Advanced Illness Collaborative (CAIC) produced the following referral workflow and guidance to demonstrate the myriad ways in which referrals to palliative care can work. This is intentionally high-level, as to provide an overall understanding of the processes while leaving room for variation depending on individual programs, health systems, etc.

Referrals occur in one of three ways: via **(1) clinicians and community**, **(2) payers**, or **(3) patients**. The first bucket, clinicians and community can refer to several sources including primary care providers, emergency room physicians, or community health workers. Payer referrals are generated internally through claims or other utilization management processes and occur through either a managed care plan (i.e. PPO, HMO, or POS) or an independent practice association (IPA). The final bucket, patient, occurs through patient self-referral.

All three of these referral sources are then routed to a palliative care provider, where they are screened for program eligibility and appropriateness. At this point, depending on the provider's decision, the patient is either enrolled in the program or denied based on not meeting eligibility criteria. The patient may also choose to decline enrollment into the program, when offered.



California Advanced Illness Collaborative - 10/29/19

Barriers to Provider-Based Referral^{xxiii}

While referrals from clinicians and the community are one of three sources mentioned above, they are arguably the most important. Providers have face-to-face interactions with patients and longitudinal relationships that provide a considerably more holistic purview of a patient's needs than what can be gleaned through more impersonal routes, such as claims. However, referrals are often a pain-point for both providers and payers. Despite expectations that referrals will simply flow in once a palliative care program is established, this is often not the case. What discourages providers from referring to palliative care? The following list of issues, also produced by the CAIC, offers some considerations on why providers are not referring patients to palliative care.

Misunderstanding

Providers do not understand what palliative care is, or confuse it with hospice

Lack of Time

Providers are too busy; forget to refer; do not have time for extended serious illness conversations with patients; do not have time to learn about new programs

Communication Barriers

Providers are difficult to get in touch with and may not read emails, newsletters, etc.

Incomplete Knowledge of Patient

Providers may not know a patient well enough, or feel they have too little knowledge of a patient and their history, to feel comfortable making a referral

Overattachment

Providers become attached to patients and do not want to relinquish care

Incomplete Knowledge of Program

Providers may be unfamiliar with a specific palliative care program or organization, and are not comfortable referring patients to it

Frustration with Eligibility

Providers may become frustrated when only certain patients qualify for the program, and therefore stop making referrals altogether

Not Beneficial to Providers

Providers may not understand the benefit to themselves of referring a patient to palliative care, and may perceive an increased workload if they do

Negative Financial Impact

Providers may perceive a negative financial impact if referring a patient to palliative care, especially when there are not fiscal incentives for referring

Unaware of Quality Benefits

Providers may be unaware of the potential benefits of palliative care for patients, or have had a previous negative experience

Taking a Closer Look at DME and Pharmacy

Palliative care patients are going to use more durable medical equipment (DME) and have specific pharmacy needs, and lack of responsiveness or timely delivery will impact satisfaction. The following bullet points highlight key questions to ask during this process.

- Are you going to use a preferred vendor?
- Is there going to be a preferred person at the plan to oversee pharmacy authorizations?
- Are you or do your existing contracts delegate some/all authorization authority?
- When do you provide your palliative care providers with incentive to provide a broader list of preferred providers for DME or pharmacy?
- Are you going to amend the performance guarantees related to palliative care in vendor (i.e. DME or pharmacy) contracts?

Durable Medical Equipment

Unlike the pharmacy benefit, the authorization authority for DME often varies by contract. Working with your physician group partners to create a standard DME process for palliative care is beneficial in order to minimize barriers to access for patients. For example, all parties (health plan, palliative care providers, and the physician group partners) can work together to identify which items are “very urgent” vs. “urgent” authorizations. For DME, if you do not have a preferred provider, consider amending the contract with that vendor to include performance guarantees related to palliative care.

Pharmacy

Though it varies, your plan may have responsibility for pharmacy authorizations. If so, it is a useful step to identify where the needs of palliative care patients are colliding with the built-in processes of your internal pharmacy processes, especially as it relates to narcotics. Consider implementing the following three policy priorities for your palliative care program:

1. Timely medication approvals
2. Allowing for medically necessary exceptions to formulary and narcotic safety or opioid management policies
3. Copay waivers that provide appropriate care to palliative care patients

Define what constitutes as “timely” – this goal should align with the overall program requirements and goals (i.e. the 24/7 coverage requirement; preventing unnecessary E.D. visits). Additionally, you will need to determine which medications qualify for exceptions based on medical need vs. which medications should be automatically excepted from overlapping coverage guidelines. For example, access to opioids may need a blanket exemption for palliative care patients where there are other medications that might be eligible for an expedited authorization.

All these types of policies will have to be reviewed by legal against rules for each line of business.

It may also be necessary to align pharmacy policies against payment policies in order to make sure medication copays are waived, as outlined in the program policy. Additionally, specific procedures should be developed to ensure that night and weekend authorizations are completed in a “timely” manner. The goal here is to create procedures within the claims system, so that when a palliative care case rate code (i.e. Some payers use S0311) hits the pharmacy department’s system, that code is associated with a tag that triggers all the palliative care program-specific pharmacy workflows. Finally, consider selecting specific pharmacy technicians as experts on the palliative care program and directing all future issues to these specialists.

