



# NAHC HHFMA Palliative Care White Paper

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**With review by: NAHC staff and members of the Hospice Association of America Advisory Board**

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*The U.S. health care system is in a state of rapid change. The impact of these shifting programs and incentives—and both their beneficial and unintended negative consequences—on Americans nearing the end of life should not be overlooked. Appropriate measurement and accountability structures are needed to ensure that people nearing the end of life will benefit under changing program policies. In assessing how the U.S. health care system affects Americans near the end of life, the committee focused on evidence that the current system is characterized by fragmentation and inefficiency, inadequate treatment of pain and other distressing symptoms, frequent transitions among care settings, and enormous and growing care responsibilities for families.*

Institute of Medicine (IOM) Report, Dying in America, 2014, page 5-3

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## I. Palliative Care – An Overview

### A. Introduction

Palliative Care (PC) and its “cousin,” Advanced Illness Management, answer a significant need of today’s health care system; however, the absence of a regulated model of care and reimbursement create both opportunities and challenges for home health and hospice organizations that provide this service. This paper is intended to share concepts and experience for providers who desire to explore and develop their own PC program.

PC programs have developed in response to needs which vary from situation to situation, and, as a result, it is difficult to provide guidance that is standardized or applicable to all situations. In this paper, the contributors share more generalized concepts, as well as details about some of the variations that exist across the United States. This paper addresses PC from the perspective of a home health or hospice provider.

### B. Caveats

As already noted, PC programs have developed differently in each market to meet specific needs. As a result, the general consensus is “if you’ve seen one PC program, you’ve seen one PC program.” Each program should be developed to meet unique goals and criteria, drawing upon the experience of others, but grounded in local needs and resources.

*Throughout the trajectory of illness, palliative medicine providers optimize disease management through comprehensive assessment, symptom management, and supportive care to patients and caregivers. This model of care enhances quality of life from the curative/restorative care stage through caregiver bereavement. Barriers and silos of care exist that impede advanced disease symptom management. Physician reimbursement and billing issues negatively impact the ability to provide palliative care services for treatment of advanced, end stage chronic diseases. For those nearing the end of life, better quality of care through a range of new delivery models has repeatedly been shown to reduce the need for frequent 911 calls, emergency department visits, and unnecessary urgent hospitalizations. Evidence suggests that palliative care, hospice, and various care models that integrate health care and supporting services may provide high-quality end-of-life care that can reduce the use of expensive hospital and institution-based services, and have the potential to help stabilize and even reduce health care costs for people near the end of life. The resulting savings could be used to fund highly targeted and carefully tailored supporting services for both children and adults (Komisar and Feder, 2011; Unroe and Meier, 2013), improving patient care while protecting and supporting families. Services must be tailored to the evolving needs of seriously ill individuals and families so as to provide a positive alternative to costly acute care and to help these patients remain safely at home, if that is their preference.*

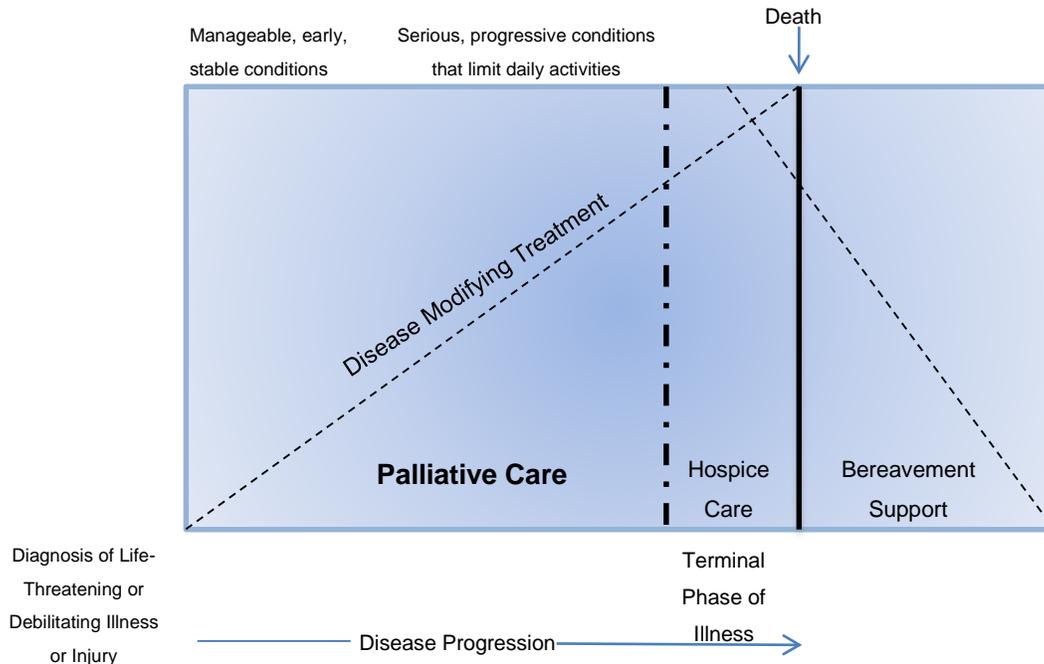
IOM, Dying in America, page 5-4

Furthermore, regulations and guidelines related to certain elements of PC, such as scope of practice, corporate practice of medicine laws, and physician practice of medicine, vary from state to state, as do

payer requirements and guidelines. So please conduct your own due diligence regarding state and local requirements that may be applicable.

## C. Context

PC is often viewed as addressing needs for support of patients and their families who face serious illness. For some, it is viewed as a pre-cursor to hospice care, as shown in the diagram below.



The Center to Advance Palliative Care (CAPC) defines PC as “specialized care for people with serious illnesses,” with the following characteristics:

- ***Focuses on relief from the symptoms, pain, and stress*** of a serious illness
- Aims to improve ***quality of life*** for both the ***patient and the family***
- Provides an ***extra layer of support*** at any age and ***at any stage*** in a serious illness, and can be provided along with curative treatment
- Supports patient and family, not only by controlling symptoms, but also by helping to ***understand treatment options and goals***

CAPC further tasks the PC team with:

- Expert management of pain and other symptoms
- Emotional and spiritual support

- Close communication
- Help navigating the healthcare system
- Guidance with difficult and complex treatment choices

PC can focus on one or some combination of the tasks above. It can also focus on a specific setting, such as a clinic or physician office, nursing facility or hospital, or be home-based. It can also be focused on specific diseases or specific symptoms (such as pain). There are untold variations that could express the combination of settings, disease focus, task, symptom(s) and delivery method available.

## **D. Payment**

One of the key challenges for PC programs is financial sustainability. Historically, most hospice and home health agencies have looked to established government payment mechanisms to fund PC services. These sources are Medicare Part B payment for physician, nurse practitioner (NP), psychologist and limited situations of Licensed Clinical Social Worker (LCSW) services, home health reimbursement or concurrent hospice care reimbursement available through Medicaid for pediatric patients or via demonstration projects. These sources rarely cover the full cost of providing PC services. Therefore, providers are increasingly looking to other sources of funding to supplement traditional payment streams.

