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STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

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OFFICE OF
INSURANCE COMMISSIONER

November 3, 2025

Rep. Dan Bronoske, Chair, House Health Care and Wellness Committee
Sen. Annette Cleveland, Chair, Senate Health and Long-Term Care Committee
Rep. Timm Ormsby, Chair, House Appropriations Committee
Sen. June Robinson, Chair, Senate Ways and Means Committee
Washington State Legislature
Olympia, WA 98504

**RE: Office of the Insurance Commissioner – Palliative Care Benefit Work Group Report**

Dear Rep. Bronoske, Sen. Cleveland, Rep. Ormsby, Sen. Robinson and members of the House and Senate health care and fiscal committees:

SB 5936 directed the Office of the Insurance Commissioner (OIC), in consultation with the Health Care Authority (HCA), to convene the Palliative Care Benefit Work Group. The Act required the work group design the parameters of a palliative care benefit and payment model for fully insured health plans, and Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plans. The work group was informed by an actuarial analysis to estimate the cost impact of establishing a palliative care benefit. We contracted with Milliman to perform the actuarial analysis and prepare the report.

The work group included members from 10 organizations representing health care and palliative care providers, health insurers, state agencies, and employers. Seven public work group meetings were held along with additional one-on-one meetings with work group members and palliative care experts. At the request of palliative care advocates and with consultation from HCA, we expanded the scope of this work to include a cost analysis for the Medicaid program.

SB 5936 defines palliative care as “expert assessment and management of a patient's symptoms, including coordination of care, attending to the physical, functional, psychological, practical, and spiritual consequences of serious illness, and assessment and support of caregiver needs.”

Palliative care comprises a mix of services and practitioners working together, including physicians, nurse practitioners, social workers, therapists, psychologists, clergy, and pharmacists. Unlike hospice, palliative care can be provided alongside curative care. For example, a patient receiving palliative care can also receive cancer treatment.

Results of the actuarial analysis

In general, Milliman's analysis based the design of a benefit (including who is eligible and when, what services are covered, and what reimbursement method is used) on two previous studies: a 2023 report by the Oregon Health Sciences University Center for Evidence-Based Policy performed for HCA; and a 2019 report by the Dr. Robert Bree Collaborative. Both studies made recommendations regarding a palliative care benefit specific to Washington state.

**Milliman found that mandating a new palliative care benefit is likely to increase premiums for fully insured commercial health plans and increase state costs for the Medicaid and PEBB/SEBB programs.** The analysis estimates that per member per month (PMPM) costs (allowed amounts) would increase by approximately $0.28 across all the markets/programs studied, resulting in $2.6 million to $4.5 million in annual state Medicaid costs beginning in plan year (calendar year) 2027. This finding is based on specific scenarios of the benefit design discussed above.

In evaluating the cost impact of a palliative care benefit, Milliman found that current research is insufficient to conclude that the benefit would yield cost savings or be cost-neutral. **Several work group members disagreed with Milliman's conclusion that a new benefit would increase costs.** These members submitted letters responding to the report and made specific policy recommendations. Their letters are included as an appendix to this report. The report discusses this issue further in the "potential cost savings" section on pg. 22.

The following table (pg. 3) shows estimates of the annual costs of establishing a palliative care benefit by health insurance market and program, beginning in plan year 2027.

- This table uses a "base case" scenario assuming specific eligibility criteria, included services, payment models, and other elements of the benefit design. See the "actuarial methodology and assumptions" section on pg. 18 of the report for more explanation.

- In this table, "Seattle region" means the Seattle Combined Statistical Area, which includes King County and surrounding counties including Pierce, Snohomish, and Kitsap.

- "Allowed PMPM" means the per member per month allowed amount that insurers would pay for palliative care services, spread across all enrollees in each market/program. This amount correlates to monthly premiums. The Medicaid program does not include enrollee premiums.

- State expenditures related to increased PEBB and SEBB costs are driven only by impacts to the Uniform Medical Plan (UMP), since UMP serves as the benchmark for the state's contribution towards employee medical coverage.

