2019

# Designing and Implementing
# **Home-Based**
# **Palliative Care**

## A Guide for Payers

*Compiled for the Stupski Foundation by Votive Health, Inc.*

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# INTRODUCTION AND BACKGROUND

## Blue Shield of California

In 2012, the Blue Shield of California (BSC) Palliative Care Case Management Pilot was developed. Through this, case managers realized that this population needs defined services and not just advance care planning. Implementing home-based palliative care (HBPC) became a priority for BSC[i]. The home-based palliative care initiative began strategically with the expectation and understanding that it would grow to be state-wide and within all product lines, or lines of business. To assist in initiating this program, BSC, in partnership with University of California, San Francisco (UCSF) and Hospice by the Bay, utilized planning and implementation grants from the California Health Care Foundation to implement a pilot in San Francisco in 2016.

In 2017, BSC partnered with Hill Physicians Medical Group (HPMG) and Snowline Hospice in the Sacramento area as their first palliative care pilot with an Accountable Care Organization (ACO). This pilot enabled BSC and HPMG to incorporate the HBPC model within a delegated risk arrangement and create clinical workflows that originated with primary care providers and health system case managers. HPMG is a key ally for BSC, making implementation of the model easier and more collaborative. HPMG also provides care to a significant portion of BSC's members in the Sacramento area. Concurrently, BSC began to roll-out a state-wide expansion of HBPC, the approach of which will be further informed and discussed throughout this toolkit.

## 2018 Outcomes at BSC

Blue Shield of California developed a balanced scorecard to report how their home-based palliative care program aligned with company goals and the Triple Aim in Healthcare, incorporating Utilization, Clinical Quality, and Satisfaction measures. These also included a measure showed goal-concordance, in line with the goals of members who have a completed advance health care planning document.

- ✓ Utilization of Serious Illness Management Services
    - More than 1,600 members – as well as their families and caregivers – received home-based palliative care services through Blue Shield and Blue Shield Promise Health Plans in 2018, nearly double the number in 2017.

- ✓ Patient and Family Satisfaction
  - Blue Shield’s home-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
  - Conversely, 90% of BSC 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
  - Blue Shield members referred to palliative care were more than twice as likely to utilize their hospice benefits when compared to the national average

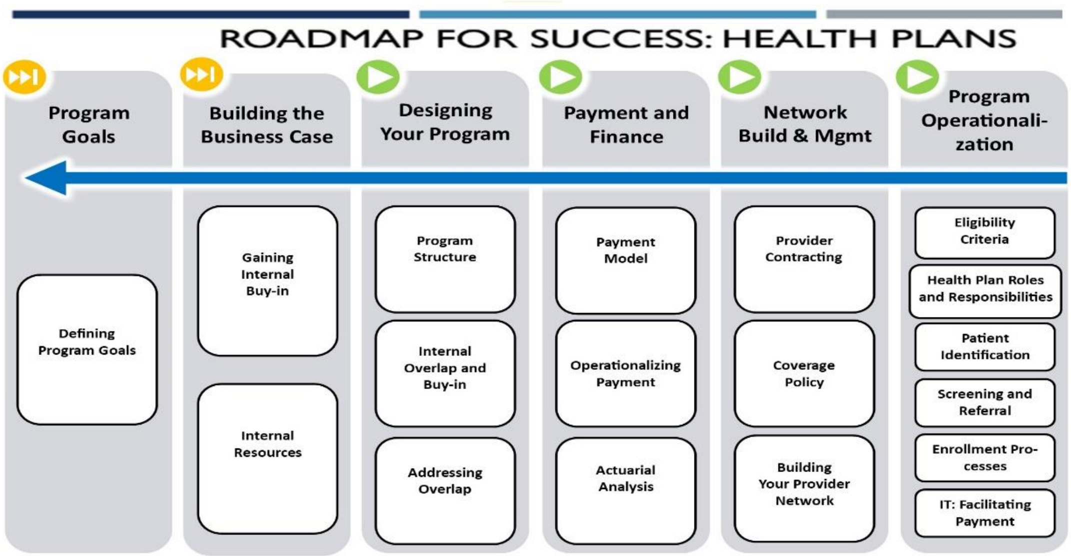
## What is the Payer Toolkit?

### *Intent*

The focus of this toolkit is on the decisions, questions, and considerations that go into designing and implementing a home-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 Blue Shield of California’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 BSC’s home-based palliative care design and implementation have been used to organize this toolkit. Insights into Blue Shield’s journey are included throughout the toolkit to provide valuable case-specific examples and illustrations.



# PART ONE: PROGRAM GOALS

## Defining Program Goals

Before developing a more detailed outline of the design for a home-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 timeframe. 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.

| 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) |

### Measurement Level: Board of Directors

Anything being reported to 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 used to seeing within other clinical programs or initiatives. For example, measuring a decrease in total cost of care is a measure plans are already tracking 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 this 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

## 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 is looking at decreasing the total cost of care, the way to achieve this is to 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 Appendix.

| 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 Home-Based Palliative Care. |

**Measurement Level: Program / Department**

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, BSC originally chose place of death as their quality measure. They ended up opting to use HEDIS / CAHPS measures instead, as these better align to the Medicare Star Rating System.

## 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?

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# 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 is being 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 to see 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 in order to ensure high quality care is being provided most efficiently and with the highest value.

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

### *Medicare Advantage Stars Rating Impacts*

Work with your MA quality team to identify and track members who may be identified as benefitting 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.

# PART TWO: BUILDING THE BUSINESS CASE

## Gaining Internal Buy-in

What are your program goals when you are contemplating offering a home-based palliative care program? How does this fit into the overall goals of your organization? To make the case for offering a home-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 for?

## 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 both essential and 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.

In order to launch a home-based palliative care program, a stakeholder at the executive level needs to be bought 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 backing of the leadership team, and that someone at the executive level 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.

The impetus for BSC to develop a business case for palliative care was that a large employer group customer (the California Public Employees' Retirement System or CalPERS) asked for a program to manage their seriously ill population. The California Public Employees' Retirement System did not define for BSC what that program should be but made it clear that their increasingly sick population needed a new intervention. This immediately gained the attention of senior leadership within the organization and made developing a palliative care solution a priority at the executive level.

### *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.

BSC had already completed their initial business case for a palliative care program when they hired their palliative care lead and the executive champion (a clinical lead) had already gained approval to develop a statewide program. Their chosen palliative care team lead, while very well-versed in palliative care clinical principles and a subject matter expert, was not a clinician. However, they did have established health plan experience, including building a palliative care program at another health plan, and a background in actuarial science.

## 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 role and find value in contributing to the program's operational goals.

**Hub and Spoke**[ii]

| 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.

Starting in 2018, the palliative care team at BSC became its own cost center, and along with a budget came its own savings targets. The team expanded (and continues to grow with program expansion) at this point in time and the "home" of the palliative care program has moved from the ACO team to the Chief Medical Officer, though it remains part of the Healthcare Quality and Affordability department.

## Case Study: Blue Shield of California

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, BSC's home-based palliative care program was folded into the ACO team and worked 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 Blue Shield and program implementation could mirror that of other ACO-based quality initiatives.