These additional sources of funding include: grants, commercial insurance contracts, arrangements with hospitals or health systems, arrangements with ACO's or other bundled payment payers, or private pay (concierge) models. All of these sources usually entail some restrictions, such as limited duration, limited target populations, application for limited funds, and/or other aspects that require initiative and negotiation. These sources of funding are usually premised on the ability of PC to avoid cost that would otherwise be incurred under other payment models, especially long lengths of stay in hospitals and ICU level of care days. This ability for PC to result in system-wide cost savings and/or improved outcomes is helping to fuel the growth of PC programs, but, nonetheless, makes it difficult to justify PC on its own as a stand-alone service line.

## **E. Palliative Care Program Goals and Target Populations**

The newer sources of funding mentioned above are driving many PC providers to examine the goals of their programs more closely. Some target their programs on a specific target population that meets the needs of a particular funding source; others target patients that are either immediately “upstream” or “downstream” from their core hospice and/or home health service, while others focus on meeting unmet needs, regardless of available funding or cross-program benefit. A related decision that PC providers face is to determine their goals with respect to financial performance of the PC service as a stand-alone service line. Many hope to at least break even from operations, or incur a loss while accruing other benefits, such as referral source or community satisfaction or improvement in certain quality outcomes, while others establish a financial contribution target. The specific financial and

service goals, coupled with local market needs, will result in different models of PC from one market and one provider to another, and in some cases, even within one provider.

The linkage of contractual payments for PC services to a particular target population (high cost outliers, specific disease category, or immediately upstream/downstream) can create a more sustainable program, but can also create confusion in the minds of referral sources, and even provider staff, if not clearly communicated.

## **F. The Variety of Palliative Care Programs**

As a result of the various factors outlined above, PC programs have developed to address different goals, settings and diseases. These variations bring with them different staffing models as well.

One key factor in sustainable delivery of PC is the non-productive time of highly paid staff. Many programs focus on settings where physicians, NPs and other staff can be as productive as possible: hospitals, SNFs and clinics. In-person home-based PC, with its related travel time, continues to be a challenge with respect to productive use of staff.

Later sections of this paper include more detailed examples of specific programs, but here are just a few examples that typify the range of approaches that different providers bring to PC (information provided based upon publicly available information that may not be entirely up to date):

**Gundersen Health System's Respecting Choices Program:** A staged approach to advance care planning which addresses that single component of PC.

**University of Pennsylvania CLAIM (Comprehensive Longitudinal Advanced Illness Management):** A home-health based program focused on cost avoidance and improved outcomes for cancer care by providing supplemental disciplines; funded by a Health Care Innovation Award from the Centers for Medicare and Medicaid Services (CMS).

**Lehigh Valley Health Network's Optimizing Advanced Complex Illness Support (OACIS):** A RN case-managed three-pronged service consisting of home-based NP consults, palliative medicine inpatient consult service, and a PC outpatient clinic associated with a cancer center intended to avoid cost and improve outcomes.

**Hospice of Michigan's At Home Choices:™** A RN case-managed set of services coupled with advanced informatics to target patients whose costs have the greatest probability of being modified by PC interventions, and is funded by contractual agreements with insurers or health systems.

See other sections of this report for more detailed discussion of other aspects of PC program development and operations.

## II. Starting a Palliative Care Program

This section serves as an overview for many of the aspects necessary for the start-up of a successful PC program. More details are provided in the other sections of this document.

### A. Palliative Care Program Goals and Target Populations

As noted in Section E of the previous chapter, PC program development needs to begin with a clear understanding of programmatic and financial goals that are shared across the organization and tested within your local community. Without this clarity, it is difficult, if not impossible, to build a successful PC service. It is worthwhile to make sure that you have a firm foundation in terms of expectations before beginning any of the other elements below. Discussions and considerations regarding program goals may include an iterative process of developing goals and testing them in terms of organization and community feedback.

### B. Measurement of Patient Potential

**Criteria for Potential Referral Sources and Site of Service**—In developing a PC program, it is important to define the criteria for potential referral sources for outpatient, facility, and home based PC programs, as well as the potential for inpatient PC services. This definition will help identify the best potential referral sources in your community and the possible sites of inpatient PC. Medicare market data is available for purchase. It will allow you to compare potential hospital-based consultation needs, as well as referral sources for community based care, by giving you data relative to hospital discharges and diagnoses. This will allow you to quantify the potential referral base from each source and to rank potential sources against each other in order to prioritize which sources to target. Unfortunately, there is little to no data available regarding non-Medicare payers.

**Identification of Types of Patients Most Likely to Need Palliative Care**—As described in the prior section, you can use Medicare market data to identify the size of each referral source's potential patient base. In order to do this, you need to obtain hospital or Skilled Nursing Facility (SNF) discharge data with diagnosis information. As part of this exercise, you should identify which diagnoses are most likely to need PC and hospice services. For example, cancer, congestive heart failure, and COPD diagnoses are frequently seen among PC, home health, and hospice patients.

PC providers based in hospital inpatient consultation services have used five percent of hospital census, excluding maternity and any inpatient psychiatric patients, as an estimate of potential PC consults and revisits. Over the years, the industry has seen well above the five percent, and some literature is suggesting up to 20 percent.

**Ranking the Best Potential Sites**—Armed with the Medicare market data and having determined which diagnoses you are seeking, you can calculate the potential referral basis of each potential site. You can then rank the sites by size of potential patients and devote your marketing efforts to the best potential sites you have identified in order to maximize your success.

## C. Identification of Referral Sources

**Using Market Data on Hospital Discharges**—You can purchase the Medicare market data that reflects the actual discharge by diagnoses information for each hospital in your service area. This data will help you identify the best possible referral sources for potential PC patients that, by diagnosis, may eventually become hospice patients as well.

**Discussions with Existing Referral Sources**—Once you have determined the site of services and armed with discharge information, the next step would be to meet with existing referral sources to identify if there is another PC provider serving their patients or if you may be able to serve those patients. Since the social work and chaplaincy costs are not covered by insurance payments, it is important to discuss the costs involved for the referral source to use your PC program. It is prohibited to give those services away for free since that would be viewed as a benefit offered to induce referrals.

**Analysis of Competing Programs**—If your discussions uncover the presence of competing programs in your market or at your current referral sources, it is important to quantify why your program is better than the competing services and what additional benefits you offer as part of your service. In essence, you must construct a detailed value proposition in order to sell the use of these services to potential referral sources. The fact that you accept many insurances held by existing patients of that site, as well as the ability to provide careful coordination of care and seamless care transitions, are important factors. In addition, the ability to offer home health services as a bridge to patients that may not be ready to elect hospice is a benefit to the referral source in assisting with reducing their overall length of stay, as well as a benefit to the patient by offering well-coordinated care with the same clinical staff.

**Education of Medical Staff at Selected Site(s)**—A key to a successful implementation is to convince the existing medical staff at the referral source site of the benefits of the PC program. Obviously, there is a benefit to the medical staff of having a very qualified and professional resource in place to handle the difficult conversations with patients and their families over the best course for a failing or seriously ill patient. In addition, many physicians need to understand the true scope of the PC program in order to receive referrals from them on an inpatient consultation level. Your PC physician must be able to sell the program to the medical staff on a department by department basis. They must be able to clearly define the benefit to the referring clinician. This is not a case of if you build it, they will come. Don't forget to include the residents and hospitalists in your meetings. They have a lot of control over the flow of inpatient services and can make a real impact on your successful implementation. Medical Directors and Advance Practice Registered Nurses at the SNFs where you have a PC contract are also important people to educate. Specialty practices with potential for PC referrals include oncology, neurology, cardiology, pulmonary and nephrology.