Table of cost results

| Market | Source of Insurance | Region | Projected 2027 Membership | Total Palliative Expenditure | Allowed PMPM |
|---|---|---|---|---|---|
| Commercial | Individual | Seattle Region | 201,000 | $497,000 | $0.21 |
| Commercial | Individual | Outside Seattle Region | 121,000 | $467,000 | $0.32 |
| Commercial | Small Group | Seattle Region | 238,000 | $400,000 | $0.14 |
| Commercial | Small Group | Outside Seattle Region | 195,000 | $433,000 | $0.19 |
| Commercial | Large Group | Seattle Region | 397,000 | $689,000 | $0.14 |
| Commercial | Large Group | Outside Seattle Region | 532,000 | $999,000 | $0.16 |
| Commercial | PEBB | Seattle Region | 150,000 | $360,000 | $0.20 |
| Commercial | PEBB | Outside Seattle Region | 152,000 | $449,000 | $0.25 |
| Commercial | SEBB | Seattle Region | 137,000 | $323,000 | $0.20 |
| Commercial | SEBB | Outside Seattle Region | 139,000 | $335,000 | $0.20 |
| Medicaid | Medicaid | Seattle Region | 895,000 | $4,775,000 | $0.44 |
| Medicaid | Medicaid | Outside Seattle Region | 907,000 | $4,150,000 | $0.38 |
| **Total Commercial** | | | **2,262,000** | **$4,952,000** | **$0.18** |
| **Total Medicaid** | | | **1,802,000** | **$8,925,000** | **$0.41** |
| **Washington Total** | | | **4,064,000** | **$13,877,000** | **$0.28** |
| **Total State Programs*** | | | **2,380,000** | **$10,392,000** | **$0.36** |

*Total State Programs is defined as the combined total of PEBB, SEBB, and Medicaid, including federal Medicaid funding. PEBB/SEBB are also included in the Commercial subtotal.

Recommendations

SB 5936 allows—but does not require—the work group to submit recommendations.

We recognize the value of palliative care services in helping patients and their families navigate serious illnesses. In evaluating a new benefit mandate, we also considered the impact on the affordability of health coverage. And we are sensitive to rising commercial health insurance premiums, expected coverage losses in Medicaid and the individual health insurance market, and state budget challenges affecting health coverage. **Given that this analysis found that a palliative care benefit mandate is likely to increase overall costs, we are not taking a position on whether the legislature should establish this benefit at this time.**

We defer to individual work group members and their organizations to make their own recommendations to the legislature regarding a palliative care benefit, as indicated by letters in the appendix to the report. As more research emerges into how palliative care affects the use and cost of other health services, we look forward to continuing to discuss this topic.

Additional findings and themes from the work group process

- Washington state's Medicaid program, PEBB/SEBB, and fully insured health plans currently cover some *limited* services that can be considered part of palliative care. For example, Medicaid covers palliative care services for children when rendered by hospice agencies but does not have an adult benefit. Fully insured health plans and PEBB/SEBB plans cover certain services included in palliative care, such as evaluation and management outpatient visits and care coordination, but no specific palliative care benefit mandate exists in those markets.

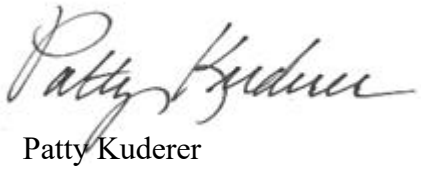
- There is a shortage of palliative care providers across Washington state. This shortage could impact enrollees' access to care should the state mandate palliative care services.

- Palliative care typically has low "take-up" rates due to lack of awareness, stigma, provider shortages, and other factors. Milliman assumed low take up rates in their analysis but projected that palliative care utilization, and hence palliative care costs, would increase in future years as take-up rates increase.

The full report by Milliman, as well as response letters from work group members, is attached for your review.

We look forward to further discussion regarding this report. Please feel free to contact Jane Beyer (Jane.Beyer@oic.wa.gov) and Nico Janssen (Nico.Janssen@oic.wa.gov) with any questions.