BSC's ACOs had four specific goals they were working toward over a 3-year contract period or budget cycle, and HBPC was an initiative that could drive their ACOs toward those goals. The initial focus of external buy-in efforts were ACOs. BSC utilized their palliative care resources evaluating the readiness of their ACOs for a home-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 Blue Shield's 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 their palliative care champion was not a clinician, the ACO team made sense as a starting place for developing the palliative care program in greater detail and provided access to and support by several key clinical ACO leaders.

# PART THREE: 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 utilization[iii]. 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 HBPC program

## Included Services

Selecting the types of services to be included in your HBPC 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 HBPC 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 HBPC provider practices, Blue Shield of California utilized the National Consensus Project Clinical Practice Guidelines as a basis for the "Services" section. This allowed BSC 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 in order 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 streamlining the onboarding of new providers who had already achieved this level of certification. BSC worked closely with each accrediting body to develop training workshops for new providers to understand the requirements for certification for HBPC and, in turn, for contracting with BSC.

Below is a high-level list of covered services that may be appropriate to include in your HBPC 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.

- Comprehensive in-home, palliative care needs assessment
- Development of care plan aligned with patient's goals
- Assigned nurse case manager to coordinate medical care
- Home-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 (Note, palliative care is a longitudinal service. A patient remains enrolled in the program during admission to and discharge from any facilities where he/she seeks care)

## Care Delivery

After identifying the desired standards and services for your HBPC 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 method 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 HBPC available.

### *Potential enrollee penetration rate*

The number of members that may be generally eligible for HBPC services varies by lines of business and the population covered within the product. There is likely more significant market penetration for HBPC in the Medicare population; however, it may be easier to implement a HBPC 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 HBPC 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 HBPC, 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 HBPC delivery. Without the support of these key stakeholders, and without adequate enrollment in the HBPC program, it will be difficult to meet quality or savings goals.

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## A Note about Commercial Products

Fewer people are likely to have a serious illness in commercial products, therefore offering HBPC 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 HBPC. However, from a health plan's perspective, the PPO commercial line of business is easier to implement HBPC, in particular 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 HBPC into its delegated financial arrangements (a challenge we address in the provider network) or gain approval from self-funded employers

After year one, BSC expanded their Sacramento pilot to all lines of fully insured business (i.e. Medicare Advantage, individual, and group markets) through one risk-bearing independent physician association, Hill Physicians Medical Group (HPMG). HPMG had one preferred HBPC provider, Snowline Hospice. This expansion provided them with a larger pool of eligible members, given that the geography and number of provider participants was initially small.

BSC's leadership wanted the program to be state-wide, based on a request from one of their large employer groups, CalPERS. Ultimately, BSC opted to offer HBPC in all lines of business, rather than only CalPERS, 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 BSC acts as Third Party Administrator only. This also includes the Medicaid LOB, both as a result of broader BSC initiatives and because of the implementation of SB 1004.

## Internal Overlap and Buy-in

The next phase in designing your program is to begin to better understand how HBPC 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 major lesson learned by the Blue Shield palliative care team was who in the company needed to be "bought in" to the program and in when to engage these critical departments.*

Based on the Blue Shield experience, the departments and types of personnel from said departments a palliative care champion should get buy-in and commitment from includes:

- ☐ 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. HBPC 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 HBPC 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.

### BSC Detailed Case Study: Interview Experience with the Case Management Team

The palliative care team lead found out the following points from an interview 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* The head of BSC case management had previously worked at another health plan. Its approach to serious illness care ran through the case management department so that program was the underlying frame for thinking about serious illness care within that department. As aforementioned and detailed here, a key employer account asked Blue Shield to create a serious illness program within the scope of the existing management fee – this request triggered the hiring of the palliative care team lead. This request came in response to a previously developed case management program

which had effectively failed due to low engagement, leaving case managers frustrated. It was critical for the BSC palliative care lead to find out -- Why did it fail?

2. *Serious illness conversations* Case management at BSC found that they were not able to engage patients to talk about serious illness in a productive way. There had been no or limited serious illness communication training amongst the staff; for example, all serious illness care was talked about with an end-of-life frame and POLST documents were being sent to patients in lieu of having conversations. The department mined data to try to identify appropriate patients for serious illness case management, but it was more specific than sensitive, so the result was that the targets were 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 were already being run through the department. This included what populations were being served and how they related to the definition of serious illness being adopted by the BSC palliative care program.

4. *Separation by line of business* Case management at Blue Shield also must separate the Federal Employee Program (FEP) Case Management program from all other case management services. Therefore, any new program being built within BSC that needed to utilize case management needed to abide by the rules separating FEP case management from other case management 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 came up repeatedly. It was clear that maintaining NCQA accreditation was a top priority for the department, so understanding NCQA 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 emerged for the palliative care team. The palliative care team needed to:

- ✓ 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 Blue Shield 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 HBPC 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 HBPC program.

The hypothesis based on a review of literature for BSC 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 HBPC program. The result of this analysis was four different risk arrangements for HBPC.

| 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 care 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 HBPC 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 HBPC program (i.e. it will re-open ACO contract negotiations), creating the opportunity to incentivize your partners to use HBPC. 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 HBPC utilization does not cost the ACO anything. Additionally, this strategy may be deployed temporarily to get stakeholders more comfortable with leveraging the HBPC 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:

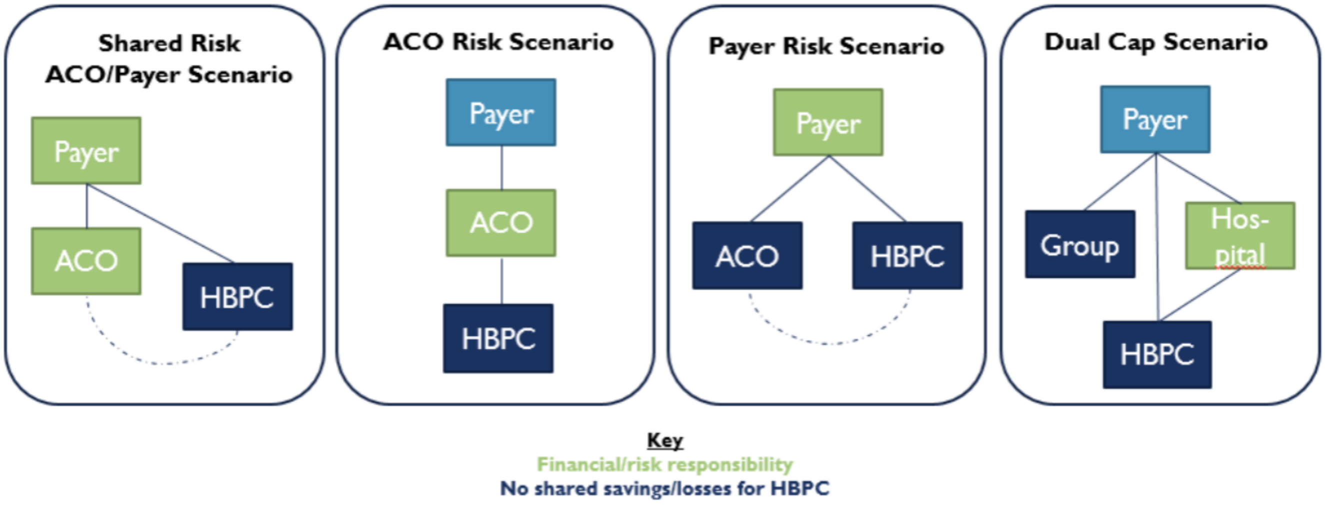
| Strategy | Training | Member Identification | Implementation Support |
|---|---|---|---|
| **Tactic** | Clinical training both in palliative care principles and in advanced care planning from reputable sources | Prospective member identification via a claims-based or clinical algorithm | Provide upfront funding to support implementation by partner ACOs. |
| **Examples** | Advance Care Planning design support through Common Practice | Using health plan analytics resources to | Providing support for a case management team to supplement |