**Education of Discharge Planning Staff at Selected Site(s)**—It is also important to educate the discharge planning staff about the scope of your PC services in the patient's home. The mere fact that your physician has seen a patient in the hospital on a consult basis does not guarantee the referral to you upon discharge. If the patient is sent to a skilled nursing facility, it is important to follow the patient's progress toward a return home or transition to hospice within the facility in order to guarantee continuation of PC services. Try to have each team member meet each of the hospital's discharge

planning staff, and even nurse navigators. This personal touch will help identify the program and solidify referral opportunities.

## **D. Identification of Key Value Statement Items for the Program**

**Identifying and Defining Patients for the Program**—It is important to clearly define the types of patients that you are seeking in order to clarify for the referral sources who are the appropriate patients for the PC program. When looking at Medicare PC programs embedded in a home health agency, it is important to clearly define the definition of homebound in order to make sure that appropriate patients are being referred for the home health bridge to hospice services. This is often a misunderstood area for hospital discharge planners. In addition, it is important to know which insurances you have under contract for physician consultations. It is a time consuming process to negotiate contracts for physician services and to credential each member of your medical staff in order to permit professional billing for the program. Most nursing facilities require credentialing, as medical staff and all hospitals require credentialing for physician services to occur. In addition, to bill Medicare, you must have a Part B number for the group physician practice. In your planning process, please allow sufficient time for contracting and credentialing or you will find that you will not be able to bill for your services.

**Lowering Hospital Length of Stay and Unplanned Readmissions**—A key benefit to a referring hospital is the ability of the PC program to reduce length of stay for difficult patients who may not be willing to be discharged without a proper care alternative and to decrease unplanned hospital readmissions as symptoms are better managed at home. Facing terminal illness is a difficult process, and family members may be anxious about their ability to provide adequate care to their loved one. Patients living alone face the same, if not more anxiety, as they face the prospect of life outside of the hospital under their own care. A good PC program will provide a welcome alternative to these concerns, as well as an appropriate level of care outside the hospital. PC programs providing consultations within a hospital will also decrease the length of stay within the hospital, and particularly within the ICU or CCU areas, by clarification of treatment goals and symptom management.

**Increasing Patient Satisfaction**—By reducing patient and family anxieties as described above, the referring hospital will find an increase in patient satisfaction. This is due to the ability of the PC program to provide quality care in the patient's home. The program will help the patient and their family transition to home, as well as provide much needed information on the patient's prognosis and what to expect as their illness progresses. The comfort of knowing that your symptoms are being controlled in the best way possible provides tremendous relief to patients and their families, which will help increase overall levels of patient satisfaction.

**Lowering In-Hospital Mortality Rates**—As noted above, the ability of the PC program to assist in the transition of the patient and provision of quality care in the patient's home can assist in lowering in-hospital mortality rates. Increasingly, however, hospital mortality rates are being calculated based upon a 30-day window from hospital admission. The latter types of measures would not be expected to be significantly impacted by PC.

## **E. Personnel, Structure and Other Resources That Support a Robust Palliative Care Program**

**Need for the Right Physician and Nurse Practitioner**—In order for the program to be really successful, careful thought must be given to select the right people to serve in the key roles of doctor and nurse practitioner. The people selected must have the appropriate background and experience in PC and hospice. For the doctor, board certification in hospice and PC is a necessity. In addition, you want people that will be able to actively and continuously educate providers and market the program. This requires excellent communication and diplomacy skills. Remember that marketing includes securing appropriate new sites for the program, as well as marketing the program internally throughout that site, in order to insure full utilization by the patients at that site. Both marketing efforts are necessary to insure success. Frequently, there will be other doctors on site that may not accept the program. They will need to be contacted directly by the program's doctor, who must constantly discuss the merits of the program and how the program will relieve the doctor of the difficult conversations regarding a patient's prognosis and how they want to best deal with death. It is amazing that complex medical school health systems somehow managed to avoid these discussions, even when it is in the patient's best interest. They simply have been trained to treat patients until the end. *Note: Some states have laws restricting the authority of the NP; check your state to see if the NP can practice independently, or can prescribe narcotics. Limitations in both of these areas will restrict the utilization of an NP.*

**Need for the Right Social Worker and Chaplain**—If included in the staffing model, a program requires that the social worker and the chaplain have extensive experience in working with patients in both hospice and PC environments. It is important that they both be flexible in their approach to serving patients. Due to multiple conflicting demands, they may be called upon to function in each other's role, especially as part of a family meeting. This will reinforce the team concept for the program, and it will be even more evident to families and patients that the team will do everything they can to make the patient comfortable. Careful selection based upon these traits is extremely necessary as these employees will really get involved in many patient and family details. They need great communication skills in order to facilitate difficult discussions. If visits are to be reimbursed, the social worker must be licensed in your state as a LCSW and appropriately credentialed in the hospital or nursing facility (if applicable), in addition to being included in your insurance contracting.

**Proper Placement of Home Health and Hospice Services within the Agency**—The program will encounter many patients not yet ready to elect hospice. As a result, they may benefit from services provided by home health until they are ready to elect the hospice benefit. Careful consideration should be given by the agency on how to provide these home health services. Some programs consider it best to offer these services through a division not closely aligned with hospice, for example a cardiac program, if this is the population being targeted. Others consider it extremely beneficial for the agency to elect to deliver these services through its hospice division rather than through its traditional home health division. The latter approach may make it easier for the patient to elect hospice since the clinical staff assigned to their care would remain constant. If traditional home health services were provided, the change in clinical staff may present a barrier to the hospice election. In addition, the need to transition a patient to hospice may not be appropriately recognized by the home health clinical staff.

The goal is to have the patient receive the appropriate services they need, which many times necessitates the transfer to hospice.

**Other Resources**—Other resources which should be considered essential elements in planning for a robust PC program include:

- Data/analytics capacity
- Ability to bill/code properly
- Management of the mix of PC staff disciplines
- Sales and marketing plan
- Education/training plan
- Compliance plan
- Legal oversight

### III. Clinical Aspects of Palliative Care

This section provides details related to several models of PC or advanced illness management programs to include: target population, program description, staffing, and the relationship of the program to certified home health or hospice programs.

#### A. Case Example: Physician-Based Palliative Care Services Model

##### Program Overview

This is a medical model of PC in which physicians and NPs lead the team of interdisciplinary members. Based on the circumstance, often you will find social workers and chaplains that are shared between the PC service and other departments within hospitals or hospice programs. Occasionally, you will see a psychologist instead of the social worker, which allows for a higher rate of billing for services by the psychologist compared to the LCSW.

**Settings** - Site of care delivery is generally focused within an acute care facility, but may also be available in nursing homes, physicians' offices or specialty clinics, and at home. The majority of services tend to be in the acute care setting. Radiation oncology, medical oncology, and chronic care clinics are excellent sites for PC involvement. Pediatric sites also include chronic care clinics, PICU and NICU, and pediatric oncology.

