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Strengthening Care for People with Serious Illness

Seven Steps for Building a Community-Based Palliative Care Benefit within Medicaid

People with complex or life-threatening conditions often need extra support to manage symptoms and make critical decisions about their care and quality of life. To build a continuum of care for people with serious illness, state health policymakers can support palliative care within Medicaid programs. High-quality palliative care can both improve quality of life and avoid unnecessary and often unwanted treatments for Medicaid enrollees with serious illness.

States can support palliative care in a number of ways and across a range of settings (e.g., in hospitals, embedded within enhanced primary care, via home health). Some states may want to develop a specialized community palliative care benefit that can provide comprehensive care and serve as a resource to other practices and service providers. The following steps can help guide the planning process in developing this service. Throughout each step, states can play a leadership role by engaging providers and stakeholders to inform benefit design.



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**STEP 1:****Define the Target Population**

Identifying and defining the Medicaid population eligible for palliative care services will drive service design and setting, and determine the overall cost - and potential cost avoidance - associated with the benefit. As diagnoses alone may not adequately define enrollees who could benefit from palliative care services and supports, so states may also want to consider Medicaid enrollees with other indicators of unmet need, such as functional impairment or high emergency department and hospital utilization.

STATE OPTIONS

Use data to identify diagnoses associated with high morbidity:

- High morbidity conditions including cancer, congestive heart failure, chronic obstructive pulmonary disease, and end-stage renal disease
- Children with potentially life-limiting illnesses

Use data to identify diagnoses and indicators of unmet need:

- Range of diagnoses and hospital/emergency department utilization
- Diagnoses and available program data, such as functional status recorded in health home or other chronic and long-term models and programs
- Risk assessment data via Medicaid managed care organizations

Map to existing eligibility or programmatic populations:

- Populations include individuals with serious/chronic illness identified in waivers, health homes, other chronic care models/programs

**STEP 2:****Estimate the Utilization Rate**

While hospice is typically available to people in the last six months of life, palliative care can be offered at any time and provided alongside curative treatment. Similar to hospice, however, palliative care is underutilized. [Recent data](#) show that only 5.6% of hospitalized patients receive an initial palliative care consultation, although [roughly half of hospitalizations nationwide are for those with multiple chronic conditions](#).

STATE OPTIONS:

Use hospice utilization data as proxy: Based on a percentage of the identified target population, states can use hospice utilization data as a conservative initial estimate for palliative care uptake. Later years can build on actual claims/encounter data.

Consider using known disease management engagement rates. For example, AHRQ found an [average of 13% engagement for health plan disease management programs](#), with higher rates in pilots that incorporate treating clinicians. [Successful home-based palliative care programs](#) cite an engagement rate of 35%.

For length-of-stay estimates, consider using the [CMMI Medicare Choices Model of community-based pre-hospice services, with an average length of stay of 99 days](#).

**STEP 3:
Define Staffing and Service Standards**

The [National Consensus Project's Palliative Care Guidelines](#) advise delivering palliative care through an interdisciplinary team that may include professionals such as:

- Physician
- Nurse practitioner
- Advance practice registered nurse
- Social worker
- Care manager
- Mental health professional
- Pharmacist
- Spiritual care professional

Team composition may vary according to available resources and workforce capacity, rural vs. urban areas, and hospital vs community-based settings. It is important that the prescriber have competency in pain and symptom management, which can be demonstrated through palliative care certification or completion of appropriate mid-career training.

Specific processes should also be included in provider requirements, such as comprehensive assessment and 24/7 access to clinicians with access to the medical record.

STATE OPTIONS:

To ensure evidence-based care, states can develop guidelines and training resources, support provider communities of learning, and create or leverage [existing resources](#) to encourage providers to adopt palliative care best practices.

States may consider [creating standards and programmatic requirements](#) to ensure that palliative care services conform to state Medicaid expectations.

States can also elect to identify and limit billing to specific types of providers/settings (e.g., licensed hospice providers), with quality assurance provisions and any licensing updates necessary to ensure team competencies for non-hospice care.

**STEP 4:****Develop Medicaid Payment Methodology**

States can choose to pay for palliative care services through Medicaid fee for service models, or by developing alternate payment methodologies that can provide flexible financial support for interdisciplinary teams and 24/7 care coordination, such as including services within an MCO's capitation rate.

