SERVICES AND BENEFITS

"Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge." Institute of Medicine, Dying in America 2014

What it is and Why it's Important

Palliative care encompasses a range of services that address symptoms and stresses of serious illness, delivered by an interdisciplinary team, and often coordinated with additional service providers. Key members of palliative care teams are the clinicians – physicians and advanced practice practitioners – who provide medical services that are medically necessary and already covered through traditional medical benefits, including Medicare Part B. In other words, palliative care is not a new service that needs a new, distinct benefit.

However, there are often limits put in place*, and there are also non-medical services that seriously ill patients need which are often not included in standard benefit packages. For these reasons, health plans and ACOs

* For example, hospice care is a well-known and comprehensive delivery model of palliative care that many health plans make available, but too often health plans unnecessarily replicate the same restrictions that exist in the Medicare hospice benefit: requiring two doctors to certify a prognosis of six months or less to live, and that the patient agrees to forgo coverage for disease-modifying treatment. As explained further below, commercial hospice benefits do not need to follow these same restrictions and individuals and the plan often benefit when these restrictions are modified.

should take steps to evaluate the benefits and services available, so that appropriate palliative care services are available to the right patients.

Health plans and ACOs must also recognize that palliative care is additive to existing medical services and treatments, and should be available regardless of diagnosis or stage of illness. At diagnosis, patients need initial discussions about the benefits and drawbacks of treatment options and what to expect in the future, as well as preliminary advance care planning. They will also need pain and symptom management while they pursue disease-directed therapies, to maximize function, independence, and quality of life for as long as possible.

Best practices in Matching Services to Needs

While the specific services provided will depend on a person's need, there are certain key service capabilities that are fundamental to the care of all persons with serious illness:

1. **Expert pain and symptom management**
2. **Meaningful 24/7 clinician availability**
3. **Shared decision making using expert communication skills, including:**
   a. **Explaining what to expect with disease progression and treatment options, in terms that the patient and family can understand**
   b. **Eliciting patient and family caregiver concerns and priorities**
   c. **Advance care planning processes**
4. **Family caregiver support, including emotional support and personal care supports for the patient**
5. **Ability to mobilize practical social supports**

Below are examples of detailed service needs by risk category (low to high in terms of severity/intractability), presented in line with the domains of the National Consensus Project Guidelines for Quality Palliative Care.

1. Physical Symptoms: Pain, Dyspnea, Nausea

Low	Medium	High
• Palliative care consult • Treatment recommendations to treating provider • Patient and family self-care teaching • Palliative care in-home medication ("comfort") pack in case of urgent need (eg low dose opioids for dyspnea crisis)	• Continued palliative care specialist consults • Self-care teaching and tools, as for Low Need • Home-based nursing and social work for member and family education, medication reconciliation, home safety and social supports assessment • Some home-based therapies (e.g. PT, OT) • Home adaptations as needed (e.g., air conditioning, gait assist devices, grab-bars etc.) • Palliative care in-home medication ("comfort") pack in case of urgent need	• Home-based primary and palliative care, inclusive of physician, nursing, social work, and spiritual care; or • Ongoing palliative care specialist co-management, if not serving in the primary clinician role • Home adaptations • Complementary services (e.g., massage or acupuncture) • Family caregiver supports such as respite care, counseling, support groups • Palliative care in-home medication ("comfort") pack in case of urgent need

2. Functional Symptoms: Impairments in Activities of Daily Living (ADLs) and Instrumental ADLs

Low	Medium	High
• Durable medical equipment (DME), as needed	• Home environment safety assessment and follow-up	• Personal care services (home health aide)

• Outpatient therapy, as needed	• Home adaptations as needed (eg, grab bars) • Home-based physical and/or occupational therapy • Personal care (home health aide), limited	• Housekeeping and other home environmental supports • Home-based therapy; may be compensatory instead of restorative