Reimbursement for services is from direct care billing of the physician, the NP who bills at 85 percent of the physician level, and at times, an LCSW or psychologist. Other services are not considered billable and must be covered by the reimbursement of the billable providers (for example, chaplain, RN, program manager or coordinator, and social worker).

The second mechanism for reimbursement is from the cost avoidance and increased bed capacity of the acute care facility. Some hospitals have paid for a percentage of PC services out of the documented cost avoidance and increased bed capacity, especially in ICU beds for facilities that have diversion issues related to ICU bed capacity.

**Core Staffing** - Disciplines and staffing models for the ideal PC Service is an interdisciplinary model of care that has dedicated staff, including:

- Hospice and Palliative Care Boarded Physician
- Hospice and Palliative Care Certified NP
- Nurse for care coordination
- Counselor- LCSW or Psychologist
- Bereavement Counselor
- Pastoral Care Counselor
- Office Coordinator

Staffing will be dependent on the volume of encounters and the site of care - inpatient, outpatient, nursing home, or home based care.

Productivity metrics are difficult to find for a PC team. This program uses the following ratio for each physician and NP full-time equivalent (FTE): 250 consultations and 1,000 revisits/year.

**Competencies** - Competencies are not specific to the site of care, but must include the following:

- Care coordination
- Advanced care planning
- Palliative sedation
- Pain management, including opioid infusions
- Ethics consultation

**Relationship with Home Health and Hospice Teams** - The relationship with home health and/or hospice to all PC programs should be very strong -- either as a referral source or as a program within the home health/hospice program. The PC service is set up as a physician specialty practice. They refer patients to home health or hospice as appropriate. The hospice program purchases medical director services from the PC Medical Practice. This provides a strong tie between the hospice program and the PC program.

**Triggers/Tiers for Services** - During the early stages of development of PC, triggers can be helpful to identify potential patient referrals into the PC program. Examples are patients with:

- multiple hospitalizations in the last 60 days
- metastatic disease
- pain as a primary diagnosis
- CHF with previous hospitalizations
- COPD with previous hospitalizations
- hospital stays greater than 5-7 days

## **B. Case Example: Sutter Health's Advanced Illness Management**

Sutter Health's Advanced Illness Management (AIM®) program bridges the gaps between the hospital setting, the community physician's office, and the home for persons living with advanced, chronic illness. These patients are considered to be at risk of dying in the next 12-18 months and may be actively pursuing curative treatment. AIM care consists of evidence-based, patient-centered behaviors, actions, and protocols to ensure patients receive the right care and support at the right time, in the right place. The AIM care model relies on frequent and ongoing contact with the patient and family and the patient's physician. It is a program of care that continues as the patient's illness progresses over time, employing consistent person-centered interventions to support the patient regardless of care setting. In doing so, the focus of care for advanced illness moves out of the hospital and emergency departments and into the patient's preferred location, their home and community.

AIM was piloted in the Sacramento Sierra Region from 2009 through 2012, with a goal of transforming care for persons with advancing illness within the Sutter Health service area. Tapping clinical expertise across the system, the AIM program is designed to take the best practices and program design elements proven successful elsewhere and combine them into one program. With an early and ongoing focus on the patient's personal goals and ways to proactively engage the person and their family in their own care in the home, the AIM program is able to demonstrate higher quality of care for patients, better health for patients, and lower total cost of care.

Over the past three years, the AIM program has moved from pilot operations to expanding across Sutter Health's footprint. In 2012, the Centers for Medicare & Medicaid Innovation awarded Sutter Health a three-year, \$13 million Health Care Innovation Award to support the expansion and evaluation of the program. Supplemented by \$21.4 million in Sutter Health funding, a course was set for roll out of the program in July 2012 with this mind:

- Improve access to PC and care management for persons with advanced illness residing within Sutter's footprint
- Support CMS' evaluation of the model in an effort to demonstrate the program's value as a potential national care model for persons with advancing illness
- Use this opportunity to 'test' how a single, clinically integrated program might be launched to serve patients across the entire system

AIM now operates in all five Sutter Health regions, with 12 teams covering 17 counties. Since the beginning of the expansion project, AIM teams have cared for more than 7,300 patients system-wide. Nearly 500 clinicians have been trained in the AIM model of care.

## **Program Overview**

Sutter Health's Advanced Illness Management (AIM)<sup>®</sup> program bridges the gaps between the hospital setting, the community physician's office, and the home for persons living with advanced, chronic illness.

### **AIM Patients**

AIM patients are considered to be at risk of dying in the next 18 months and may be actively pursuing curative treatment.

To meet clinical eligibility, a patient must have a high burden of disease and one of the following:

- Hospice appropriate or
- Rapid, significant functional decline or
- Rapid, significant nutritional decline or
- Reoccurring, unplanned hospitalizations or ED visits or
- Physician wouldn't be surprised if the patient died in the next 12 months

## AIM Care

AIM care is delivered consistently, rigorously, over time and across settings, thereby moving the focus of care for advanced illness out of the hospital and into the home and community. AIM care includes evidence-based, patient-centered behaviors, actions and protocols to ensure right care at the right place and at the right time.

- Dual therapeutic approach: curative + palliative
- Frequent and predictable MD communication
- Health literate self-management tools and communication
- AIM Five Pillars of Care:
  1. Personal goal setting with advance care planning
  2. Red flag symptom identification and management plans
  3. Medication management
  4. Ongoing coordination regarding physician follow up visits
  5. Patient engagement and self-management support tools
- Standardized note in the electronic health record (EHR), viewable across the care continuum

## Core Staffing and Tiers of Service

RN and MSW services supported by Hospice and Palliative Care Certified Physician

### In the Hospital: AIM Care Liaison (RN)

### In the Home: AIM Home Health

- AIM Home Health RN: Visits in the home to case manage patients who meet HH eligibility; caseload 16-18 patients
- AIM Home Health MSW: Visits in the home for patients who meet HH eligibility
- Home Health PT, ST or OT: If needed, visits in the home for patients who meet HH eligibility

### AIM Transitions

- AIM Transitions RN: Visits in the home to case manage patients who do not meet HH eligibility
- AIM Transitions MSW: Visits in the home for patients who do not meet HH eligibility