IT: Facilitating Payment

If implementing claims-based billing, you need to determine which code(s) to use. The payment method selected will impact the code selection process.

Billing Specifications

Effective January 1, 2014, The National Uniform Billing Committee (NUBC) approved the updated UB-04 billing specifications for the data elements and codes included on the UB-04 claim form and in the electronic HIPAA Institutional 837 Health Care Claim transaction standard. A revenue code set, 0690-0699, has been defined as “Pre-hospice/ Palliative Care Services” and is applicable for services that are provided prior to the formal election of hospice care. These services may consist of evaluation, consultation and education and support services. No specific therapy is excluded from consideration. Care may be provided in the home, hospitals, skilled nursing facilities, or nursing homes by palliative care teams, hospice organizations, or palliative care specialists.

As stated by the rules defining the code set, “unlike hospice care, palliative care may include potentially curative treatments and there is no requirement for life expectancy parameters.” Two potential revenue codes for use in this set to be paired with a community-based palliative care code are 0699, “other” revenue, or 0690, “general” revenue. A potential disadvantage of using the “general” code is that it could be used by someone or something else in the future.

In July 2016, The NUBC also approved the updated CMS-1500 billing specifications for the data elements and codes included on the CMS-1500 claim form and in the electronic HIPAA Institutional 837 Health Care Claim transaction standard. This introduced a new HCPCS code, S0311, to the Medicare Fee Schedule, to be dedicated to comprehensive management and care coordination for advanced illness, per calendar month. While this code is considered “status: ineligible” and are not set to pay through Medicare Fee-for-Service, they are available for use by commercial health plans seeking to pilot community-based palliative care payment through claims.

Utilize CMS Codes

While there has been little uptake on the utilization of either the revenue code set or the HCPCS code dedicated to palliative care, The Centers for Medicare and Medicaid Services (CMS) strongly advise utilization of these codes for claims configuration to improve evaluation and tracking of reimbursement for these services. Because they are not set to pay for Medicare Fee-for-Service, providers you are looking to contract with may not have them added to their code set for billing. Collaborate with your contracted providers to determine what they would need to do to utilize these codes prior to patient enrollment.

Considerations for Code Selection
Ensure that the code you're selecting and potentially including in provider contracts is not reserved for something else or being used for another pilot within the plan
Make sure that the selected code is included in risk adjustment for all necessary programs
Confirm that the selected code is currently built into the health plan's claims system
Ensure that the provider's claims system can bill for the selected code and that the palliative care providers are licensed to bill for the code in the state in which the program is being developed

Checklist on Coding Issues

- Have you chosen an unused revenue code and an unused HCPCS code to assign your palliative care program?
- Are these codes configured in all your IT systems?
- Are these codes loaded correctly into the electronic data interchange (EDI)?
- Is your chosen revenue code (as part of a code set) loaded into your contracted providers' EMR so that they can bill electronically?
- Is the revenue code reserved by the National Uniform Billing Committee? Make sure to use an unreserved code so that electronic billing can work.
- If you choose to do a pilot, are you using the same codes for the pilot and when you scale the program?
- Have you aligned necessary revenue and HCPCS codes with requirements for different provider claims forms (e.g. CMS-1500 claims form does not require a revenue code, UB-04 claims form do)?
- Have you aligned the underlying line of service contract with the provider type billing for the program?
- Have you accounted for differences in risk arrangements and other contractual variations across lines of business?
- Do your codes qualify for risk adjustment? If not, how will you structure your payment?
- Do other regulatory limitations on your contracted providers interfere with claims processing?
- Have you decided which codes will be billed in the case rate, and which will be billed outside?

Additional Considerations

Incentivizing advance care planning

To incentivize the use of advanced care planning codes, consider keeping these outside of the case rate so they can be billed as needed throughout the beneficiary's use of your palliative care services.

APPENDIX A

Measurement Criteria

CAPC Recommended Quality Measures

As health plans, policymakers, and other stakeholders develop interventions to improve health care delivery for people with serious illness, quality measures can incentivize providers to improve care and evaluate impact. This document provides recommended quality measures for a palliative care or serious illness initiative, along with high-level implementation considerations.

Category	Type	Quality Measure/Measurement Area	Related NQF #	Considerations
Access	Structure	Availability of interdisciplinary team, with 24/7 clinical response (yes/no). ⁱ Team members should also demonstrate appropriate competencies.		Demonstrates availability of qualified teams. Can be collected through attestation (with audit as needed) or through programmatic certification
Access	Process	Racial/ethnic composition: comparison of a program's patient mix to the broader population it serves (e.g., hospital, county, ACO or plan population, etc.)		Opportunity to evaluate for any racial/ethnic disparities. This can be calculated via claims when race/ethnicity data available
Satisfaction	Patient Reported Outcome	Patient survey on how true: "I felt heard and understood by this provider and team"	pending	Patient experience measure. The American Academy of Hospice and Palliative Care is the measure steward
Satisfaction	Patient Reported Outcome	Likelihood to recommend the services or program (i.e., Net Promoter Score)		Patient derived measure. Ensure consistent survey language to enable aggregation of the data
Clinical Quality	Process	Proportion of patients who have a surrogate decision-maker documented in the medical record, or documentation that patient did not wish/was unable	#0326	NQF endorsed measure also includes "advance care plan" and is only validated for patients 65+ Providers can report