3. Psychological Symptoms: Depression, Anxiety, Trouble Coping

Low	Medium	High
• Linkage to community supports • Psychopharmacology • Referral to psychological and/or psychiatric services for both member and family caregivers	• Linkage to community supports • Psychopharmacology • Referral to psychological and/or psychiatric services for both member and family caregivers • Substance use counseling, as needed • Counseling facilitation services, such as transportation or home visits	• Linkage to community supports • Psychopharmacology • Referral to psychological and/or psychiatric services for both member and family caregivers; and/or • Home-based counseling • Family counseling, in the home • Substance use counseling, as needed

4. Social and Economic: Food, Transport, Environmental Supports, Friendly Visiting

Low	Medium	High
• Benefits and entitlements assistance • Linkage to community supports	• Benefits and entitlements assistance • Linkage to community supports, with follow-up • Linkage to financial assistance, with follow-up	• Benefits and entitlements assistance • Linkage to community supports • Psychological counseling • Food, transport, safety, and housing services as needed • Linkage to financial assistance, with follow-up

5. Spiritual, Religious, and Existential: Chaplaincy, Structured Worship

Low	Medium	High
• Linkage to spiritual supports in the community	• Linkage to spiritual supports in the community, with follow-up • Chaplain “consult”	• In-home Chaplain visits, as needed

6. Caregiver Support: Training, Trouble coping, Respite

Low	Medium	High
• Caregiver linkage to community supports	• Caregiver psychological counseling • Caregiver spiritual counseling • Supplemental caregiver education	• In-home respite care or respite stay in a care facility • Personal care services for the patient • Caregiver counseling and education

Many organizations have created home-based palliative care programs to deliver the full range of services, varied according to level of need. See Case Studies, including ProHealth, Sharp and Kaiser Permanente.

Best practices in Coverage and Benefit Design

Modifying and Adding Health Plan Benefits

Recall that some palliative care services are already covered under Part B codes as medical services, and some members – through luck or their own self-advocacy – will already be accessing pieces of what they need. However, to have a broader impact, health plans should **conduct a comprehensive review of all existing benefits and policies available to a person with serious illness** to ensure adequate coverage of their holistic medical, home health, pharmacy, skilled nursing, and behavioral health needs.

A comprehensive benefit review should start with the services listed in in ***Best Practices in Matching Services to Needs***. For some needs – such as home health care, medical supplies, DME, or specialist visits – a health plan may cover the services necessary, but would need to evaluate and potentially amend its policies that impact access to those services, such as:

- Can co-payments be eliminated, or deductibles waived for certain services, such as palliative care specialist consultations?
- Can the home care benefit eligibility be modified, to cover home visiting services of nurses, social workers and other professionals for those identified as having a serious illness, regardless of meeting "homebound" or "skilled need" criteria?
- Can performance guarantees of turn-around time for delivery of supplies and durable medical equipment be added to network provider contracts?

For other needs, a health plan will need to evaluate and potentially change prior authorization requirements, utilization limitations, or benefit periods, or consider development of additional benefits. For example:

- Can in-home respite care and/or adult day care be made available for members with overwhelmed family caregivers?
- Can the home health benefit be modified to enable personal care services for members who need assistance with "instrumental activities of daily living" (e.g. food preparation)?
- Can marriage and family counseling be made available to seriously ill members and their families without utilization limitations?
- Can home adaptation be added as a benefit for those authorized under certain circumstances?

Reconsider utilization criteria and limits to coverage even for those services that may rarely be used. Developing coverage maximums and eligibility criteria for these services and documenting them as part of medical policy allows for increased timeliness and appropriateness of responses by utilization managers and medical directors while also mitigating the risk of allowing individual or single case considerations to be extended to those without a defined need. This not only improves the patient, family, and provider experience through transparency in coverage determinations, but also decreases time and resources spent reviewing appeals and grievances from seriously ill people and their family caregivers.