Sincerely,



Patty Kuderer
Insurance Commissioner

MILLIMAN REPORT

# Washington Palliative Care Analysis

## Prepared for the Washington State Office of Insurance Commissioner

November 1, 2025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# Introduction

Substitute Senate Bill 5936 mandates that the Washington State Office of the Insurance Commissioner (OIC), in consultation with the Health Care Authority (HCA), convene a work group to design the parameters of a palliative care benefit and payment model for the benefit of fully insured health plans. SSB 5936 defines palliative care as "expert assessment and management of a patient's symptoms, including coordination of care, attending to the physical, functional, psychological, practical, and spiritual consequences of serious illness, and assessment and support of caregiver needs. Palliative care is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness, and can be delivered alongside life-prolonging or curative care." The bill calls for the work group to consider:

- clinical eligibility criteria;
- the services included in a palliative care benefit;
- appropriate staffing, including staffing models and provider training;
- evaluation criteria and reporting requirements;
- payment models.

OIC was authorized to contract for actuarial analysis as necessary.

Milliman, Inc. ("Milliman") was contracted to support this project. This support includes actuarial analysis as well as additional reporting to support the work group's considerations listed above, including the development of at least two payment models. Milliman's support addresses commercial fully insured and Medicaid sources of insurance for both adult and pediatric populations. It was outside of the scope of the study to review self-funded plans. This report addresses the five items listed above, as well as the additional actuarial analysis. Commentary on and comparisons to Medicare coverage may be provided where pertinent but are not the focus of this report.

While this report provides a landscape of palliative care, outlines considerations when designing a palliative care benefit, and provides a cost estimate of a palliative care benefit, there are benefit design, cost sharing, and operational decisions that need to be made to implement a palliative care benefit. This report does not make recommendations in these areas but rather highlights important issues to consider during the design process.

# Executive Summary

Palliative care is an interdisciplinary practice that leverages professional expertise to deliver an array of services to patients and their families that focus on improving the quality of life for people with serious illness and their care partners. Essential palliative care skills include clinical expertise, communication, cultural competence, and interdisciplinary collaboration. Teams of palliative care providers can include physicians, advanced practice practitioners, nurses, social workers, pharmacists, therapists, psychologists, and clergy.

Washington faces shortages of palliative care providers, especially in rural and underserved areas. For example, only a small fraction of licensed physicians specialize in palliative care, with most concentrated near Seattle. This small number of specialty-trained physicians, one of the disciplines involved in palliative care, is part of a broader healthcare workforce challenge, impacting access to care, particularly for the state's aging population. To address these gaps, Washington is investing in workforce development, expanding training programs, supporting telemedicine, and targeting resources to underserved regions.

Choosing an appropriate payment model for palliative care is essential for ensuring access to high-quality care, controlling costs, and influencing provider and patient behavior. Linking payments to quality and value can support effective, patient-centered palliative care.

As palliative services expand throughout Washington, establishing robust evaluation criteria and reporting requirements for commercial and Medicaid managed care plans will be important in understanding the effectiveness of palliative care. Regular, standardized reporting—integrated with existing state systems—can ensure effective monitoring and guide policy and resource decisions. Collaboration among agencies, payers, and providers is essential for success.

Washington is considering a community-based palliative care benefit. This decision was influenced by the following reports, which include guidance around the clinical eligibility criteria used for and services to be included in a potential palliative care benefit:

Adults (Individuals 21 years and older)

- *Palliative Care*, published by the Robert Bree Collaborative
- *Washington State Palliative Care Reimbursement Summary Report*, published by the Health Care Authority and Oregon Health Sciences University
- *Payment Reforms to Improve Care for Patients with Serious Illness (PACSSI)*, published by the American Academy of Hospice and Palliative Medicine

Children (Individuals under 21 years of age)

- *Standards of Practice for Pediatric Palliative Care,* published by the National Hospice and Palliative Care Organization
- *Hospice Services Billing Guide,* published by Washington Apple Health (Medicaid)

At the direction of the OIC, Milliman summarized the guidance provided in these reports and supplemented this guidance with additional diagnosis and procedure code information to provide specific eligibility criteria that can potentially be used for a palliative care benefit in the commercial and Medicaid markets. To be eligible, adults are required to have a diagnosis of serious illness or at least three chronic conditions, functional limitations, and recent, unplanned acute hospital care. Children must have a life-limiting medical condition with complex needs requiring case management.