Category	Type	Quality Measure/Measurement Area	Related NQF #	Considerations
Clinical Quality	Patient Reported Outcome	Patient survey (yes/no): "In the last six months, did you get as much help as you wanted for your pain from this provider and team?"	pending	Patient experience measure. The American Academy of Hospice and Palliative Care is the measure steward

Clinical Quality	Process	Proportion of patients with documented symptom assessment completed	#1634 #1637 #0420	NQF endorsed quality measures for pain screening or assessment and pain plan of care) but not yet for other or combined symptoms. Providers can report
Clinical Quality	Process	Proportion of patients with functional and/or cognitive assessment completed	#2631 #2872e	NQF endorsed measures are for specific settings or types of assessments only, but consider application more broadly. Providers can report
Clinical Quality	Process	Proportion of patients with their caregiver burden formally assessed		Not yet commonly collected Zarit Burden Interview is an evidence-based tool that may be useful. Providers can report.
Utilization	Outcome	Rates of “avoidable” hospitalization; risk- adjusted as appropriate		Can be pulled from claims data. NCQA HEDIS ‘hospitalization for potentially preventable complications’ specifications can provide useful guidance

Category	Type	Quality Measure/Measurement Area	Related NQF #	Considerations
Utilization	Process	Appropriate hospice utilization (e.g., hospice referral rate, or hospice length of stay (LOS) for those referred, or proportion of patients with a hospice LOS less than seven days or more than 180 days)		Hospice length of stay can be pulled from claims data

ⁱ Home-based Care Program Credentialing Recommendations; retrieved from <https://www.capc.org/defining-and-measuring-quality/> (<https://www.capc.org/documents/download/946/>)

APPENDIX B

Sample Job Descriptions

Director, Palliative Care

Primary Job Purpose

The Director, Palliative Care leads the development and ongoing execution of all initiatives and programs supporting palliative and end-of-life care. The position collaborates cross-functionally with Network Management and Contracting, Government Affairs, Case Management, Strategic Communications, Wellness, and Product Development to design systems and programs that deliver person-focused palliative care across all provider settings and lines of business. The role will build relationships with internal and external entities and will be responsible for creating and implementing tactics to optimize partnerships between Regence and employer groups, provider groups, and community organizations. Responsible for driving tactical execution of the Palliative Care strategy and program implementation to ensure work stays on track, quality results are achieved, and the program continually evolves to become a comprehensive, best-in-class program.

Minimum Requirements

Competencies and Knowledge:

Demonstrated ability to lead high performing teams, manage managers, and direct vendors.

Strong communication and facilitation skills with all levels of the organization, including the ability to resolve issues and build consensus among groups of diverse stakeholders.

General business acumen including understanding of market dynamics, financial/budget management, data analysis and decision making.

Experience in performance-based healthcare payment models, health plan operations and/or healthcare provider operations. Specific experience with palliative care required.

Proven self-starter with a consistent ability to follow through on commitments.

Demonstrated analytical ability, able to 'think outside the box, and able to move abstract concepts to concrete actions and effective strategies.

Experience in new product/service development, especially in healthcare and/or with a significant information technology complement.

Demonstrated broad knowledge of product development, management principles, strategic and operational planning, project implementation and performance monitoring, and financial analysis.

Strong verbal and written communication skills including ability to resolve issues and build consensus among groups of diverse stakeholders.

Demonstrated understanding of program evaluation concepts and methodologies, with expertise in program effectiveness analysis, measurement, and reporting. Proven ability to use both qualitative and quantitative data to drive results and implement change.

Demonstrated ability to meet the expectations and requirements of internal and external customers; establish and maintain effective relationships with customers and gain their trust and respect.

Demonstrated leadership skills in both direct and matrixed reporting relationships, with a proven ability to select, delegate, coordinate and motivate staff, and to evaluate and improve individual and team effectiveness.

Results orientation with demonstrated ability to plan, organize, budget, prioritize and execute work within scope, time, resource and budget constraints.

Normally to be proficient in the competencies listed above:

Director, Palliative Care would have a bachelor's degree or higher in business management or healthcare administration or related field, 7 years of experience in healthcare and 5 years of supervisory experience or equivalent combination of education and experience. Experience in payor side healthcare is strongly preferred.

Required Licenses, Certifications, Registration, Etc.

General Functions and Outcomes

Works closely with Medical Directors, VPs, Core Team, and Workstream Committees to clarify program goals and create operational plans to continuously improve our Advanced Illness Program and services.

Provides day-to-day leadership of direct reports and cross-functional project teams comprised of business, communications, technology and vendor/consulting resources. Works collaboratively with teams to plan, design, develop, implement, and manage the work.

Serves as a subject matter expert on trends, best practice, competitive intelligence, and effectiveness regarding advanced illness care management, communications, provider services and reimbursement, product design, federal and state policy, and evaluation and performance metrics.