The examples in the table below illustrate the types of review of benefit coverage and policies, as well as potential changes:

Needed Service	Covered Under a Standard Benefit?	Suggested Policy Determinations/Eligibility Criteria
Palliative care consultations	Yes	Eliminate cost-sharing for visits billed by palliative care specialists, as well as for all billed advance care planning conversations.
Durable medical equipment (DME)	Yes	Ensure that urgent supplies and DME (e.g. breathing apparatuses, compressors, etc.) are covered under a performance guarantee, requiring all contracted vendors to deliver supplies in less than 8 hours.
Home environment safety assessment and follow-up	No	Cover service by specified service providers licensed with the state to perform home assessments for all individuals with moderate functional impairment.
Home adaptations or modifications (e.g., grab bars)	No	Cover service for all individuals with moderate functional impairment up to a specified dollar amount.

Home-based physical and/or occupational therapy	Yes	Ensure that all individuals with moderate functional impairment can access services and not simply those who are determined homebound. Ensure that services provided can be both restorative and rehabilitative in nature.
Personal care services	Sometimes	Cover a defined number of home health aide hours per week for all individuals with significant functional impairment. Cover non-emergency transportation for members meeting eligibility criteria.
Respite services for family caregivers	No	Ensure that individuals living at home and meeting the nursing facility level of care who have a primary caregiver providing greater than 16 hours per month of primary caregiving have access to a defined number of hours of in-home respite and/or a specified number of adult day care days per week.
Access to a Spiritual Professional	No	Ensure that certified healthcare chaplains are covered. Getting started with this benefit can focus on advance care planning visits.
Marriage and Family Counseling	Yes	Eliminate utilization limitations. Consider elimination of cost-sharing.
Personal Emergency Response System	No	Ensure that all individuals who meet the following criteria have coverage for a basic monitoring device: Spends most of time at home alone; dependent for more than 3 ADLs; legally blind; have had a recent fall resulting in hospital stay; is at high risk for falls.

Improved coverage policies should reflect the urgency of a serious illness and can improve care transitions across settings and decrease gaps in care, such as those monitored as part of the Medicare Advantage Star Ratings. For example, a program that would authorize limited coverage for home maintenance can help decrease an individual's risk for falls. In addition, programs that allow for home health aides or cover instrumental activities of daily living can improve medication adherence and therefore reduce readmissions due to non-compliance.

Not All Modifications Need Be Benefits

Consider that improvements for seriously ill members can be done through network development as well. Noted above is the suggestion that medical supply and DME providers be held to performance guarantees for quick turn-around. Additionally, while phlebotomy is a standard service covered by an individual's medical benefit, individuals with serious illness may have limited mobility and be unable to access outpatient laboratory services. The same is true for mobile laboratory and imaging services. Mail-order and on-demand pharmacy delivery are also essential when caring for the seriously ill.

Some additional services can be provided through the structure of a health plan program, such as Case Management, rather than filing it in the product. While the services provided may not have as much transparency or visibility as a defined benefit, a program offered through a case management department rather than directly through a member's benefits may be an even more effective way to engage seriously ill members in decision-making (see **Section 2: Engagement and Assessment**).

Hospice Benefit Considerations

Some commercial health plans have revised their hospice coverage policies to remove the limitations that exist in the Medicare hospice benefit, enabling hospice care to be delivered concurrently with treatment, and modifying authorization requirements to remove barriers and improve access to the necessary skills and supports available in hospice.

Specific changes to the commercial hospice benefit have included:

- Removal or revision of the 6-month-prognosis requirement to access hospice benefits. Some plans have extended eligibility for hospice services to a period of 12-months, and a few have considered removing a time-bound prognosis for eligibility.
- Allowance for concurrent care provided alongside hospice, including total parenteral nutrition, wound care, palliative chemotherapy, palliative radiation, etc.
- Allowance for concurrent disease treatment provided alongside hospice, including for cancer, cardiac disease, and COPD.
- Revision of discharge criteria to decrease the number of live discharges from hospice to remove or extend requirements for re-authorization for people who are enrolled in hospice longer than one year and stabilized due to the care they receive in hospice.