|  |  |  |  |
|---|---|---|---|
|  | Office hours with experienced palliative care clinicians<br>Center to Advance Palliative Care (CAPC) organizational membership<br>Access to in-person training by Vital Talk to enhance communication skills<br>Customized case manager training in advance care planning through CSU Shiley Institute for Palliative Care. | develop target lists of potentially eligible members for the ACO or partnering home-based palliative care provider<br>Collaborating with ACO to fund a vendor to support identification and outreach of eligible members<br>Reimbursing for an analyst within the health system to develop an algorithm for identifying patients | the work of contracted palliative care providers<br>Paying for a dedicated palliative care coordinator for the ACO<br>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 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 home-based palliative care program for certain lines of business, a determination will have to be made as to whether the HBPC 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 payer, it was found that one of four general approaches to contracting for HBPC 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 HBPC provider. The HBPC 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 HBPC provider and pays the HBPC provider for its services. Both the health plan and ACO share in savings generated by home-based palliative care.

### *ACO Risk Scenario*

The ACO contracts with a HBPC 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 HBPC provider. Unlike the shared risk model, the ACO's capitation rate is not reduced by the cost of providing HBPC, 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 HBPC through a hospital. The health plan pays for the services but allows the hospital to keep some of the savings generated from the HBPC program.

## 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 HBPC, 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 HBPC team or if you would like to assign an internal case manager to oversee the case while a member is receiving HBPC. Most HBPC 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 HBPC 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 HBPC 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 HBPC may occur.

### *Create a hierarchy*

BSC worked with internal utilization management and case management departments to identify internal programs targeting members with the same disease criteria and then created 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 HBPC, they would not be considered eligible for telephonic case management unless the member declined a palliative care offering first. This ensured that outreach coordinators knew 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 served 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 HBPC services in the community.

### *Develop a training plan*

Consider developing a training plan for internal clinical staff who manage cases with serious illness so that they understand where HBPC 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 HBPC 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 HBPC providers but also can cause undue patient abrasion if not educated about the HBPC 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 HBPC.

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: Landmark Health*

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

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

In addition, Blue Shield 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 home-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 HBPC 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 home-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 Primer[iv] 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 | This arrangement allows health plans to easily demonstrate savings attributed to the inclusion of |

| | | |
|---|---|---|
| | 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. | palliative care services. It is also often the fastest way to initially reimburse the cost of services.[v] |
| **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. [vi] | 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.[vii] |

| | | |
|---|---|---|
| **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 home-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).

## Case Study: Blue Shield of California

In 2016, the Blue Shield team was challenged to develop a home-based palliative care payment model. Utilizing the above recommendations, they then asked the following three questions:

Who is providing the care?
What services are being provided?
What is a typical protocol?

A palliative care team ideally consists of an interdisciplinary team of professionals including a physician, registered nurse, social worker, advanced practice nurse, and other (i.e. chaplain, 24-hour nurse, home health aide, etc.). Given this team make-up, BSC identified the applicable services to include in care, for example a home visit with a physician or a telephone consultation with a nurse. Based on published literature from effective HBPC programs elsewhere, a typical home-based palliative care protocol is 6 months, with highest resource utilization occurring in the first 2 months (the Stabilization period).

With this knowledge, the Blue Shield actuarial team was able to calculate the total estimated base costs for 6 months for all services expected to be rendered for an average HPBC patient, subsequently breaking this down into a per month resource-based cost. As a final step, they added an additional 15% for additional administrative costs, such as a chaplain or 24-hour nurse line, finalizing their fee schedule for a bundled case rate payment. This case rate has been successful in provider negotiations and has been proven to cover the costs for all HBPC services rendered by their provider network.

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## 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?

**Importance of Understanding System Limitations**

Blue Shield's claims system cannot perform "bundled" payments; thus, they selected a code that would initiate a per member per month payment to the palliative care program. They then have providers submit encounter data—codes that are not reimbursed outside the case rate but can be used to risk adjustment purposes.

Blue Shield opted to move immediately towards claims-based billing through their electronic data interchange (EDI) system and used paper claims while the system was being finalized. This was in large part because they had opted to roll-out the program more broadly and felt they could not appropriately scale using a roster-based approach. Additionally, one of the goals of their program was to ensure simplicity for their contracted providers—they believed that using claims would make the payment process more simplistic for the traditionally hospice-only providers that were running the palliative care programs since they had more familiarity with submitting claims than performing roster billing. BSC believed this would help providers for the future when HBPC became reimbursed through claims-based codes.

| Key Considerations for Each Approach | |
|---|---|
| **Claims-based Billing** | **Roster Billing** |
| ➢ Automated process; once it's set up correctly, it requires less resource time<br>➢ Improves health plan auto-adjudication rate<br>➢ Can be resource expensive and time consuming to build correctly<br>➢ Automation allows for the ability to scale more quickly<br>➢ Likely simpler for program providers, as many are familiar with submitting claims and have automated processes<br>➢ 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<br>➢ CMS uses claims-based billing rather than roster billing and likely would if they were to implement a program<br>➢ 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<br>➢ Falls outside the claims system, making it more difficult to track spending and utilization on a regular reporting schedule<br>➢ Requires a level of closeness to the program because of manual review required—it's clear who is in the program at all times<br>➢ Requires more communication between the providers and health plan on a regular basis—the providers must submit the forms in order to get paid<br>➢ 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[viii]. 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 understand 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 in order 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 home-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 HBPC 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 HBPC 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 HBPC 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 HBPC 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:* Blue Shield performed this exercise and found that they 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 home-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 HBPC 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 HBPC providers can do to close those care gaps – for example, if your HBPC 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 home-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.