Represents program goals and initiatives with various audiences. Cultivates and maintains relationships with key internal and external stakeholders.

Develops and oversees monitoring and reporting procedures to ensure deliverables are on track. Communicates program status and areas of risk or opportunity.

Ensures there is an effective process for decision making related to program initiatives, translates directions into action and partners with business operation units, information technology staff, and organizational change specialists to lead related organizational change.

Handles all management level responsibilities for direct staff, including performance reviews, employee development, hiring, coaching, counseling, and retention.

Provides leadership in developing, implementing, and communicating short and long-range plans, goals, and objectives for the function. Aligns team goals with the organization's vision and strategy.

Manages the organization by ensuring clear performance expectations along with appropriate skills sets.

Fosters an effective work environment and ensures employees receive recognition, feedback and development. Participates in organizational talent management and succession planning.

FTE's Supervised

5-8

Job Specific Competencies

Decision Quality: Makes good decisions (without considering how much time it takes) based upon a mixture of analysis, wisdom, experience, and judgment; most of his/her solutions and suggestions turn out to be correct and accurate when judged over time; sought out by others for advice and solutions.

Directing Others: Is good at establishing clear directions; sets stretching objectives; distributes the workload appropriately; lays out work in a well-planned and organized manner; maintains two-way dialogue with others on work and results; brings out the best in people; is a clear communicator.

Planning: Accurately scopes out length and difficulty of tasks and projects; sets objectives and goals; breaks down work into the process steps; develops schedules and task/people assignments; anticipates and adjusts for problems and roadblocks; measures performance against goals; evaluates results.

Political Savvy: Can maneuver through complex political situations effectively and quietly; is sensitive to how people and organizations function; anticipates where the land mines are and plans his/her approach accordingly views corporate politics as a necessary part of organizational life and works to adjust to that reality; is a maze-bright person.

Presentational Skills: Is effective in a variety of formal presentation settings; one-on-one, small and large groups, with peers, direct reports, and bosses; is effective both inside and outside the organization, on both cool data and hot and controversial topics; commands attention and can manage group process during the presentation; can change tactics midstream when something isn't working.

Priority Setting: Spends his/her time and the time of others on what's important; quickly zeros in on the critical few and puts the trivial many aside; can quickly sense what will help or hinder accomplishing a goal; eliminates roadblocks; creates focus.

Process Management: Good at figuring out the processes necessary to get things done; knows how to organize people and activities; understands how to separate and combine tasks into efficient work flow; knows what to measure and how to measure it; can see opportunities for synergy and integration where others can't; can simplify complex processes; gets more out of fewer resources.

All Employee Core Competencies

Customer Focus: Is dedicated to meeting the expectations and requirements of internal and external customers; gets first-hand information and uses it for improvements in products and services; acts with customers in mind; establishes and maintains effective relationships with customers and gains their trust and respect.

Integrity and Trust: Is widely trusted; is seen as a direct, truthful individual; can present the unvarnished truth in an appropriate and helpful manner; keeps confidences; admits mistakes; doesn't misrepresent him/herself for personal gain.

Drive for Results: Can be counted on to exceed goals successfully; is constantly and consistently one of the top performers; very bottom-line oriented; steadfastly pushes self and others for results.

Problem Solving: Uses rigorous logic and methods to solve difficult problems with effective solutions; probes all fruitful sources for answers; can see hidden problems; is excellent at honest analysis; looks beyond the obvious and doesn't stop at the first answers.

Learning on the Fly: Learns quickly when facing new problems; a relentless and versatile learner; open to change; analyzes both successes and failures for clues to improvement; experiments and will try anything to find solutions; enjoys the challenge of unfamiliar tasks; quickly grasps the essence and underlying structure of anything.

Peer Relationships: Can quickly find common ground and solve problems for the good of all; can represent his/her own interests and yet be fair to other groups; can solve problems with peers with a minimum of noise; is seen as a team player and is cooperative; easily gains trust and support from peers; encourages collaboration; can be candid with peers.

Palliative Care Clinical Program Manager

Job Description

In a results-oriented environment, the clinical program manager will execute data improvement efforts, incentive strategies and new improvement tactics to bring additional value to our Accountable Care Organization (ACO) partnerships. To do this, the Clinical Program Manager is expected to coordinate with internal, cross-functional matrix teams, as well as with clinical leadership and staff in provider organizations. The Clinical Program Manager will be responsible for participating in project teams and working with external vendors, assigning and monitoring work of team members and providing guidance and leadership to ensure timely execution of deliverables. This position may include limited accountability for managing budgets.

In partnership with the ACO team, the Clinical Program Manager will also be accountable for building strong, collaborative relationships with targeted provider organizations. The Clinical Program Manager is responsible for developing and managing communications about the health plan's palliative care initiatives, through the development of internal and external proposals and presentations, palliative care contracts, implementation guides and other adhoc assignments. Additionally, this position organizes interdepartmental activities and has some operational responsibilities.