For both adults and children, palliative care services can include assessments, behavioral health and psychosocial support, goals of care conversations, caregiver and spiritual support, advance care planning, pharmacy and symptom management, functional needs assessment, ongoing management (including care coordination and case management), and 24/7 telephone support. For the pediatric analysis, per discussion with the OIC and work group, the palliative care services are structured to align with the current Apple Health Pediatric Palliative Care benefit. Other alternatives for a pediatric palliative benefit could be considered, such as aligning the benefits offered to adults, though the utilization patterns for pediatric beneficiaries may differ from those of adults.

The actuarial analysis estimates how much, if any, additional cost would accrue to the state and insurance carriers should the state implement a new palliative care mandate in the commercial and/or Medicaid markets. There are several key assumptions in this analysis impacting the cost of the palliative care benefit:

1. Eligibility – The analysis uses a claims-based approach to identify enrollees eligible for palliative care. The claims-based approach suggests that less than 0.15% of the commercial population and less than 0.65% of the Medicaid population are eligible.
2. Take-up Rate – Not all enrollees eligible for palliative care will use the benefit. This analysis assumes 15% of eligible adult enrollees and 8% of eligible pediatric enrollees may use the benefit.
3. Impact on non-palliative medical spending - Given the limitations of research and available studies in the area of palliative care, we believe the most appropriate and supported assumption would be no net reduction in non-palliative medical spending due to the addition of a palliative care benefit.

We project population-wide additional medical claim costs of between approximately $0.14 and $0.32 allowed per member per month (PMPM) for the commercial market, and between $0.38 and $0.44 PMPM for the Medicaid market (including both federal and state share of expenditures) for this benefit in 2027 should it be mandated as of January 1, 2027. In the years after 2027, we would expect these costs to rise by a significant percentage, potentially doubling or more in later years as the take-up rate for this benefit increases due to increased visibility, increased provider availability, and other factors.

There is some variation in these estimates between Seattle and Non-Seattle areas, which we discuss in our Financial Evaluation section later in the report. We also note that there may be significant variation in cost by eligibility group for Medicaid. We discuss the implications of potential variation by eligibility group later in this report.

# Palliative Care Background

Palliative care is an interdisciplinary practice that leverages interprofessional expertise to deliver an array of services to patients and their families that focus on improving the quality of life for people with serious illness and their care partners. Since Dame Cicely Saunders founded the modern hospice and palliative care movement in the 1960s in England, the model has evolved to draw upon the skills of a multidisciplinary provider team that collaborates with patients and their families.[1]

This holistic approach includes managing the symptoms of pain and physical decline, as well as addressing the emotional detachment, social isolation, and depression that can accompany a life-limiting illness.

While sometimes discussed interchangeably, home health, hospice care, and palliative care are not synonymous. Home health is short-term and intermittent focused on recovery following an acute event. Hospice care focuses on the last months of life and requires patients to discontinue curative therapies. Palliative care is a broader term for care focused on comfort, quality of life, and symptom management for those with serious illness. Palliative care uses services that are adapted to fit the patient's needs rather than their prognosis. Exhibit 1 compares key attributes of home health, hospice and palliative care.

**EXHIBIT 1: A COMPARISON OF HOME HEALTH, HOSPICE, AND PALLIATIVE CARE**

| | HOME HEALTH | HOSPICE | PALLIATIVE CARE |
|---|---|---|---|
| **Focus** | Recovery/Rehab | Comfort at end of life | Symptom relief/quality of life |
| **Eligibility** | Homebound, need skilled care | Terminal illness, 6 months or less | Serious illness, any stage |
| **Concurrent Curative Treatment** | Yes | No | Yes |
| **Location** | Home | Home, facility, hospital | Home, hospital, clinic |

Patients can receive palliative care services while they continue to pursue treatment for their illness.[2] The focus of this study and the model that Washington is considering is a community-based palliative care model.