# PART FIVE: 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<br>*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[vii] | Why It's Important[vii] | 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<br>➢ Impacts quality/cost evaluation | ➢ Analytics (Reporting)<br>➢ Analytics (Evaluation) |
| **Program Services and Standards** | What clinical and administrative services you agree to provide for the payment | ➢ Impacts staffing ratio and scope<br>➢ Often includes visit requirements | ➢ Clinical Coding<br>➢ Actuarial<br>➢ Legal<br>➢ Communication |
| **Payment Model and Price** | Type, method, and amount being reimbursed | ➢ Contribution to budget for staffing, overhead<br>➢ Impacts quality/cost evaluation | ➢ Actuarial<br>➢ Legal<br>➢ Contract Negotiation<br>➢ 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<br>➢ 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<br>➢ Must be captured and reported | ➢ Analytics<br>➢ Clinical Coding |
| **Other Provisions** | Any other requirements negotiated between Payer and Provider in order to receive payment | ➢ Can impact administrative overhead | ➢ Analytics<br>➢ Contract Negotiation<br>➢ Legal |
| [ix]*Center to Advance Palliative Care. 2019. Payment Accelerator: What's in a Contract.* | | | |

## 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.

**Palliative Care Steering Committee**

**Program Oversight and Implementation**

Business Owner; Business Driver; Clinical Lead; Contracting Manager

**Operations Sub-committee**

**Address and review operational workflow, contracting, and claims opportunities and challenges**

*Actuarial; Legal; Contract Negotiation; Clinical Coding; Claims*

**Member Enrollment Workgroup**

**Create patient referral workflow process and refine as needed throughout the program. Track enrollment versus capacity after program launch.**

*Case Management; Utilization Management; Vendor Programs; Communication; Analytics (reporting); ACO; Product*

**Clinical Workgroup**

**Address and review clinical operational challenges and opportunities**

*Case Management; Analytics (reporting); ACO; Medical Directors*

**Data Workgroup**

**Review report development and data challenges, as needed**

*Analytics (reporting); Analytics (evaluation); Clinical Coding; Product; Actuarial*

## 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.

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## 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 HBPC 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 home-based palliative care fits into the initial stages of designing your program is important because it can impact:

(1) How HBPC 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.

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

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 HBPC 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 HBPC programs.

Blue Shield of California opted to offer HBPC to members as a primary medical service under its medical benefit. There is no prior authorization for the palliative care service though there is utilization management for benefits not included under the case rate such as DME, medications, or home health. Additionally, BSC is not charging a copay or deductible. The impetus for these decisions was:

- to remove as many service access barriers as possible to encourage utilization;
- did not want affordability to prevent their members with advanced illness from taking advantage of the program; and
- BSC contracted mainly with hospice providers to build its network - these providers oftentimes do not have as much experience managing co-pays and deductibles. Removing cost sharing had the added benefit of reducing contracted provider administrative burden (this is discussed further in the contracting section).

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# 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 HBPC 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[x]—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[xi] that are not otherwise excluded from coverage under the Medicare program (see §1862 for exclusions).[xii] 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".*[xiii]

In other words, benefits can be thought of as a collection of services.[xiv] 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 it its service area or the plan can make its own coverage determinations but must provide CMS an objective evidence-based rationale for their policy.[xv]

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

**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.

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.

## 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 the 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, HBPC 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 HBPC 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?

### Case Study: Blue Shield of California

Blue Shield based their clinical model on a program that had been successfully rolled out at various Kaiser Permanente sites with input from other successful programs like that at Sharp Healthcare in San Diego.[xvi] What had not been tried before was scaling this type of intervention across all lines of business, regardless of risk arrangement in a non-integrated system. As outlined previously, Blue Shield chose to strategically position their program to align with their accountable care organizations' (ACO) goals throughout the launch of the program, prior to palliative care becoming its own cost center. An additional incentive for proceeding with this strategy was that Blue Shield also wanted to be sure that palliative care was integrated in with primary care practice. They encouraged their contracted medical groups, starting with those under an ACO contract, to have partnerships with palliative care providers (mostly hospice and home health providers) who have the capacity to develop a robust interdisciplinary team-based palliative care program. Members of the interdisciplinary team must be available to patients 24 hours a day, seven days a week. In addition, a nurse case manager is also part of each team who is available to providers and patients, and who can coordinate additional care that the patient needs. All palliative care team members must obtain credentialing through the Joint Commission or the American College of Health Care and receive a designation in community-based palliative care. By January 1, 2020, all team members must receive this certification.

During their pilot in 2016, BSC worked with two palliative care teams based out of physician organizations. Other participants in the CHCF pilot in other parts of the state had worked with hospice agencies. One takeaway from the CHCF pilot was that if HBPC was going to scale, payers and providers were going to need to find one another, and CHCF financed a comprehensive mapping of existing palliative care providers. This database was a good starting point for BSC - using CHCF's database, Blue Shield was able to see what community-based programs existed, where the providers were, and what services they offered. Blue Shield then ran its current provider contracts against the CHCF data to construct a strategy for its provider network to build out its community-based palliative care service program. Specifically, BSC focused on where their ACO provider contractors overlapped with the CHCF database. However, this strategy only took them so far in terms of building a robust provider network and thus, they also employed their ACOs to find more providers.

## 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.[xvii]

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<br>• Documentation of surrogate/medical decision-maker is not usually on file<br>• 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<br>• 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<br>• Your patients have access to an interdisciplinary inpatient palliative care team (with board-certified clinicians) where you can refer patients<br>• 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<br>• You have an outpatient/ambulatory palliative care team.<br>• 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 HBPC 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 Workforce 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 workforce assessment or environmental scan (*see Appendix D)* that helps assess readiness to implement the program. The workforce 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 HBPC 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 HBPC and partner more closely with these providers.

Blue Shield's palliative care team was less likely to engage quickly if an ACO's population did not contain a substantial subset of patients who might be eligible for palliative care. The workforce assessment also helped BSC to prioritize which palliative care providers their ACOs were already working with for contracting evaluation.

# PART SIX: PROGRAM OPERATIONALIZATION

## Eligibility Criteria

Predicting life span is challenging and clinicians have proven to be poor predictors of mortality[xviii]. 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.