Scope & Responsibilities:

- Responsible for planning, execution and evaluation of large and complex program initiatives to improve access to palliative care while improving quality and reducing utilization, across all lines of business.
- Develops and monitors measurement strategies for large change and improvement initiatives, including research projects.
- Manages program(s) from initiation/pilot phase through delivery/spread and monitors for continuous improvement.
- As part of a broader palliative care and ACO team, advances the goals of the business unit, strategies and objectives.
- Becomes an expert in company palliative care initiatives, as well as the products, functions, marketing and/or service policies and procedures that support those initiatives.
- Serves as a palliative care expert with internal constituents to drive successful improvement initiatives for all membership.
- Educates and works with external partners and participating practices as needed to identify innovation opportunities in palliative care and adopt improvement actions.
- Exercises independent judgment in developing methods, techniques and evaluation criterion for obtaining results.
- May assist in the planning and direction of budgets.
- May act as the business unit liaison to corporate initiatives and projects.

Nature of Supervision:

- Provides guidance and leadership to and may supervise project consultants.
- Ensures various team members provide high quality and cost-effective services.
- Demonstrates ability to work with and influence team members functioning in a matrix environment.
- Demonstrates thought leadership, excellent project management skills, knowledge and experience with program evaluation and consulting skills.

The Clinical Program Manager, Palliative Care is responsible for the development and execution of targeted, palliative care initiatives in support of the HMO, PPO, and Medicare lines of business. This includes the design and development of contract language, standard operating procedures, process workflows, and implementation guides. The clinical program manager also has accountability for aligning palliative care initiatives with other aspects of the palliative care program and for ensuring that current and future palliative care programs align with long-term organizational strategies.

Qualifications

Registered Nurse (RN, LVN, BSN), PA or Master's degree (MPH, MHA, MSW) preferred; or equivalent experience.

- At least 5 years of experience or equivalent combination of experience and education.
- At least 5 years of healthcare experience in population health management, palliative care, or hospice.
- Experience with quality improvement/process improvement techniques required.
- Knowledge of quality measurement and Medicare STAR Program desired.
- Previous project/program management experience required.
- Experience in the CA delegated model or with highly integrated clinical delivery systems preferred.
- High Integrity/Ethics/Trust.
- Strong ability to drive for results.
- Strong facilitator with demonstrated excellence in driving multi-disciplinary and cross-functional teams to consensus.
- Demonstrated ability to influence in a healthcare environment.
- Seasoned Critical Thinking.
- Ability to manage large, complex projects.
- Communication – the ability to summarize complex information succinctly, using QI methodology as a guide.
- Experienced in Change Management Processes, including Improvements and Redesign.
- Skilled at facilitating and growing Collaboration and Motivation amongst geographically disperse teams.
- Strong Interpersonal Skills and demonstrated ability to build relationships in fast-paced environments Financial/Quantitative Acumen.

APPENDIX C

Cost Savings and Assumptions for Palliative Care Services

Paper	Participants	Enrollment in palliative care	Data years	Conditions	Methods & Analyses	Cost avoidance findings	Hospice outcomes
Brumley JAGS 2007	HMO. 145 in treatment arm, 152 controls. Avg 74 years old. Target disease + <12 months prognosis + ER/hospital in past year + PPS<=70%. Usual care = home health when applic.	Mean 6.5 months	2002-2004	CHF, COPD, cancer as primary disease.	RCT. Analyses controlled for differential time alive/in study (control patients lived longer).	Overall costs 33% lower. \$12,670 vs. \$20,222 per person. Or \$95.3 vs. \$212.8 per day. \$3,525 difference per patient per month, after program costs accounted.	No difference in hospice rate (25% treatment, 36% usual care).
C. Kerr JPM 2014 (cost). C. Kerr JPSM 2014 (other outcomes)	88% Medicare. 149 recipients (decedents) with IH as payer (in cost study; 499 in other study). 84% >65 years old.	Median 3.9 months in cost study; 3.2 in other report (cancer 11 weeks, other diseases ~16 weeks).	2010-2012	Cancer (58%), CHF, coronary artery disease, COPD, etc.	Decedent cohort, propensity score matching.	Overall costs 36% lower. \$3,908 lower PMPM across the final 3 months of life, after accounting for program costs.	70% vs 25% in usual care used hospice, and median of 34 days vs. 9 days, both p<.001.
Lustbader JPM 2016	MSSP ACO track 1. 82 recipients who died (out of 975 served), median age 91. Median Charlson 8.	Median 2 months	2014-2016	Homebound frailty, CHF, COPD, cancer (57%), dementia.	Decedent cohort, 569 usual care. Not matched per se.	Overall costs 37% lower. \$12,000 lower across final three months. Does not take program costs into account.	57% vs 37%, median LOS 34 days vs 10 days, both p<.001