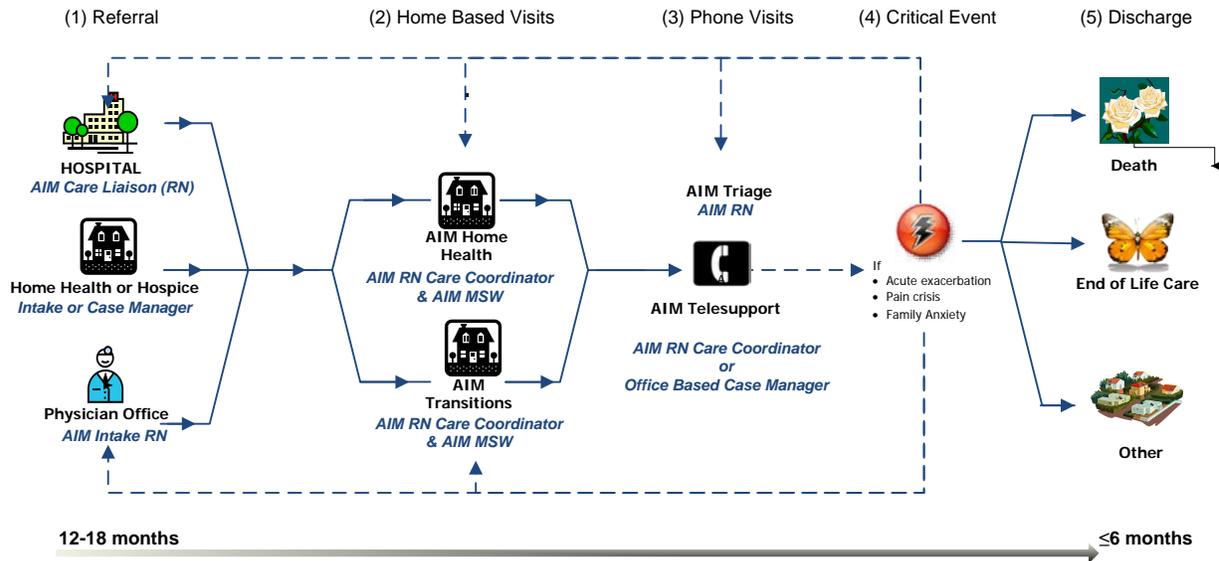
### Over the Phone: AIM Telesupport

- AIM Telesupport RN: Visits over the phone to case manage patients who are relatively stable, following visits from AIM Home Health or AIM Transitions
- AIM Triage RN: Provides after-hours advice to patients and caregivers when contacted; provides tuck-in services at the request of patient's case manager

### Staffing Caseloads

- AIM HH RN average caseloads: 16-18 with an average of 4 visits per day
- AIM Transitions RN average caseloads: 16-20 with an average of 4 visits per day
- AIM Telesupport RN average caseloads: 65

## AIM Patient Flow



## Competencies

- Care management and coordination
- Medication reconciliation
- Symptom management
- Health coaching for self-management
- PC consultation
- Advance care planning

## Relationship to Home Health and Hospice

AIM is a nurse-led interdisciplinary program with MD oversight. AIM Home Health services and some AIM Transitions services are provided under the Home Health license. The remaining AIM Transitions, Telesupport and Triage services are licensed through the hospice license for PC consultative services.

## Reimbursement for AIM Services

AIM Home Health services are reimbursed through standard home health benefits. Other aspects of the program are funded by Sutter Health and a grant from Centers for Medicare and Medicaid Innovations. Sutter is advocating for adoption of future value-based population reimbursement.

## Common Policies

- AIM Administrative Eligibility
- Discharge from AIM

## Benefits of Practice Model

- Dual therapeutic approach: curative + palliative
- Continuous during periods of illness and wellness
- Flexible to ensure right service, right place, right time

- Streamlined and timely communication via EHR
- Patient centered with focus on personal goals
- Improved quality of life
- Reduced utilization
- High patient, caregiver and provider satisfaction

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### **C. Case Example: “Bridge” Programs**

Bridge programs are designed for patients who are eligible for hospice but choose not to elect it, patients who are expected to soon be eligible for hospice, or patients who have been discharged alive from hospice.

Some Bridge programs operate with a core of volunteers that are trained to make periodic outreach calls to these patients. Their training and education is tied to communication and identification of possible decline: decreased functional ability, an increase in physician visits, hospitalizations, etc. Once a volunteer observes one or more of these signs, a hospice nurse or coordinator would then call the patient or physician’s office to reassess hospice appropriateness.

Other programs are staffed by a nurse or social worker. The target patient population and goals are the same: to support the patient and to ease access to hospice at the appropriate time. There is generally no payment for this service, and not all patients will transition to hospice care. Setting up the admissions and discharge criteria and sticking to them is important to avoid any inducement risks. The aim is to track these patients and offer a hospice introductory visit as an option for them as their illness and/or openness to hospice care progresses.

## **IV. Palliative Care Reimbursement**

In this section, we describe the major payers of palliative services and how hospices can participate in providing palliative services today and in the future as payment reform unfolds. For a hospice that bills for physician or NP services, the hospice must enroll with the payer and comply with all the eligibility and payer billing requirements. These requirements are also briefly described with links providing more details.

### **A. Medicare Part A Coverage for PC Services**

While Medicare Part A does not have a dedicated PC benefit like the hospice benefit, there are home health care agencies that will provide PC and bill Medicare under Part A for services that could include nursing, social work, and spiritual care visits as part of the home health episode. Home health services are covered 100 percent under Medicare Home Health Prospective Payment System. Rates are issued annually and paid using the Home Health Resource Grouper for patients who are homebound with a skilled need and meet criteria of care.

These programs can experience financial and quality outcome challenges, as the program will have frail patients in a state of decline having negative outcomes, such as falls, increased weakness, failure to meet goals, and failure to improve. These patients often end up going in and out of the ER, or can be admitted numerous times for inpatient care, resulting in Low-Utilization Payment Adjustments (LUPAs) and further negative outcomes, such as wounds due to skin breakdown and falls. It can also be difficult to get physician orders for these patients who would need frequent order changes due to pain, nausea, etc.

If a Medicare beneficiary is receiving skilled services from a Medicare certified home health agency (HHA), and the beneficiary has been diagnosed with a life limiting terminal illness, but chooses to continue curative treatments, thereby rendering him ineligible for the Medicare hospice benefit, the HHA may contract to purchase specialized pain control services from the hospice provider. The HHA could then enter into a contractual arrangement with a Medicare-certified hospice to purchase specialized nursing services. The hospice would bill the HHA, and the HHA would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which, in this example, are home health services, and, therefore, included in the HHA's episode payment). In this example, the HHA would maintain a medical record on the patient, and the hospice submits any documentation related to pain management to the HHA.

### **B. Medicare Part B Coverage for PC Services**

Medicare does not use the term palliative so coverage is provided by standard Medicare Part B benefits for these specific services. Under Medicare, beneficiaries may see a physician or NP as many times as they wish during a year. However, patients may be responsible for a 20 percent co-payment for every visit after paying the deductible of \$147 (2015). Part B Medicare imposes no restrictions on the type or

number of physicians a beneficiary may visit. Medicare does restrict the higher home visit reimbursement codes for patients who are homebound.

For a hospice that provides physician services for PC, the hospice must enroll in Medicare Part B by filing an application with CMS. The enrollment process includes obtaining a National Provider Identifier (NPI) number and completion of an application through the Provider Enrollment, Chain and Ownership System (PECOS) (CMS 855I and CMS855R) and billing trading agreements. For newly enrolling, re-enrolling/re-validating, or adding a new practice location, the application fee for CY 2015 is \$553. See the link below for specific enrollment steps:

[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll\\_PhysOther\\_FactSheet\\_ICN903768.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf)

Effective October 1, 2009, Medicare issued a HPC (Hospice Palliative Care) specialty code (17) for physician palliative services. In order to be able to bill Medicare for PC services, physicians must have Hospice and Palliative Care listed as a specialty in the National Plan & Provider Enumeration System (NPES). In order to add this specialty, physicians will need to file a new CMS855I enrollment form with Medicare. While specialty code 17 provides greater specificity for data collection, there is no additional reimbursement above what would otherwise be available under Medicare Part B billing.