According to the health plans that have modified their hospice benefits in these ways, they have found these changes help to increase the hospice election rate while greatly reducing hospital readmission rates for individuals who otherwise would have been discharged from, or ineligible for, hospice. In addition, these changes have increased access to grief and bereavement resources for caregivers both prior to and after the death of their family member. By extending these services through concurrent care provisions or extended eligibility determinations, plans have seen an improvement in patient and family satisfaction and a reduction in grievances made by family members of people with serious illness.

Getting started

1. Starting with the comprehensive review

Creation and expansion of new benefits can take years to develop and implement, especially if they are constructed as formal benefits within an insurance product. At a minimum, health plans should review current payment and coverage policies that would affect people with serious illness the most. When revising and documenting policies for those with serious illness, begin by assessing coverage determinations using two questions:

1. Would changing coverage determinations or authorization processes keep the person with serious illness out of the hospital or from needing a higher level of care?
2. Is the policy or process set up in a way that can accommodate urgent needs, especially after- hour requests and crises?

By identifying gaps in coverage, gaps in process, and barriers to receipt of care in line with treatment preferences and then reviewing access to needed services under current benefit design, areas for improvement are identified.

A relatively simple step involves revision to cost sharing requirements, such as the removal of a co-payment or coinsurance for advance care planning conversations or palliative care consultations, as noted above. From there, benefit limitations can be addressed, such as changes to the home care, and hospice benefit. Lastly, additional defined benefits for those with serious illness may be included as part of a broader benefit design, such as personal care, nutritional services, caregiver support, and/or social services and supports.

2. Benefit additions should start with a pilot

For new benefits or services offered, pilot the benefits with a smaller population or a specific product to gain experience with how the benefit will be used. Once the assumptions in the benefit design and pricing have been tested, subsequent implementation of the new benefit or service can be expedited and medical expense can be better predicted.

1. The importance of data

Changes in coverage, payment policies, or authorization processes will often require a clinical and actuarial assessment to ensure consistency with evidence-based care and to assess the impact on medical costs and premiums. Utilization, cost, and outcome data are necessary to quantify the total impact of proposed changes and can also be used to proactively identify emerging trends in patient or caregiver needs.

2. Consider distinct benefits for pediatric palliative care and services

Children and their families with serious illness need specialized services to address physical symptoms, functional needs, and psycho-social-spiritual stresses. For example covering Child-Life Specialists, family transportation, creative arts therapists, and caregiver/sibling counseling is especially critical in these cases.

The Affordable Care Act includes a provision that all Medicaid beneficiaries under 18 years old are allowed to access hospice benefits without forgoing any curative treatment. Hospice entails home-based specialty palliative care services along with emotional and spiritual support for the child and family.

3. Limitations on Medicare Advantage Plans

Medicare Advantage plans are often limited by federal regulation in what can be added as a new benefit. For example, the Medicare uniformity requirement precludes varying benefit design within a Medicare Advantage plan based on health status or other enrollee characteristics. Consult your compliance team for benefit changes in this line of business.

4. Education on existing benefits

Some health plans are working to educate their members and providers about existing covered benefits that can be accessed for people with serious illness. While many services that would benefit those with serious illness are already covered by a health plan, patients and providers alike are often not aware of what is available. A prime example is a consultation by a billable palliative care specialist, which is a covered benefit under most medical plans; yet because “palliative care” is not a defined benefit, some assume that palliative care specialist visits are not covered. Thus, it is critical that benefit clarification and navigation be improved so that providers and those facing serious illness know what is available to them and how to access those services.

One good place to start is by educating case managers about existing covered benefits that can meet the individual’s needs (e.g., palliative care specialist visits, home health for skilled needs, mental health counseling services). Communications that clarify existing benefits for network providers is another important aspect.