Cassel JAGS 2016	Medicare Advantage. 368 recipients matched to 1,075 controls. Avg 82+ years old.	Mean 4.8 months for cancer, 7.2 months for other conditions	2008-2014	CHF, COPD, dementia, cancer	Decedent cohort, propensity matching. Dropped 76 enrolled > 18 months and 49 < 30 days. Matching and analyses stratified by disease group.	Overall costs 49% - 59% lower. \$2,700 - \$4,250 net cost savings per patient per month, after program costs accounted.	87% enrolled in hospice. Cancer: median of 15 days. Other: medians of 39-46 days.
Ruiz Innov Aging 2017 – three models. See also Ruiz Health Aff 2017 – five models.	Medicare FFS. 3,339 recipients (36% of the 9406 served who were deceased). 57% age 75+.	Mean 3.7 months	2013-2016	Mixed (HCC used to identify comparators).	Decedent cohort, county-level similarity. Excluded those enrolled < 30 days before death. Propensity matched 1:1.	Overall costs 29.4% lower in final 30 days of life. \$4,606 lower costs per patient in final three months; program costs not in patient-level analysis (aggregate program costs and savings to Medicare reported elsewhere).	More likely to be in hospice in final 2 (15.8%) or 4 (19.7%) weeks of life, both $p<.001$
Chen JPSM 2018 (cost). Chen JPM 2015 (model, other outcomes).	Medicare only. 50 recipients, mean age 87 (all 60+), home-bound. All but one had some dementia.	1-3 months	2012-2013	Homebound with dementia as well as 40% CHF, 28% COPD, 14% cancer	Comparison group = eligible but not enrolled due to lack of program capacity. Difference-in-differences approach to matched controls combining pre-post and between-group differences. Survivors and decedents.	Overall costs 68% lower.* \$18,251 lower costs per patient in year after enrollment; program delivery costs not mentioned; may not capture all home care services.	No difference in hospice rate (11% treatment, 4% controls, $p=.06$).
Yosick JPM 2019	Medicare Adv. 204 recipients, 176 of them analyzed. Mean 86.5 yo, 88% > 80 years old.	Mean 6 months	2015-2016	Cardiovascular, kidney, COPD, cancer, etc.	Met predictive criteria for over-medicalized death, but could not be reached, opted out, hospice, or dead. Propensity weighting, both survivors and decedents.	Overall costs 20% lower. \$619 lower per patient per month, program delivery costs not mentioned	19% enrolled in hospice, no data on comparison group.

CMS 2020	MCCM. 3,603 decedents (of 4,988 enrolled)	Mean 3 months for cancer, 4.4 months other	2016-2019	COPD, CHF, cancer, HIV; 6-month prognosis	Decedents. Markets, hospices and persons matched for comparison sample. Baseline and performance periods. D-in-D regression.	Overall costs 40% lower in last 30 days; 29% in last 90 days. \$5,967 net savings per decedent (25% reduction). Not as much if stayed in MCCM rather than transitioned to hospice.	Rate 20% higher, timing 1 week earlier.
Gordon Le JPM 2021	21% Commercial, 58% Medicaid, 21% Medicare Adv. 396 enrolled vs. 110 referred but not enrolled.	In this 12-month snapshot, mean 3.4 months; median 2.6.	2019	Mixed. 43% had cancer; 21% chf; 9% COPD. Etc.	Enrollees for any period of time in CY2019. Group comparisons, not matched per se.	Overall costs: Commercial 51% lower, MA 21% lower, Medicaid 25% higher. \$23,314 savings for those enrolled 1-5 months; \$26,409 for those enrolled 6-12 months, \$26,643 total (LOB combined). Did not take PC program costs into account.	26.8% of PC went into hospice, no data on comparison group or LOS in hospice.

Economic findings from home-based palliative care programs: RCT and observational studies with comparison group, taking health plan perspective on costs (total cost of care).

* Chen: for computing overall cost of care savings as percentage, took post-enrollment year for intervention group and year 2 for control group, without reference to their baseline costs.

APPENDIX D

Evidence-Based Publications

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APPENDIX E

Workforce and Capacity Assessment

Purpose

- Assemble a complete picture of partner current practices and capabilities
- Identify knowledge gaps between enterprise and Agency staff
- Identify and prioritize action items to ensure readiness for value-based contracting for home-based services

Process

Step 1: Notify partner of intent to conduct a workforce assessment, at the Enterprise and Agency levels

- Begin at enterprise level
- Inform partner that this will involve structured interviews with a clinical and administrative leader, completion and submission of an Excel template (to capture quantitative data), and may include sharing existing collateral used to describe Enterprise programs and outcomes, policy documents, etc.
- Ask Enterprise contact to broker introduction to appropriate agency-level leads who will be interviewed; include in initial communications with those individuals information about process and purpose of Workforce assessment

Step 2: Conduct semi-structured interviews

- Begin at Enterprise level
- Depending on Enterprise size, the Enterprise assessment can be completed in 1-3 meetings if it is conducted outside of other partner interactions (single agenda item meeting)
- Agency level assessments can likely be completed in 1-2 meetings
- Use below interview guide
- Current practice is to not send question topics in advance
- 2 VH staff are needed; 1 individual to ask questions and take light notes, 1 individual who is mostly silent who takes comprehensive notes
 - The two sets of notes should be combined and any discrepancies adjudicated
- At close of each interview session verify any items that the partner has agreed to forward; send email asking for items (send reminders, as needed)

Step 3: Request partner complete Excel file that asks for quantitative data

Step 4: When interviews and data submission are complete for Enterprise, create Enterprise profile that summarizes responses, and send to interviewees to validate

Step 6: Repeat steps 2-5 at Agency level

Step 5: Use validated profile to create prioritized list of action items, including training plans

Workforce Assessment Semi Structured Interview Questions

We are interested in learning about your current workforce and the structures and processes you are currently using to care for people with serious illness. The information you provide will help us understand what is in place, your strengths, and where further development may be indicated. There are no right or wrong responses. After this interview we will be following up with some data requests, and we will use that information to validate and round out the narrative information you provide today.