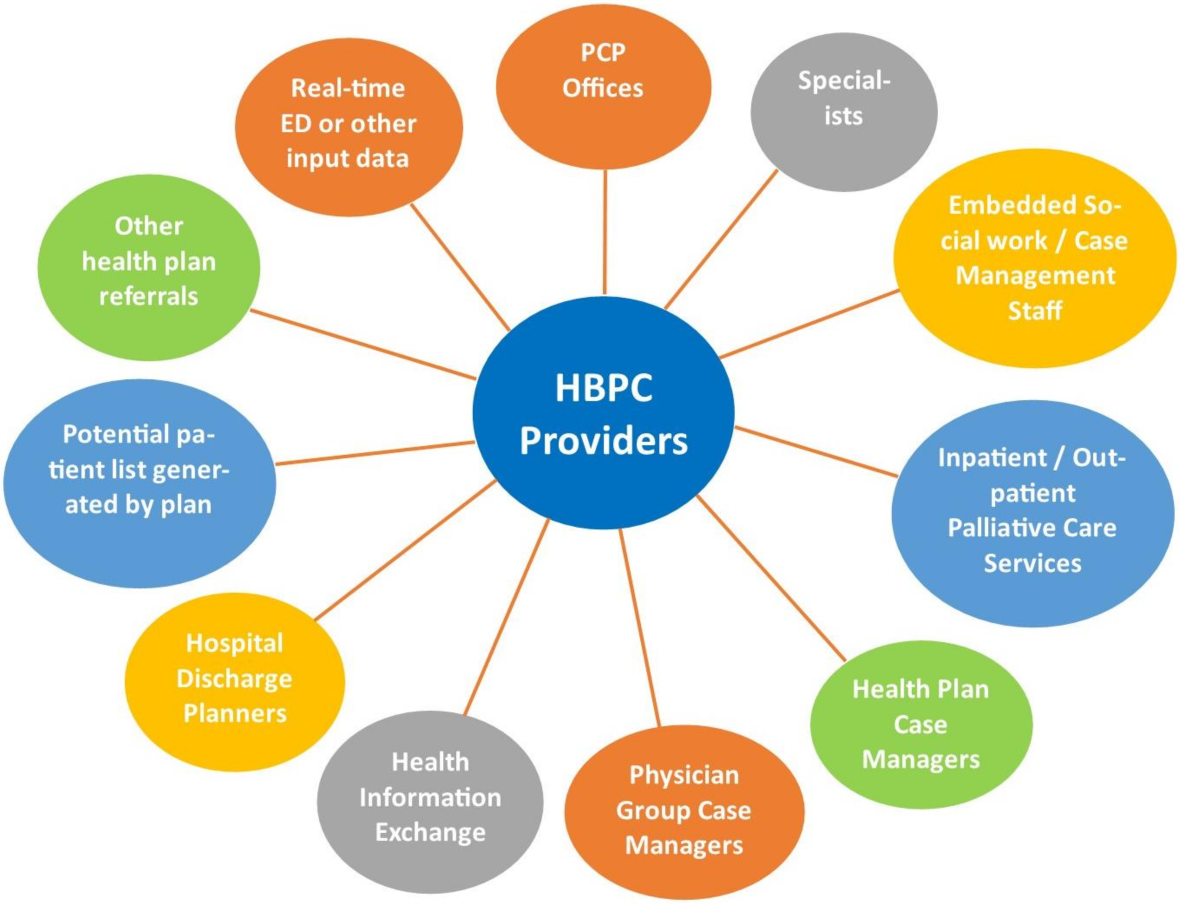
The following tools were created by Blue Shield of California to identify patients as eligible for their HBPC program. The criteria are outlined below:

| | |
|---|---|
| *Blue Shield 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<br>☐ NYHA Class 3 or 4 congestive heart failure<br>☐ 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<br>☐ Cerebral vascular accident/stroke: Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia<br>☐ Chronic kidney disease (CKD): Signs of uremia (itching, confusion) or edema in a patient not on dialysis, patient on dialysis with poor functional status<br>☐ End-stage liver disease (ESLD): Encephalopathy refractory to medications, coagulopathy, renal dysfunction<br>☐ Severe dementia: Needs help with ADLs, changes in personality, difficulty eating, recurrent infections, recurrent falls, and/or non-ambulatory<br>☐ Other (fill in): ____________________________ |
| The patient meets at least **one of four** criteria: | ☐ One or more ER visits within past 12 months<br>☐ One or more hospitalizations within past 12 months<br>☐ Hospital readmission within past 30 days<br>☐ Current clinician referral prompted by:<br>○ Uncontrolled symptoms related to underlying disease (e.g., pain, shortness of breath, vomiting) AND/OR<br>○ Inadequate home, social, family support |

| **<u>Step 2:</u> 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<br>[npcrc.org/files/news/palliative_performance_scale_PPSv2.pdf](npcrc.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)<br>☐ Complex care requirements: dependent on one or more ADLs, complex home support for ventilator/antibiotics/feedings<br>☐ High-risk factors: low health literacy, medication non-adherence, a frequent no-show to outpatient appointments, cognitive impairment<br>☐ Would you be surprised if this patient died within one year?<br>☐ Patient declined hospice enrollment<br>☐ 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<br>☐ The patient is not currently enrolled in hospice |

**Referral Methods: How can a patient be referred into a home-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 HBPC 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).

Blue Shield used several various tactics in conjunction with their provider partners in order to increase enrollment with varying degrees of success. The process to increase enrollment in the program is still ongoing at the time of publication and some of these tactics are still in use.

The following chart is based on the roll-out of Blue Shield's program and 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 HBPC 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<br>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<br>Review patient panels to see if patients could benefit | Plan creates lists of potentially eligible patients<br>Referring providers review based on eligibility criteria and refer to palliative care provider |
| **Pros** | Low labor<br>Scalable<br>Centralizes control and approval of members into program | Eligibility screening completed in advance of referral<br>Patients more likely to follow advice of trusted referral | Most likely to be accurate and comprehensive<br>Facilitates up-front buy-in from medical group leaders and case management staff |
| **Cons** | Low engagement rates<br>Can be overinclusive<br>Algorithms can be inaccurate | Under-identifies members based on provider bias<br>Involves provider education and buy-in to program | Labor Intensive<br>High level of buy-in from all stakeholders<br>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*

A number of vendors on the market have created algorithms to analyze a health plan's data looking for the right patients for this intervention.[xix] 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.[xx] 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.<br>● 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.<br>● 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<br>● Some states have real time emergency room data that is available through a state database. If available, this | ● 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*<br>● Even for utilization indicators that signal functional impairment, authorizations may be shared with provider partners in risk arrangements<br>○ *In some of Blue Shield's value-based contracts, authorization for DME lies outside of Blue Shield's purview. DME can be used as an indicator of decline.*[xxi] |

| | |
|---|---|
| utilization data would inform an algorithm more quickly than claims data. | |

## 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 HBPC 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[xxii] to educate internal case managers in order 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 HBPC 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 HBPC 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)[xxiii] for screening. The PCPs can screen the list using the "surprise question", and then refer to the home-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? Support patients and families?

Some additional tactics to use will be external for the referral community and HBPC 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 HBPC 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 HBPC 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.

With one of their ACO partners, Blue Shield paid for a serious illness program manager to help build, manage, and grow the HBPC care program as well as funding a virtual care management team to add an additional layer of support for patients referred to the program.

### *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 home-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 HBPC 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.

Blue Shield saved 10% of their training slots for their home-based palliative care providers in hopes that an environment of mutual trust that would benefit both the patients, families, and provider community would emerge.

### *Online Serious Illness Communication Training*

Paying for membership to the Center to Advance Palliative Care (CAPC) or other training[xxiv] 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 HBPC 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.

Blue Shield is funding many of their health systems and provider groups, mostly those in risk-based ACO contracts, to have membership to CAPC. Blue Shield is tying contractual performance guarantees to paying for memberships – thus, they are tracking how many PCPs and specialists the provider group or system has and comparing that number to the number that have taken CAPC modules.

