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How States Can Embed Palliative Care in Health Care Reform Initiatives

State policymakers have a number of different opportunities to integrate palliative care into current health care initiatives.

Opportunities for State Policymakers

State health reform efforts increasingly focus on providing comprehensive and well-coordinated care to people with serious illness to improve quality of care and drive down costs.

Palliative care can be an important component of these strategies. Research shows that palliative care can:

- Result in cost savings and lower service utilization during the last three months of life
- Reduce hospital costs of care in Medicaid populations
- Lower intensive care unit admissions
- Improve patient quality of life

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What Is Palliative Care?

Palliative care is an interdisciplinary service addressing the symptoms and stresses of serious illness. It includes elements such as:

- Pain and symptom assessment and management
- Care coordination
- Advance care planning
- Shared decision-making for treatment options
- Caregiver assessment and support
- Psychological and spiritual counseling and support

Palliative care is appropriate for individuals at any age and at any stage of illness, from curative to chronic illness to end-of-life.

Unlike hospice care, palliative care can benefit people with serious illness prior to end-of-life and is provided concurrently with curative treatment.

State Solutions and Promising Practices

Many models and Medicaid authorities already provide a framework for providing palliative care services. States can use these models to advance access to palliative care.

Medicaid 1915(c) Home and Community-Based Services Waivers

These waivers provide home and community-based services (HCBS) such as personal care for target populations such as older adults and people with disabilities. As of 2022, over 300 waivers are active across states. States can use these waivers to target services, including palliative care, to specific groups.

Strategies for embedding palliative care in 1915(c) HCBS waivers:

- The HCBS entity can include assessment for palliative care services and linkage for consultations in required activities.

Colorado's 1915(c) HCBS waiver for children with life-limiting illness specifically for palliative care services includes:

- In-home respite care that can incorporate home health, nursing, personal care, and expressive therapy
- Palliative care services such as care coordination (telehealth allowed), pain and symptom management, and counseling supports

Medicaid Managed Care

In this model, managed care organizations (MCOs) are paid a per member/per month payment for delivering a comprehensive package of Medicaid services through a contract with the state. In 2022, 40 states and DC had comprehensive Medicaid managed care.

Strategies for embedding palliative care in Medicaid managed care:

- Train care managers to assess subsets of patients for palliative care needs and to conduct goals of care conversations.
- Ensure palliative care specialists are included in Medicaid MCO networks.
- Support specialty palliative care teams through distinct payment models.

Washington's Medicaid program, Apple Health, has integrated Medicaid managed care for health care and behavioral health services to help provide whole-person care under one health plan. Washington has defined rules for palliative care for individuals 20 and younger in Medicaid and lists palliative care for adults as a covered service within its Apple Health contract.

Home health services, including palliative care, through state-licensed agencies is also listed as a covered service in the Apple Health contract.

Note: Although palliative care is a listed covered benefit in the rules, the Washington State Hospice and Palliative Care Organization is currently trying to secure full interdisciplinary team funding for the state's Health Care Authority to design a Medicaid palliative care benefit for reimbursement.

California's 2022 Enhanced Care Management Policy Guide

As part of California Advancing and Innovating Medi-Cal (CalAIM) — a framework that encompasses delivery and payment reform across Medi-Cal, California's Medicaid program — this policy guide identifies the need for palliative care as part of the comprehensive health assessment:

"Activities in the Comprehensive Assessment and Care Management Plan core service must include, but are not limited to: [...] In the Member's care plan, incorporating identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD [substance use disorder], LTSS [long-term services and supports], oral health, palliative care, necessary community based and social services, and housing."

Medicaid Managed Long-term Services and Supports (MLTSS)

In Medicaid MLTSS, managed care plans, through contracts with the state, deliver a comprehensive package of services that includes long-term services and supports (LTSS). Within Medicaid MLTSS, states' Medicaid agencies provide MCOs with capitated payments to deliver LTSS. As of 2022, 23 states had Medicaid MLTSS for older adults and adults with physical disabilities.