STATE OPTIONS:

Leverage codes currently in use to enable fee-for-service billing for discrete components of palliative care team services:

- Physician Services, which include:
 - Evaluation and management
 - Advance Care Planning
 - Chronic Care Management, Complex Chronic Care Management, and Principal Care Management
 - Transitional Care Management
- Mental Health/Counseling Services
- Other rehabilitative services and supports (e.g., HCPCS codes for supportive services)

Develop a bundled fee structure (e.g., per diem, per member/per month) that incorporates staffing and service expectations.

- Consider tiering fixed payments based on levels of patient need.
- Some patients may have intense needs upon program enrollment, and stabilize with palliative care delivery. Payment models may be structured to reflect this trajectory.



STEP 5: Identify State Medicaid Authority

Palliative care is medically necessary treatment that can be financed using several different Medicaid authorities.

STATE OPTIONS:

Use or amend existing Medicaid state plan options to support discrete services:

- Physician services
- Outpatient mental health services
- Other rehabilitative services and supports
- Health Homes for individuals with chronic conditions

Include palliative care service within 1915(c) waivers to promote access to palliative care for people with complex conditions, and to enhance outcomes within home and community-based long-term care.

Develop palliative care service models via a state 1115 waiver to allow for flexible benefit design and to test new approaches to care for people with serious illness.

Consider opportunities to build palliative care into value-based purchasing strategies to align with goals such as reduced hospitalization, rebalancing long term care, improving patient satisfaction, and promoting integrated, patient-driven care.



STEP 6: Calculate Net Cost

States can forecast the cost of the benefit based on proposed reimbursement methodology and the target population, informed by expected utilization and length of stay. Policy makers may also want to factor in cost avoidance resulting from appropriate use of palliative care benefits.

STATE OPTIONS:

States may want to build in cost avoidance assumptions based on clinical research related to use of palliative care services. For instance, palliative care has been shown to result in:

- [Lower service utilization and more cost savings during the last three months of life](#)
- 37% reduction in [Intensive Care Unit](#) admissions
- An increase in [hospice length of stay](#)

Much of the cost savings associated with use of palliative care (reduced hospitalization and emergency department utilization) will be realized by the payer covering medical expenses, such as Medicare for dual eligible individuals. To better assess cost savings, states will want to segregate and analyze claims data for 1) people over age 21 with Medicaid only coverage, 2) people over age 21 with both Medicare and Medicaid coverage (dual eligible), and 3) people under age 21 (pediatrics).



STEP 7: Identify Quality Measures

Palliative care can contribute to improved outcomes on HEDIS quality measures commonly used by state Medicaid programs, such as Plan All-Cause Readmissions and Emergency Department Utilization, and on CAHPS patient experience measures. Additional measures can help states track the quality of care being delivered, and its impact on members receiving the service.

STATE OPTIONS:

Structure and process measures enable Medicaid programs to measure the adoption of key program features, and/or implementation of processes and protocols that align with best practices. [The Center to Advance Palliative Care](#) has developed a brief list of recommended measures, including structure, process, and outcome measures.

Targeted measures for patients with complex needs: As part the development of a continuum of care for people with serious illness, states can adopt measures such as [Medicaid Beneficiaries with Physical and Mental Health Integration Needs & Medicaid Beneficiaries with Complex Care Needs](#). These two measures provide states with specifications on identifying the population with complex needs, and observing programmatic impact via reductions in emergency department utilization and/or hospital admissions.

New measurement strategies:

- [Patient Directed Outcome Measure](#): Quality services and improved outcomes for people with serious illness are driven by person-centered care. In an effort to better track what matters to patients with complex care needs, NCQA has developed and is testing the Person-Directed Outcome measure (PDO), designed to elicit measurable personal goals of care, and creates a structure for tracking documentation, follow up, and achievement of goals. While applicable in a variety of care settings, the measure may be particularly useful in long term care and behavioral health systems, where person-driven planning for complex needs is a particular priority.
- Two measures, [Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood](#) and [Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain](#) are currently under development and moving through the National Quality Forum approval process.

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