Today we will gather information about your entire organization (Enterprise level), and in the coming weeks we will look to conduct similar interviews with clinical and administrative leads at the Agency level.

Enterprise Name:

Names, titles, and contact information for the designated clinical and administrative leads:

Interview type: Enterprise Agency

Clinical Lead:

Administrative Lead:

Date(s) administered

Staff: Interviewer: Scribe:

ENTERPRISE OVERVIEW <i>Tell us about your Enterprise as a whole</i>	How do you describe your organization – what is your mission and core business?
	How many years have you been in operation?
	Please name your Agency Locations/Metropolitan Service Areas
	Which agencies have Medical Group (Part B) Practices or Facility Licenses?
	For Facilities, which type of license:
	Are all Agencies using a common EHR?

ITEMS TO BE FORWARDED:

VOLUME ACROSS SERVICES <i>Tell us about the number of individuals you are caring for, across all business lines, across all agency sites</i>	Home Health Average Daily Census: no centrally available data
	Home Infusion Average Daily Census:
	Hospice Average Daily Census:
	Palliative Care Average Daily Census:
	Other (Specify serious illness business line) Average Daily Census:

ITEMS TO BE FORWARDED:

GOALS PERFORMANCE AND QUALITY MEASURES <i>Tell us about your goals and the processes you use to monitor performance/quality</i>	Do you have an Enterprise-wide quality /performance measurement program?
	Are there any Pay for Performance Measures agreed upon by any value-based program? If yes, can you describe the targets?
	Performance:
	Quality:
	Do you administer any surveys at the Enterprise level that address patient or referring provider experiences/satisfaction?
	If no, are all agencies using the same survey tools?
	Do you have any dashboards or slide sets that you use to monitor quality internally or that you share with external groups?

ITEMS TO BE FORWARDED:

PALLIATIVE CARE PROGRAM OVERVIEW <i>We would like to get some more detailed information about your in-home palliative care programs</i>	Please describe your palliative care model (services, staffing model, staffing ratios, target population)
	What do you call that service?
	Did you have a specific patient population in mind when you created the PC service?
	How many locations run the model you described?
	Are there any other models being run?
	How many years have you been offering PC?
	Are there Enterprise-endorsed policies or procedures for palliative care that agency locations are expected to use?
	Tell us how the PC service was started – did you get it going and then look for partners/revenue sources or was it in response to a market need/opportunity?
	What revenue model(s) do you bill (VBC, episodic, PDGM, encounters, etc.)?
	Are any locations accredited or certified in PC?

ITEMS TO BE FORWARDED:

STAFFING ACROSS CLINICAL SERVICES <i>We would like to get a better understanding of your overall workforce. Which disciplines are you currently using, and tell me how you use them</i>	Do your agencies share staff across clinical services?
	Hospice & Palliative Medicine Physicians (MD, PA, DO):
	Non-Specialty Physicians (MD, PA, DO):
	Physicians Making Urgent Visits (MD, PA, DO):
	Nurse Practitioners/ARNP:
	Registered Nurse:
	Intake/Referral Nurse:
	Chaplain:
	Social Worker (not LCSW):
	Licensed Clinical Social Worker (LCSW)
	LVN/Home Health Aide:
	Case Manager:
	Community Health Worker:
	Pharmacist:
	Behavioral Health Interventionist/Mental Health Practitioner:
	Psychiatrist:
	Volunteer Services:
	Art, Music, or other Expressive Therapy Provider:
	Health Coach:
	Medical Assistant:
	Dietician:

ITEMS TO BE FORWARDED:

SERVICES <i>We would like more information about the clinical services agencies are offering currently, across any care model or payer type. Which are being offered, and if for only one payer or under a specific arrangement, please specify.</i> <i>Do you do provide these services directly, or do you have a downstream agreement/with a partner?</i> <i>Do you have any contracts at the Enterprise level to provide these services?</i>	Telemedicine (Audio/Audiovisual):
	Advance Care Planning:
	Individualized Care Plan Development:
	Treatment Decision Support/ Goals for Care:
	Care Coordination (Calls, Referrals, Chart Transfers, Authorizations):
	Case Management (short term):
	Case Management (longitudinal):
	24/7/365 Telephone Support for Care Coordination:
	24/7/365 Telephone Support for In-Home Visits
	Home Infusion
	Wound Care
	Skilled Nursing
	Medication Administration - Intravenous (IV)
	In Home Annual Wellness Visits
	Care Transitions (To or From Hospital, Home Health, SNF, Hospice, Home, etc.)
	Financial Counseling
	Blood/Lab Draws
	Telemedicine (Videoconferencing)
	Assessment, Recommendations, and coordination for DME, Supplies
	Medication Reconciliation and Review
	Medication Management and Dispensing
	IV Insertion
	IV Hydration
	Ordering Diagnostic Tests
	Ordering of Therapies
	Medication Administration - Non IV
	Breathing Treatments
	Palliative Care Needs Assessment (Interdisciplinary)
	Grief and Bereavement Services
	Caregiver Services and Supports
	Remote Patient Monitoring