Some key features of Medicare Part B fee-for-service of physicians, NPs, and LCSW:

- PC is covered for Part B physician services at 80 percent of the usual and customary fees
- Patient is responsible for 20% of the coinsurance unless covered by Medicare supplement plan
- Subject to annual physician fee schedule
- Evaluation & Management (E&M) billing codes must be supported by the clinical documentation
- Medicare also covers services and supplies furnished as “incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills.” To be billed as “incident to,” the services of non-physician practitioners, such as NPs, must meet four criteria:
  - The services must be performed under a physician's “direct supervision”
  - The services must be performed by employees (including leased employees) of the supervising physician, the physician's group or the physician's employer
  - The physician must initiate the course of treatment of which the NP's services are a part
  - The physician must perform subsequent services of sufficient frequency to reflect the physician's continuing active participation in managing the course of treatment
- An NP's services (other than “incident to” services) are reimbursed at 85 percent of the amount shown on the participating physician fee schedule
- To bill Medicare for NP services (other than “incident to” services), each NP needs a provider number
- NPs are allowed either to bill Medicare directly under their own provider numbers or to reassign their billing rights to employers or other contracting entities. For a physician practice to receive payment for services provided by NPs whom it employs or contracts with, the NPs must reassign their payment rights to the practice
- Healthcare Common Procedure Coding System (HCPCS) modifiers to the Common Procedural Terminology (CPT) codes are required for NP services, such as AK (NP, rural, team member), AV (NP, rural, not a team member), and AL (NP, non-rural, team member)

- LCSW psychotherapeutic services are billable with DSMIV diagnoses. See link below for billing for mental health services:  
[http://www.cms-billing.com/forms/NHIC\\_Medicare\\_B\\_Mental\\_Health\\_billing\\_guide\\_2008.pdf](http://www.cms-billing.com/forms/NHIC_Medicare_B_Mental_Health_billing_guide_2008.pdf)
- Claims are submitted on a 1500 claim form
- CPT coding is based upon setting and either complexity or time (the latter when coordination of care or counseling comprises 50 percent or more of the encounter). For further guidance on Evaluation and Management documentation and coding, including the 1995 and 1997 guidelines, see the following link:  
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>

### **Coordinating Coverage, Reimbursement, and Care for Palliative Care Services to Patients on the Medicare Hospice Benefit**

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an independent attending physician who is not an employee of the designated hospice nor receives compensation from the hospice for those services.

These independent attending physician services are billed through Medicare Part B to the Medicare contractor, provided they were not furnished under arrangement with the hospice. The independent attending physician codes services with the GV modifier "Attending physician not employed or paid under agreement by the patient's hospice provider" when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. The Medicare contractor makes payment to the independent attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service. When the attending physician is an employee of the hospice, he/she cannot bill Medicare Part B directly. In this case, the physician bills the hospice provider who, in turn, bills Medicare and reimburses the physician.

When the independent attending physician furnishes a terminal illness related service that includes both a professional and technical component (e.g., x-rays), he/she bills the professional component of such services to the Medicare contractor on a professional claim and looks to the hospice for payment for the technical component. Likewise, the independent attending physician, who may be a NP, would look to the hospice for payment for terminal illness related services furnished that have no professional component (e.g., clinical lab tests).

In the case of PC services, multiple scenarios can exist. If the PC physician is both an independent physician and designated by the patient as the primary care provider, they bill Medicare Part B directly, as noted above. If the PC physician is the PCP and related to the hospice program, then they must bill the hospice program which bills Medicare under Part A. These fees are included in the Medicare Hospice Aggregate Cap Calculation. If the PC physician is not the PCP, but is brought into the case as a consulting physician, the physician should first have a Consulting Agreement with the hospice, and should bill the hospice directly. Then the hospice will bill Medicare for the service (which would also be included in the Aggregate Cap).

Effective January 1, 2005, Medicare allows payment to a hospice for specified hospice pre-election evaluation and counseling services when furnished by a physician who is either the medical director of or employee of the hospice.

Medicare covers a one-time only payment on behalf of a beneficiary who is terminally ill (defined as having a prognosis of 6 months or less if the disease follows its normal course), has no previous hospice elections, and has not previously received hospice pre-election evaluation and counseling services.

HCPCS code G0337 “Hospice Pre-Election Evaluation and Counseling Services” is used to designate that these services have been provided by the medical director or a physician employed by the hospice. Hospice agencies bill their home health and hospice Medicare contractor directly using HCPCS G0337 with Revenue Code 0657. No other revenue codes may appear on the claim.

Claims for “Hospice Pre-Election and Counseling Services,” HCPCS code G0337, are not subject to the editing usually required on hospice claims to match the claim to an established hospice period. Further, contractors do not apply payments for hospice pre-election evaluation and counseling consultation services to the overall hospice cap amount.

Medicare must ensure that this counseling service occurs only one time per beneficiary by imposing safeguards to detect and prevent duplicate billing for similar services. If “new patient” physician services (HCPCS codes 99201-99205) are submitted by a Medicare contractor to the Common Working File (CWF) for payment authorization, but HCPCS code G0337 (Hospice Pre-Election Evaluation and Counseling Services) has already been approved for a hospice claim for the same beneficiary, for the same date of service, by the same physician, the physician service will be rejected by CWF, and the service shall be denied as a duplicate.

## **C. Medicare Part C Coverage for PC Services**

Medicare Advantage (MA) plans are required to cover the same services as traditional Medicare and to apply no more restrictive coverage criteria. The relationship between providers and MA plans is contractual, however, and providers will need to carefully review their contracts with each MA plan to ascertain payment amounts and pre-requisites such as prior approval.

Unlike Medicare fee-for-service, Medicare Advantage gives physicians a financial incentive to recommend hospice for patients nearing the end of life because, under existing law, when plan members enroll in hospice, fee-for-service Medicare becomes the payer. This hospice “carve-out” makes it attractive for a plan to shift patients likely to be high cost from its rolls to the Medicare Hospice Benefit, but also decreases the incentive for the plan to develop high-quality PC services. As of the date of this publication, federal policymakers are evaluating whether this “carve-out” should continue.

Medicare Part C Medicare Advantage Plans:

- Coverage must be same as Part B
- Physicians must contract with the Part C carrier
- Services subject to carrier fee-for-service rates, authorization, and billing requirements

## D. Medicaid Coverage for PC Services

PC services, while not defined per se, can be billed to the extent that they qualify as reasonable and necessary under each state's plan. Medicaid rates, however, may be less than other payers. Some states are considering a "PC bundle" under Medicaid managed care or innovation grants.

### Key Features of Medicaid Palliative Services

- Professional services are dependent on state plans, provider agreements and rate setting.
- Medicaid third party administrators (TPAs) or Managed Care Organizations (MCOs) authorize palliative services subject to payment review and billing requirements, such as authorizations and timely filing.
- Future payment reform with CMS State Innovations Models (SIM) could change how Medicaid reimburses PC services. See <http://innovation.cms.gov/initiatives/state-innovations/>
- SIM multi-payer payment and delivery models offer the opportunity to accelerate health transformation. These efforts are designed to reduce reliance on payment methodologies based on volume and encourage movement toward payment based on outcomes by reinforcing the expectation that providers and payers must be engaged in order to create meaningful delivery and payment system reforms.