## 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.

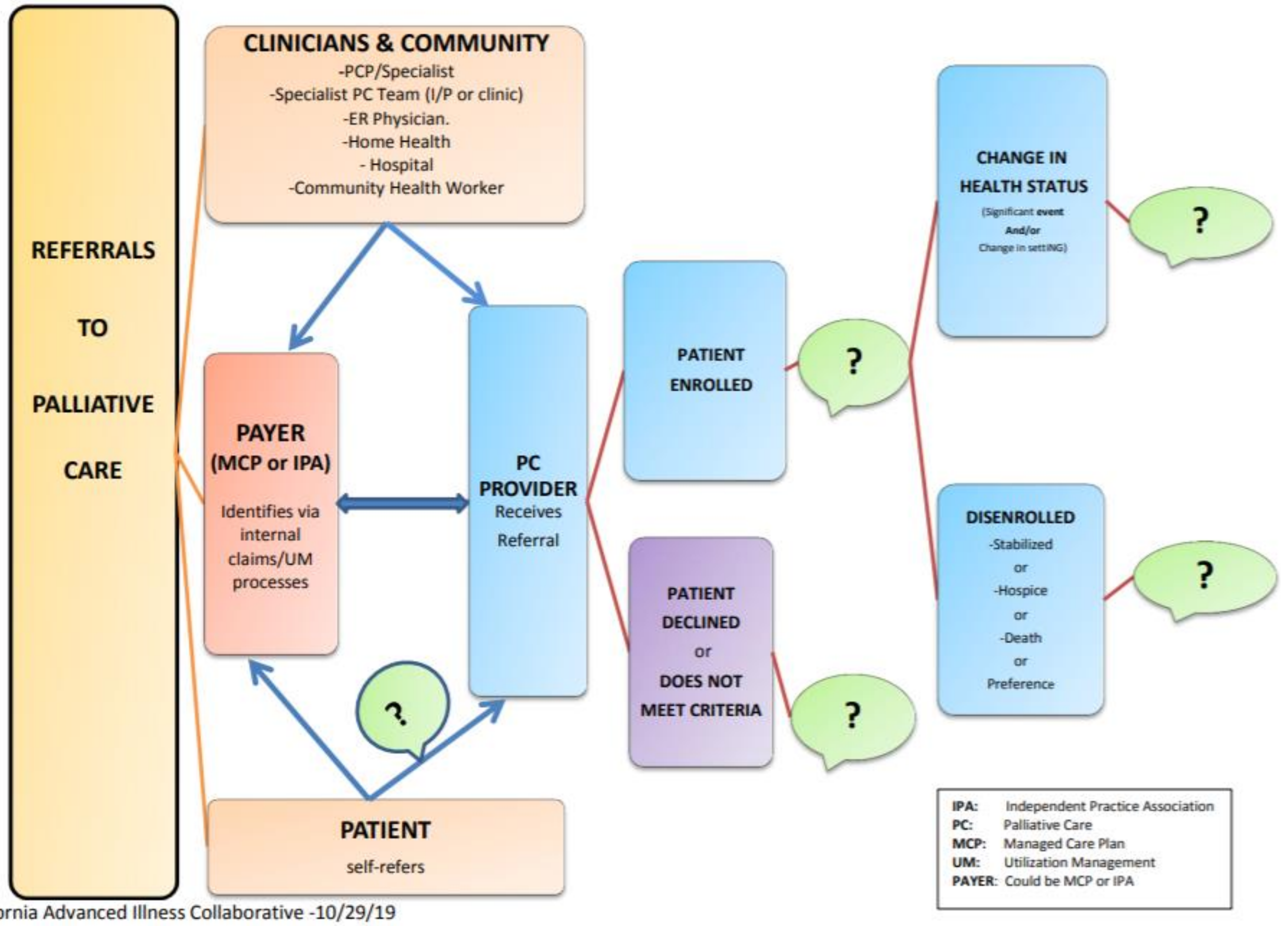
| **Other Considerations** | |
|---|---|
| Communication | Who else must be alerted that the patient is enrolled (PCP? Case Manager?) |
| Enrollment Workflow | How does the enrollment workflow look? How do you incorporate the palliative care referral process for your plan into referring providers' systems 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[xxv]

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 Referrals[xxvi]

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. BSC uses 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.

Once a patient is enrolled in palliative care, Blue Shield decided that the patient needs to have different authorizations regarding durable medical equipment (DME) and pharmacy. During their pilot in San Francisco, BSC learned that a lack of expedited authorization for certain equipment and prescriptions (i.e. commodes and opioids) could lead to a patient going to the ER and potentially, being admitted to an inpatient setting. They ultimately developed a manual process of the palliative care provider calling the palliative care team who negotiated these authorizations internally. This was not a workable or scalable solution, especially given that the authority to approve authorizations lies with different entities depending on the underlying contract.

## 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 home-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 home-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*

In order 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.

### *Regulatory change and licensing issues*

Senate Bill (SB) 294 in California allowed for hospice providers to deliver pre-hospice palliative care services (including skilled care) via their hospice license. Blue Shield had to reconfigure their claims system to process claims that were being rejected due to a general skilled service limitation on the hospice facility license that was not allowing hospice claims for palliative care to be processed. If a regulatory change is in process, you may want to consider the timing of connecting your claims reconfiguration to avoid re-opening in a model contract and therefore, a negotiation.

During their pilot, Blue Shield contracted physician group providers who were on a fully insured, PPO contract. These contracted providers only required a HCPCS code to bill. Once they moved to a full program, the claims to the program were still following rules related to the underlying PPO contract from the pilot.

Blue Shield had to be sure to account for differences between the core structures of their PPO contracts and their HMO and Medicare Advantage contracts in the business rules underlying the claims process – for example, taking into account delegation of financial responsibility and risk arrangements. Furthermore, Blue Shield had to configure their system to be able to accept claims from contracted hospice and home health providers as well as physician groups – i.e. to be able to accept revenue codes and a HCPCS code.

# Appendix A: Measurement Criteria

## Palliative Care Program Impact on Medicare Advantage Star Ratings

Palliative Care, specialized care that addresses the symptoms and stresses of serious illness, has significant impact on health care quality. This document highlights the key measures used in MA star ratings that palliative care can impact and provides guidance on workflow and considerations for implementation.

| Item Name | Data Source | Plan Average | Palliative Care Program Impact | Workflow | Considerations |
|---|---|---|---|---|---|
| Care for Older Adults--Advance Care Planning (new for 2020) | HEDIS | N/A | Advance care planning discussions are a standard part of palliative care services, both initially and ongoing | Measure can be incorporated into provider documentation on member encounters | Consider using the advance care planning codes (99497 and 99498) to capture discussions |
| Care for Older Adults--Functional Status Assessment | HEDIS | 4.0 | Functional Status is a standard part of palliative care initial assessment and care plan development | Measure can be incorporated into plan or provider upfront screening/triage and care plan development and maintenance | If you have palliative care providers who are being held accountable for these measures, consider excluding from your IHA vendor plans. If measure is "topped out," palliative care impact may be minimal |

| | | | | | |
|---|---|---|---|---|---|
| Care for Older Adults--Medication Review | HEDIS | 4.3 | Medication Review is a standard part of palliative care initial assessment and care plan development | Measure can be incorporated into initial intake documentation and on regular intervals thereafter | If you have other entities responsible for medication review and reconciliation, make sure to coordinate for members who may be in overlapping programs |
| Care for Older Adults--Pain Assessment | HEDIS | 4.4 | Pain assessment is a standard part of palliative care initial assessment and care plan development | Measure can be incorporated into initial intake documentation and on regular intervals thereafter. | Palliative care programs may use the Edmonton Symptom Assessment System, a tool not otherwise commonly in use |
| Medication Reconciliation Post-Discharge | HEDIS | 3.0 | As above, medication review is a standard part of palliative care initial assessment and care plan development | Should occur upon first visit/initial assessment when discharged to palliative care program, or as part of a post-discharge visit if member is already engaged | |
| Plan All-Cause Readmissions | HEDIS | 2.8 | Both inpatient and community-based palliative care services have been shown to reduce readmissions significantly (Cassel 2018; Enguidanos 2012) | This should be used as an evaluation and quality improvement measure for palliative care programs, measured at regular intervals, and on a population level (aggregate) | |