ITEMS TO BE FORWARDED:

REFERRAL RELATIONSHIPS <i>Please describe any relationships with different types of referral sources or specialty practices and whether, to your knowledge, they are running a preferred provider or value-based program (ex. Heart failure clinic, oncology bundled payment program, ACO, PMPM for services, MCCM, SIP, pilot with private payer, etc.)</i>	High Risk Clinic:
	Hospitals:
	Health Plan Case Management:
	ACOs:
	Oncology:
	Cardiology:
	Pulmonology:
	Dialysis Centers:
	Skilled Nursing Facilities:
	Others:

ITEMS TO BE FORWARDED:

Endnotes

- i. Elrod, J., & Fortenberry, J. Jr. 2017. The hub-and-spoke organization design: an avenue for serving patients well. BMC Health Services Research. 17(1). Retrieved from <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2341-x#Tab1>.
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- iii. Center to Advance Palliative Care. 2019. Payment Primer: What to Know about Payment for Palliative Care Delivery.
- iv. California Healthcare Foundation. 2015. Five Ways to Pay: Palliative Care Payment Options for Plans and Providers. Retrieved from <https://www.chcf.org/wp-content/uploads/2017/12/PDF-FiveWaysPayPalliativeCare.pdf>.
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- vii. U.S. Department of Health and Human Services. 2019. Integrating Care Through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges. Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. Retrieved from <https://aspe.hhs.gov/system/files/pdf/261046/MMI-DSNP.pdf>.
- viii. Center to Advance Palliative Care. 2018. Payment Accelerator: What's in a Contract.
- ix. Medicare Advantage plans must cover all Part A and Part B Medicare benefits.
- x. If an item or service is classified as an original Medicare benefit, all Medicare Advantage plans must cover it if: (1) its coverage is consistent with general coverage guidelines included in original Medicare regulations, manuals, and instructions (unless otherwise superseded); (2) it is covered by CMS' national coverage determinations; or (3) it is covered through a decision made by the local Medicare Administrative Contractors with jurisdiction in the geographic areas covered by an MA plan.
- xi. Palliative care is not explicitly excluded.
- xii. 42 C.F.R. 422.2
- xiii. "Service" is never explicitly defined under the Medicare Advantage statute or regulations. But under Medicare, "service" is defined as, "medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services and use of hospital RPCH or SNF facilities" (42 CFR 400.222).
- xiv. Medicare Managed Care Manual Section 90 of Chapter 4.
- xv. In the broader palliative care literature, there is discussion of how palliative care can help all ACOs to achieve savings. See Dana Lustbader, CAPC toolkit, etc.
- xvi. Ahmad, M., Eckert, C., McKelvey, G., Zolfagar, K., Zahid, A., & Teredesai, A. (2018, April). Death versus Data Science: Predicting End of Life. In Thirty-Second AAAI Conference on Innovative Applications of Artificial Intelligence.
- xvii. We did not evaluate any specific algorithms for the purposes of this tool kit.
- xviii. Center to Advance Palliative Care, Serious Illness Strategies for Health Plans and Accountable Care Organizations, pg. 16.
- xix. Ibid
- xx. Ibid

xxi. BSC created a provider attribution model for each line of business so that every patient has an attributed “primary care provider” The attribution model is based on preponderance of visits and a provider hierarchy so the “PCP” may end up being an oncologist or cardiologist

xxii. California Advanced Illness Collaborative (CAIC). 2019. In Person Meeting #2. PowerPoint Presentation.

xxiii. California Advanced Illness Collaborative. 2019. 10 Issues That Might Discourage Providers from Referring.

NOTES

[illegible]





A serious illness can be profoundly disruptive, isolating and financially challenging, not just to patients and their families, but to their caregivers, who are often unpaid and overburdened.

Since its founding in 2010, The Coalition to Transform Advanced Care (C-TAC) has been their champion and their advocate. Representing their interests and working with legislators, decision makers, and advocates to find common ground and craft policies that deliver more comprehensive, equitable, and consistently funded care at scale.

Founded in 2010 by Bill Novelli and Tom Koutsoumpas, social change leaders and hospice benefit visionaries, C-TAC now occupies a unique space in the healthcare ecosphere. We are a nonprofit and recognized as the voice of the patient and family impacted by serious illness. We know the players and the landscape. We understand the issues. We collaborate across political parties, silos, disciplines, and disease groups.

Which earns us the ear—and trust—of everyone from industry changemakers to policy makers to families.

C-TAC is a coalition of 170 organizations that share our vision of person-centered care that meets patients' goals and honors their dignity. Together we are opening the door to a new healthcare paradigm built on greater equity, public engagement, and workforce development.

Coalition to Transform Advanced Care (C-TAC)

P.O. Box 34364 • Washington, DC 20043 • 202.930.0610 • info@thectac.org