States that have Medicaid MLTSS for older adults and adults with physical disabilities (as of 2022)

AZ	CA	DE	FL	HI	ID	IL	IA
KS	MA	MI	MN	NJ	NM	NY	OH
PA	RI	SC	TN	TX	VA	WI	

23 States

Strategies for embedding palliative care in Medicaid MLTSS:

- Include palliative care-related requirements, such as pain management, in contracts.
- Require care managers to provide person-centered planning and end-of-life care.
- Include broad definitions for program eligibility in contracts that include those with complex care needs.

South Carolina's Healthy Connections Prime Financial Alignment Initiative (FAI) model demonstration incorporates palliative care by including a palliative care benefit in its contract, which covers comfort care and pain management. Eligibility includes those with a serious, chronic, or life-limiting illness who may not qualify for hospice services.

Note: a CMS final rule from May 2022 notes a plan to transition capitated FAI demonstration models to integrated dual-eligible special needs plans (D-SNPs) by 2025.

Arizona's Inclusion of End-of-Life Care Education in Case Manager Requirements

Arizona's Long Term Care System — for older and physically disabled individuals — managed care contract requires case managers to inform members, individuals authorized to make treatment decisions for a patient, and designated representatives about person-centered planning services and end-of-life care; and provide assistance to members in accessing services. The contract defines end of life care as:

"A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness."

Dual-Eligible Special Needs Plans (D-SNPs)

D-SNPs are a managed care option for beneficiaries eligible for both Medicare and Medicaid ("dual-eligible" beneficiaries) in Medicare Advantage. Some states require Medicaid MCOs to offer an affiliated D-SNP that serves dual-eligible beneficiaries to better integrate Medicaid and Medicare services. As of January 2023, 45 states and DC have contracts with D-SNPs.

Strategies for embedding palliative care in D-SNP requirements:

- Incorporate care manager training, care manager assessments, referrals to palliative care, and palliative care providers in-network into D-SNP contracts.

California's CY2024 D-SNP Policy Guide includes care coordination requirements for D-SNPs around the provision of palliative care, including guidance around eligibility, providers and settings, and services.

Connecting to Providers with Serious Illness Training through D-SNPs

In an analysis of three listening sessions held by the Center to Advance Palliative Care (CAPC) in collaboration with NASHP with Medicaid-serving organizations, representatives from Medicaid managed plans, certified home health agencies, and palliative care programs recommended that D-SNPs should demonstrate capacity to connect enrollees with a clinician trained in serious illness communication skills, such as through palliative care telehealth organizations or their own nurse care managers.

Patient-Centered Medical Homes (PCMH)

In the PCMH model, care is coordinated by a primary care physician and incorporates physical and behavioral health care support, interdisciplinary teams, patient-centered care, and care coordination. As of state fiscal year 2023, 24 states report having PCMH in place for Medicaid beneficiaries.

Strategies for embedding palliative care in PCMH:

- Train PCMH nurse care managers in both assessment and communications.
- Train prescribing clinicians in effective pain management targeted to those with palliative care needs.

Oregon legislation established the Patient-Centered Primary Care Home Program in 2009. PCMH recognition criteria include:

- A process for coordinating hospice and palliative care and counseling
- A process for discussing end-of-life planning

Medicaid Health Homes

Medicaid Health Homes is a model of care for beneficiaries with serious chronic conditions that is team-based, focused on care coordination and case management, and incorporates behavioral health, physical health, and LTSS. Medicaid Health Homes' core services are:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care and follow-up
- Patient and family support
- Referral to community and social support services

As of 2022, 18 states and DC have state plan amendments to establish health homes.

Strategies to embed palliative care in Health Homes:

- Health Homes could provide ongoing care coordination and support.
- Palliative care specialists can provide targeted consultations when screening a patient or a caregiver for needs.

Washington State Legislation Supporting Palliative Rural Outreach and Patient Decision Aid Certification

As part of the Washington Rural Palliative Care Initiative, Washington State developed the Palliative Care Road Map funded through the state legislature. The roadmap includes information for patients and caregivers on palliative care services and supports, including culturally sensitive content. Through Washington State legislation, the Washington State Health Care Authority's medical director is authorized to certify patient decision aids for assisting patients in shared decision-making.

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