| | | | | | |
|---|---|---|---|---|---|
| Reducing the Risk of Falling | HEDIS/HOS | 2.5 | When fatigue, nausea, other symptoms are well managed with palliative care, and fall risks are anticipated and addressed, falls will decrease | This measure should be incorporated into provider documentation and care plan development. | |
| **Part D** | | | | | |
| Antipsychotic Use in Persons with Dementia | Prescription Drug Event (PDE) Data | N/A | When pain and other symptoms are well-managed, behavioral issues decrease, thereby decreasing the risk of antipsychotic utilization | | Dementia population subset only |
| High Risk Medication | Prescription Drug Event (PDE) Data | N/A | Medication Review is a standard part of palliative care initial assessment and care plan development, with specific attention to high-risk medications | Consider identifying population with high risk medications and serious illness for palliative care referral. Following medication reconciliation, high-risk medications should be justified, and contraindications should be addressed. | Targets should not be set to zero; rather, aim for justification of high-risk drugs, evidence of goals of care discussion, and appropriate use of high-risk drugs based on the beneficiary's goals. |
| Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes | FU Associates | N/A | When pain and other symptoms are well-managed, behavioral issues decrease, thereby decreasing the risk of antipsychotic utilization | | SNF-enrolled population only. Targets should not be set to zero, as some utilization of antipsychotics may be appropriate, however infrequent. |

# 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 | NQF # | Purpose/ Considerations/ Caveats |
|---|---|---|---|---|
| Access | Structure | Availability of interdisciplinary palliative care team, with 24/7 response of some kind in selected facility(ies) (yes/no)[xxvii] | | Reporting; program level; annual frequency<br>Structure measure that demonstrates palliative care capabilities; can be assessed through survey or achieving accreditation/certification. |
| Satisfaction | Patient Experience | CAHPS (Consumer Assessment of Health Providers and Systems)[xxviii] | #0009 | Forecasting; program level; quarterly frequency<br>Different versions of CAHPS available based on setting/audience. |
| Satisfaction | Outcome | Likelihood to recommend the services or program (i.e., Net Promoter Score) | | Reporting; organization level; annual frequency<br>Practice-level reporting or plan can choose to send out surveys for all provider programs. Consider standardizing the surveys or asking for a copy of the surveys providers use in order to determine how to aggregate the data to display to Department leaders and above. |

| Category | Type | Quality Measure | NQF # | Purpose/ Considerations/ Caveats |
|---|---|---|---|---|
| Advance Care Planning | Process | Rates of patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan[xxix] | #0326 | Reporting; organization level; annual frequency<br>Specified for patients 65+, but consider application to patients aged <65 with serious illness. |
| Clinical Quality | Process | Proportion of patients with pain screening or assessment (and/or with pain plan of care)[xxx] | #1634<br>#1637<br>#0420 | Reporting; organization level; annual frequency<br>Ideally it would be important to assess for other symptoms (e.g., breathlessness, nausea, fatigue, etc.), but scalable quality measures are not yet available. |
| Clinical Quality | Process | Proportion of patients with functional assessment (ability to perform activities of daily living and instrumental activities of daily living)[xxxi,xxxii] | (Related) #2631 | Reporting; organization level; annual frequency<br>Functional information systematically captured in Medicare post-acute care settings due to IMPACT Act requirements; identify opportunities to leverage this information where possible. |
| Clinical Quality | Process | Proportion of family caregivers with caregiver burden formally assessed[xxxiii] | | Reporting; organization level; annual frequency |
| Utilization | Outcome | Rates of avoidable hospital and/or emergency department utilization; risk adjusted as appropriate | | Forecasting; program level; quarterly frequency<br>Pull from claims data. Develop a plan to determine unwanted/unnecessary utilization. Set appropriate targets for consumer behavior/demographics (i.e., target should not be zero as this could disincentivize appropriate and necessary utilization). |

| Category | Type | Quality Measure | NQF # | Purpose/ Considerations/ Caveats |
|---|---|---|---|---|
| Utilization | Outcome | Days at home: number of days a patient remains outside of an institutional care setting during a standardized time period[xxxiv] | | Forecasting; program level; annual frequency<br>CMS level currently in development, recommend use of standard measure once available. |
| Utilization | Process | Appropriate hospice utilization (e.g., hospice referral rate or hospice length of stay (LOS) for those referred or proportion of hospice LOS less than seven days or more than 180 days for those referred) | | Forecasting; program level; annual frequency |

# 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 he 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.

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# 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: Evidence-Based Publications

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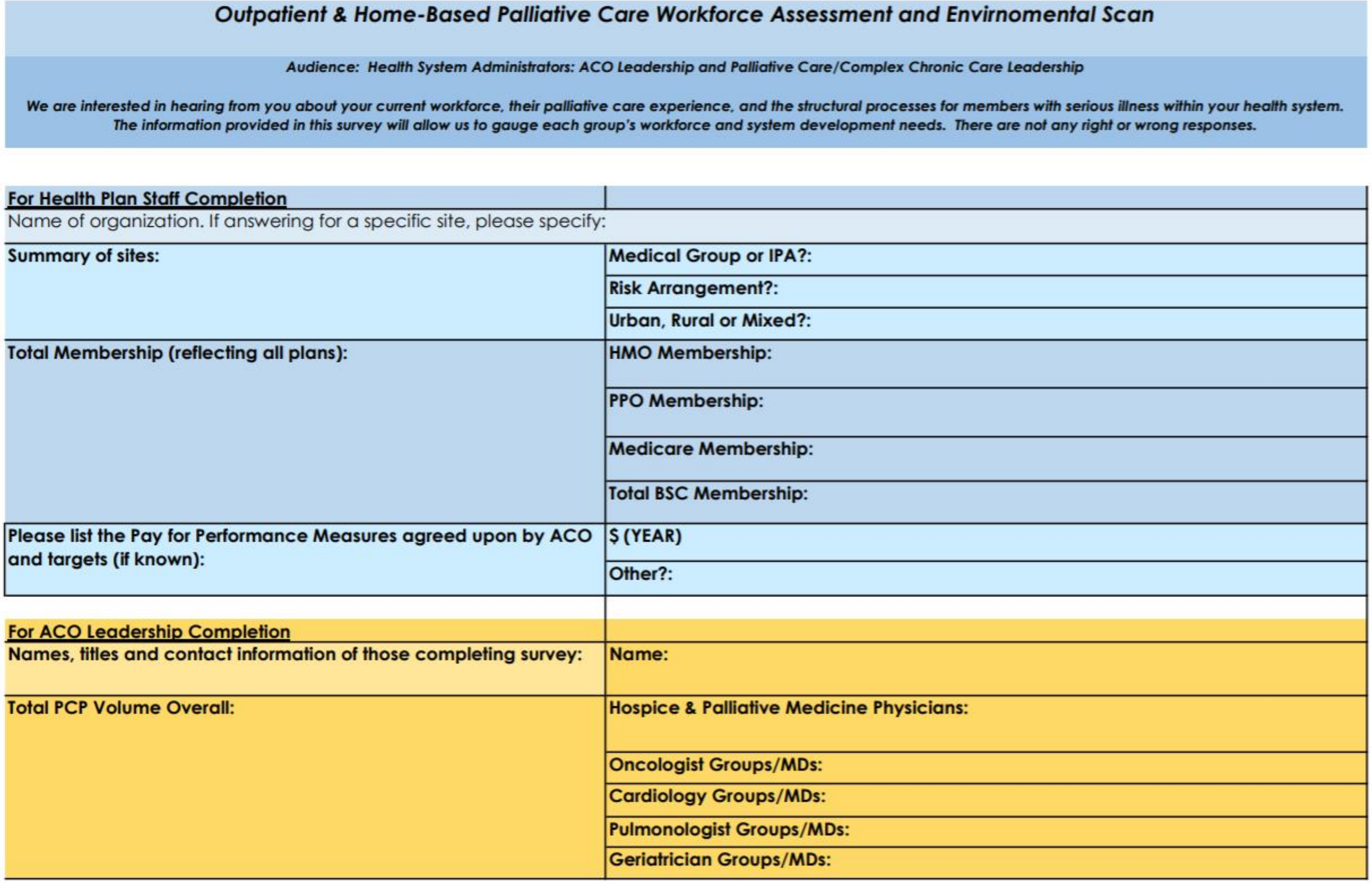
# Appendix D: ACO Workforce Assessment