## E. Private Insurance Coverage for PC Services

Private insurance plans, generally offered as Employer Group Health Plans, define patient eligibility, PC benefits, physician/NP rates, and billing requirements. Provider agreements stipulate if authorization is needed to bill. Timely filing limits can be much shorter than other payers, increasing exposure to claims denials.

New models for advanced disease care that allow patients to receive hospice-like services and disease treatments at the same time are being offered by some commercial plans. These benefits could expand palliative services to covered members.

PC partnerships are forming to offer payment and incentives to providers that integrate PC practices and demonstrate associated quality outcomes. See the following link: [https://www.capc.org/media/filer\\_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-provider toolkit-2015.pdf](https://www.capc.org/media/filer_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-provider toolkit-2015.pdf)

The PC partnerships strive to ensure that PC and related services (such as advance care planning discussions) are defined as medically necessary and to enhance member benefits and provider reimbursements to reduce financial and awareness barriers to PC services. Key features of the PC partnership include:

- Medical policies should cover PC home visits for both physicians and non-physician team members.
- Benefits should include hospice and PC services offered concurrently with medical treatment, even if a reasonable limit is placed on those services.
- Preauthorization policies should support early and ongoing as-needed engagement of PC services.
- Reasonable payment fees for PC specialists to include PC team members, such as social workers, chaplains, and dedicated care coordination service professionals.

- Adherence to PC standards and the achievement of specific related outcomes (such as the conduct and documentation of goals-of-care conversations, assessment and treatment of distressing symptoms, safe opioid practices, appropriate and timely hospice referrals, and routine assessment of and support for family caregiver needs).
- Inclusion of all providers (i.e., primary care, hospice, specialist and PC providers) and care delivery team members in payment innovation program incentives for the outcome measures listed above.

## **F. Veterans Health Administration (VA) Coverage for PC Services**

All VA facilities have a Palliative Care Consult Team (PCCT) as a resource for hospice and PC provided in the VA facility and coordinated in the community. In the past, the VA furnished home hospice services through a limited fee for service program using Medicare LUPA rates. Today, all enrolled veterans are eligible for a comprehensive array of needed in-home services. These services in VA's Medical Benefits Package, including hospice and PC, are playing an increasingly important role in VA's integrated health care delivery system (see Title 38 Code of Federal Regulations (CFR) 17.38(a)(1)(xi)A).

One out of every four dying Americans is a veteran. Veterans often carry experiences from their service that present unique challenges, and, unfortunately, many of them may not know about or have access to hospice and PC. In an effort to address these concerns and respond to the needs of veterans, the National Hospice and Palliative Care Organization partnered with the Department of Veterans Affairs in 2010 to create a program called *We Honor Veterans*. See the following link: <http://www.wehonorveterans.org/whv-community-partner-levels>

Another VA program, *Reaching Out*, provided a grant opportunity sponsored by NHPKO, in collaboration with the Department of Veterans Affairs, for hospice providers who are experienced in providing quality hospice and PC for rural and homeless veterans.

## **G. Alternative Methods of Funding Palliative Care**

Under current traditional fee-for-service provider contracts, physician and NP reimbursements generally do not cover the cost of these professional palliative consultation services. Hospices or home health agencies that elect to provide palliative services in hospitals, nursing facilities, or the patient's homes are faced with absorbing the additional costs or finding funding to subsidize the losses. Hospices and home health agencies that provide palliative services are now increasingly likely to negotiate with hospital systems, free standing hospitals, and nursing facilities to cover the costs of palliative consultation services not covered by third party payers. As PC programs demonstrate reduced overall costs for these institutions, such as outsourcing cost-effective palliative services or reducing readmission penalties, they are in a favorable position to negotiate contract rates that cover the full cost of palliative services.

## **H. Proposed Legislation in Support of Palliative Care Planning**

The Care Planning Act establishes Medicare reimbursement for healthcare professionals and provides a voluntary and structured discussion about the goals and treatment options for individuals with serious illness, resulting in a documented care plan that reflects the informed choices made by patients in consultation with members of an interdisciplinary team, faith leaders, family members and friends.

In February 2015, the U.S. Department of Health and Human Services (HHS) announced a new multi-payer payment and care delivery model to support better care coordination for cancer care as part of the Department's ongoing efforts to improve the quality of care patients receive and to spend health care dollars more wisely, contributing to healthier communities. The initiative will include 24-hour access to practitioners for beneficiaries undergoing treatment, and an emphasis on coordinated, person-centered care, aimed at rewarding value of care, rather than volume. The Oncology Care Model encourages participating practices to improve care and lower costs through episode-based, performance-based payments that financially incentivize high-quality, coordinated care. Participating practices will also receive monthly care management payments for each Medicare fee-for-service beneficiary during an episode to support oncology practice transformation, including the provision of comprehensive, coordinated patient care.

## **I. Summary - Reimbursement for PC Services**

In summary, the financing and organization of the U.S. health care system are undergoing significant changes that have major implications for end-of-life care. These changes are resulting from the ACA, as well as from private-sector payment initiatives and state policies. However, absent incentives and mechanisms for true integration across program eligibility, benefits, and financing, it will be impossible to achieve an effectively functioning continuum of care for people with advanced serious illnesses (IOM, "Dying in America," page 5-34). In the meantime, hospice and other entities are encouraged to develop palliative services with existing reimbursement and strategic partnerships with other providers to optimize reimbursement to provide essential PC services in all settings.

## V. The Value Proposition for Palliative Care

This section outlines key benefits of PC services, and outlines metrics that can be used to support and demonstrate on an ongoing basis the value of a PC program.

### A. Marketing Palliative Care Services

Payers, providers, and communities are collaborating to find ways to market PC. Hospitals and health care system administration are particularly interested in driving down costs while providing increased quality. An example includes a study (1) of New York State hospitals enrolled in the Medicaid program. The patients who received patient care incurred \$6,900 less in hospital costs in an admission than a matched group receiving usual care. The potential impact on annual savings ranged from \$84 million to \$252 million for hospitals with 150 plus beds having a fully operational PC team. Other marketing benefits include much lower inpatient hospital admission rates for participants. In addition to the bottom line, administrators see benefits to medication error reductions, compliance with accreditation standards, patient satisfaction, and increased capacity.

Another study (2, 3) demonstrated cost savings during the last three months of life and the last two weeks of life, enhanced hospice entry, and longer length of stay in hospice.

Studies also prove physician and clinician interest specifically in areas of outcomes, patient control, and patient satisfaction. Of particular interest are improvements in symptom domains (anxiety, appetite, dyspnea, well-being, depression, and nausea). Patients are spending less time in intensive care units and are more likely to receive hospice referrals. Many studies demonstrate longer survival rates, improved outcomes and lower costs. Multiple studies supporting PC in oncologic settings have shown improvements in the percent of patients completing treatment, quality of life for both the caregiver and patient, longer life, and less costly hospitalizations when PC is

*An approach that enabled more people to remain in their homes or home-like settings in the final stages of life would better align with the preferences of many patients and families than the current system. A significant barrier to improving the quality of end-of-life care and controlling costs is that the mix of services currently delivered and paid for fails to provide for precisely those needs that drive repeated reliance on the emergency and acute care systems: around-the-clock access to meaningful help, house calls and home care/caregiver support, and long-term services and supports. Although some states have used the demonstration and waiver authorities under Medicare and Medicaid to create a more comprehensive continuum of services for the elderly and people who have disabilities, the nation is far from achieving an easily accessible, reliable system of care for people who have advanced serious illnesses and are nearing the end of life. Clearly, significant changes in the approach to service delivery would be needed to effectively integrate traditional medical care and social services.*

IOM, "Dying in America," page 5-34

provided along with oncology services. Patients also benefit from higher length of stay in the hospice benefit. In addition to improvements in multiple symptom management, studies show increase in advance directive completion and increase in likelihood of dying at home.