## *Outpatient & Home-Based Palliative Care Workforce Assessment and Envirnomental Scan*

***Audience: Health System Administrators: ACO Leadership and Palliative Care/Complex Chronic Care Leadership***

***We are interested in hearing from you about your current workforce, their palliative care experience, and the structural processes for members with serious illness within your health system. The information provided in this survey will allow us to gauge each group's workforce and system development needs. There are not any right or wrong responses.***

| | |
|---|---|
| **For Health Plan Staff Completion** | |
| Name of organization. If answering for a specific site, please specify: | |
| **Summary of sites:** | **Medical Group or IPA?:** |
| | **Risk Arrangement?:** |
| | **Urban, Rural or Mixed?:** |
| **Total Membership (reflecting all plans):** | **HMO Membership:** |
| | **PPO Membership:** |
| | **Medicare Membership:** |
| | **Total BSC Membership:** |
| **Please list the Pay for Performance Measures agreed upon by ACO and targets (if known):** | **$ (YEAR)** |
| | **Other?:** |
| | |
| **For ACO Leadership Completion** | |
| **Names, titles and contact information of those completing survey:** | **Name:** |
| **Total PCP Volume Overall:** | **Hospice & Palliative Medicine Physicians:** |
| | **Oncologist Groups/MDs:** |
| | **Cardiology Groups/MDs:** |
| | **Pulmonologist Groups/MDs:** |
| | **Geriatrician Groups/MDs:** |

| | |
|---|---|
| **Please indicate provider/agency who you refer to the most and why. Please specify if owned by your organization:** | **Inpatient:**<br>**Top 2 Utilized Facilities:** |
| | **Dialysis Centers:** |
| | **Skilled Nursing Facilities: Top 2** |
| | **High-risk post-discharge clinics:** |
| | **In Home Medical Management:** |
| | **In Home Annual Wellness Visits:** |
| | **In Home Promary or Geriatric Care:** |
| | **Home Health Agencies:** |
| | **Home Hospices:** |
| | **Palliative Care Consultations:** |
| | **Advance Care Planning:** |
| | **Case Management:** |
| **If you have a current inpatient palliative care team, please describe the connection between the inpatient team and community/outpatient services:** | |
| **If you have a current palliative care team that provides outpatient or in-home palliative care, are these disciplines are already established (Y/N)?** | **Physician Administrator (Please name):** |
| | **NP/ARNP:** |
| | **PA:** |
| | **RN:** |
| | **Pharmacist:** |
| | **Social Worker:** |
| | **LVN/Aide:** |
| | **Chaplain:** |

| | |
|---|---|
| | **24/7 Telephone Support:** |
| | **Financial Counseling:** |
| **Please describe your relationship with the following specialty practices and whether, to your knowledge, they are running a specialized program (ex. Heart failure clinic, oncology bundled payment program, etc.).** | **Oncology:** |
| | **Cardiology:** |
| | **Pulmonology:** |
| | **Nephrology:** |

Closing:
Thank you for completing the survey. If you have any questions or additional comments, please contact Clinical Program Manager at xxxxxxxx.

## End Notes / References

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[ii] 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.

[iii] Brumley, R., Enguidanos, S., & Cherin, D. 2003. Effectiveness of a Home-Based Palliative Care Program for End-of-Life. Journal of Palliative Medicine. 6(5): 715-724.

[iv] Center to Advance Palliative Care. 2019. Payment Primer: What to Know about Payment for Palliative Care Delivery.

[v] 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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[viii] 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.

[ix] Center to Advance Palliative Care. 2018. Payment Accelerator: What's in a Contract.

[x] Medicare Advantage plans must cover all Part A and Part B Medicare benefits.

[xi] 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.

[xii] Palliative care is not explicitly excluded.

[xiii] 42 C.F.R. 422.2

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[xiv] "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).

[xv] Medicare Managed Care Manual Section 90 of Chapter 4.

[xvi] Cassel, B., Kerr, K., McClish, D., Skoro, N., Johnson, S., Wanke, C., & Hoefer, D. 2016. Effect of a Home-Based Palliative Care Program on Healthcare Use and Costs. Journal of the American Geriatric Society. 64(11): 2288-2295.

Brumley, R., Enguidanos, S., & Cherin, D. 2003. Effectiveness of a Home-Based Palliative Case Program for End-of-Life. Journal of Palliative Medicine. 6(5): 715-724.

[xvii] 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.

[xviii] 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.*

[xix]We did not evaluate any specific algorithms for the purposes of this tool kit.

[xx]Center to Advance Palliative Care, *Serious Illness Strategies for Health Plans and Accountable Care Organizations*, pg. 16.

[xxi]*Ibid*

[xxii]*Ibid*

[xxiii]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

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

[xxvi] California Advanced Illness Collaborative. 2019. 10 Issues That Might Discourage Providers from Referring.

[xxvii] Recommended Standards for Hospitals and SNFs; retrieved from https://www.capc.org/defining-and-measuring-quality/ (https://www.capc.org/documents/download/127/)

[xxviii] https://www.ahrq.gov/cahps/index.html

[xxix] NQF Quality Positioning System

[xxx] NQF Quality Positioning System

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[xxxi] https://www.hosonline.org/

[xxxii] NQF Quality Positioning System

[xxxiii] https://dementiapathways.ie/_filecache/edd/c3c/89-zarit_burden_interview.pdf

[xxxiv] https://www.nejm.org/doi/full/10.1056/NEJMp1607206