Opportunities also exist for payers, providers and communities to work together to find ways to deliver and finance PC. Multiple toolkits are offered online as a reference guide for organizations that lead the financing of healthcare (commercial insurers, self-funded employers, and federal and state agencies). Providers may also be interested in working in shared risk arrangements. PC strategies for payers consist of community collaboration and awareness. Examples include collaboration with providers, churches, medical societies, and health systems to strengthen awareness of the benefits of PC. Payer profiles with specific case studies, such as Aetna, Excellus Blue Cross Blue Shield, and Highmark Insurance saw a total cost reduction of \$12,000 per member by referrals to PC (4, 5).

### Resources for Marketing Palliative Care

1. Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries, HEALTH AFFAIRS, Vol 30, No 3, March 2011, R. Sean Morrison, et al
2. Cost Savings and Enhanced Hospice Enrollment with a Home-Based Palliative Care Program Implemented as a Hospice – Private Payer Relationship, JOURNAL OF PALLIATIVE MEDICINE, Volume 17, Number 12, 2014, Christopher Kerr, MD, PhD, et al
3. Clinical Impact of a Home-Based Palliative Care Program: A Hospice-Private Payer Partnership, JOURNAL OF PAIN AND SYMPTOM MANAGEMENT, 2014, Christopher W. Kerr, MD, PhD, et al
4. Improving Care for People with Serious Illness through Innovative Payer-Provider Relationships, Center to Advance Palliative Care (CAPC), [https://www.capc.org/media/filer\\_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-providertoolkit-2015.pdf](https://www.capc.org/media/filer_public/0f/2f/0f2f8662-15cf-4680-baa8-215dd97fbde6/payer-providertoolkit-2015.pdf)
5. Presenting the Case for Palliative Care, in A GUIDE TO BUILDING A HOSPITAL-BASED PALLIATIVE CARE PROGRAM – 1 BUILDING THE CASE FOR HOSPITAL PALLIATIVE CARE, Center to Advance Palliative Care (CAPC), pages 1.29 – 1.32 (*Note: many CAPC resources are now available only to members*)
6. Evidence-Based Practice of Palliative Medicine, 2012, Nathan E Goldstein MD, R. Sean Morrison MD
7. 5 Characteristics of programs that capture the value of palliative care, June 2014 <http://www.advisory.com/research/physician-executive-council/resources/posters/5-characteristics-of-programs-that-capture-the-value-of-palliative-care>

In assessing opportunities to market PC services, consider the following:

- Priorities of your target audience
- Decision-making process of targets
- How PC will compare to other alternatives for meeting end of life care needs
- Identification of clinical, administrative, or other key champions affiliated with target

## B. Making the Case for PC – Metrics

The appropriate metrics will vary with the model, setting and goals of each PC program. Measures can include both process metrics, such as volume, conversion rates, setting, contracts per patient, duration of service, etc., and/or outcome metrics, such as symptom control, quality of life, patient/family satisfaction, staff satisfaction, comparative cost to other alternatives, and quality. Potential metrics can be found in literature endorsed by professional organizations. They include:

- National Consensus Project Clinical Practice Guidelines
- IOM proposed Core Components of Quality End-of-Life Care
- CAPC Payer-Provider Partnerships Essential Skills and Structures
- National Quality Forum Measures

The Joint Commission (TJC) has developed standards and elements of performance for Advanced Certification for Palliative Care Programs in hospitals. We understand that TJC is considering expansion of standards to include other settings of care beyond acute care.

Key considerations for PC programs to consider when selecting measures include:

- Ability to compare to control groups of non-PC patients
- Correlation to program/target goals
- Ready availability of data

In making the case to establish a PC program to a new potential host facility, it is important to emphasize the value of what is truly best for the patients they serve. By having certified staff attend to the patient's palliative needs, like pain control and symptom management, the potential host facility is addressing patient needs in the best possible way. In addition, many host facilities recognize that their medical staff are not inclined or equipped to handle difficult conversations over the patient's prognosis or the decision to discontinue aggressive treatments. As a result, patients and families feel comfortable with the facility addressing their needs in a personal and caring way, which will result in increased patient satisfaction for the hosting facility. In addition, with the guidance of the PC staff, patients are offered the information they need to properly set their future course of treatment.

PC programs have been able to document a reduction in the length of stay at the host facility as patients and their families feel more comfortable leaving the host facility on a timely basis. There is not the uncertainty of what to do after discharge as a good PC service will assist the patient and their family in what types of services are available to them. This is particularly important in cases where the decision to elect hospice is not the patient's first choice. Under a palliative program, those patients could be assisted at home through home health services until they feel comfortable in electing hospice. Meanwhile, their pain and symptoms are under control and being actively managed, which is a true benefit for those not ready to elect hospice, but in need of those services. In short, the case is clearly made to a potential host facility that everyone will benefit under the PC program.

## **VI. Next Steps**

As noted in other sections of this report, PC is in the process of evolution and development. Not only is PC evolving, but this development is occurring within the context of other changes within the larger health care arena. NAHC and its members have the opportunity to play key roles in several aspects of this ongoing process.

### **A. Sharing Best Practices**

As PC evolves, it will be increasingly valuable for providers to share data related to best practices, predictive instruments/analytics, overcoming barriers and justification of PC in terms of Triple Aim goals (lower cost, higher quality/satisfaction and access). NAHC is committed to support this process through papers such as this one, topics for its conferences and webinars, and encouraging the sharing of best practices in general.

### **B. Policy Advocacy**

As best practices become clearer, we can envision public policy efforts by NAHC and its members to establish standardized approaches to delivery and reimbursement of PC. NAHC will be monitoring the development of PC programs with the intent to recommend policy changes on a timeline and in a manner that supports the development of PC while not squelching innovation and creativity in the evolution of PC services. In alignment with the previous paragraph, the immediate focus will be on support for the development of metrics for providers and insurance plans related to effective care at the end of life. Policy options for NAHC to consider include:

1. Working in concert with other PC stakeholders to identify and promote palliative care best practices and to expand the availability of PC services
2. Testing of palliative care programs in the Centers for Medicare and Medicaid Innovations
3. Exploration of a stand-alone Medicare PC benefit
4. Permitting categorical waivers within Medicare shared savings initiatives, such as ACOs, that allow at-risk entities to utilize PC services
5. Authorizing Medicare Advantage Plans to provide PC services as part of a benefit extension
6. Expanded and/or clarified standards for coverage of PC as part of the Medicare home health benefit through application of the Skilled Management and Evaluation of a Care Plan Service under 42 CFR 409.43 and 409.33 along with use of specific physician CPT codes on PC with adequate reimbursement to match.