In patients with "serious or advanced illness" such as cancer, heart failure, chronic obstructive pulmonary disease (COPD), dementia, and other life-limiting conditions, palliative care can help alleviate the burden of disease for patients and their caregivers and may have the potential to reduce avoidable acute care costs.[3] [4] [5]

Palliative care services provide an extra layer of support in addition to the therapeutic care patients are already receiving. Palliative care services, which may include advance care planning, counseling, and pain management, has been found to improve the quality of life for individuals with serious illness by supporting autonomy, reducing symptom burden, providing support during treatment, and addressing the spiritual, emotional, and related needs that can accompany serious health conditions.[6] Palliative care is provided by a specially trained team of doctors, nurses, social workers, chaplains, and other specialists who work together with a patient's other doctors to provide relief from the symptoms and stress of illness.[7]

# Palliative Care Staffing

### CURRENT WASHINGTON STATE HOSPICE AND PALLIATIVE CARE LANDSCAPE FOR MEDICAID

Currently, Washington Apple Health (Medicaid) covers hospice services for adults and both hospice and palliative care services for children rendered by state-licensed hospice agencies.[8] Washington Apple Health defines a hospice agency as a person or entity administering or providing hospice services directly or through a contract arrangement for clients in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and volunteer.[9] In Washington, the certificate of need requirement for hospice agencies ensures that proposed facilities or services are necessary to maintain quality patient care within a particular region or community.[10]

For hospice services, Washington Apple Health reimburses the hospice agency through a hospice daily rate. The pediatric palliative care benefit covers up to six pediatric palliative care contacts per client, per calendar month. Washington Apple Health pays providers for pediatric palliative care services per contact.[11]

## TYPES OF PROVIDERS ELIGIBLE TO PROVIDE PALLIATIVE CARE SERVICES

For purposes of considering payment models, the types of providers eligible to provide palliative care services need to be identified as those are the providers that would be eligible for reimbursement. While some state Medicaid programs utilize their hospice agencies to provide non-hospice palliative care services to patients, there are other approaches to establishing eligible providers.[12]

States are responsible for licensing providers and institutions and can specify the types of institutions and locations where palliative care services may be delivered and providers that may deliver them. In Texas, palliative care services are delivered by licensed home health agencies.[13] According to a comprehensive review of state palliative care policies and programs performed by the National Academy for State Health Policy, hospice agencies in Texas may provide supportive palliative care to patients not enrolled in hospice by adding the home health category designation to their license. Four states — Florida, Massachusetts, New York, and Tennessee — define palliative care within statutes that promote advance care planning (ACP) and/or information sharing.[14] This approach allows the ACP billing codes to be billed by all physicians and qualified health professionals, including nurse practitioners, physician assistants, and clinical nurse specialists, for services to all patients, regardless of setting.[15] However, not all members of the team may have the ability to bill for their services.

While palliative care and the services provided by home health agencies overlap, requirements for home health agency credentialing do not typically include requirements specific to palliative care services.[16] For example, palliative care includes around-the-clock, on-call support, while home health care is intermittent care.[17] In contrast, hospice care is, by definition, palliative care, although hospice eligibility is limited to those individuals with a life expectancy of 6 months or less while a palliative care benefit generally covers services without regard to life expectancy.[18] Some states utilize existing hospice agencies to provide palliative care services outside of the hospice setting because the hospice credentialling process includes specific requirements related to services, staffing, and personnel competencies that are relevant to palliative care services. For example, hospice agencies are required to assess the patient's spiritual needs and desires. For Medicare and Medicaid programs, home health and hospice agency requirements are outlined in the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoP).[19] [20]

Whether providers eligible for reimbursement under a palliative care benefit are an existing provider type or a newly defined provider type, it is important to establish minimum health and safety standards to ensure the delivery of high-quality palliative care. In addition to the Medicare CoPs, there are multiple professional certifications, program certifications, and accreditation programs that may be considered. For example, the Maryland Health Care Commission’s Report to the Legislature (November 2023) recommends revising initial licensing requirements and continuing education curricula to include education on palliative care for all applicable health care providers and requiring that all community-based palliative care programs meet accreditation requirements under one of the accreditation organizations, such as the Community Health Accreditation Partner (CHAP).[21] [22]

## ESSENTIAL SKILLS

Skills important to delivering palliative services will vary based on licensure, scope of practice, and practice setting. Clinicians, including those who evaluate, prescribe, assess, and provide direct patient care, all benefit from honing a core set of essential palliative skills that inform decision-making and advance patient-centered care.[23] Key areas of focus include physical health; emotional and mental health; spiritual practices; health-related social needs (HRSNs); communication skills; interdisciplinary collaboration; cultural competence; and legal and ethical issues.

## TRAINING RESOURCES

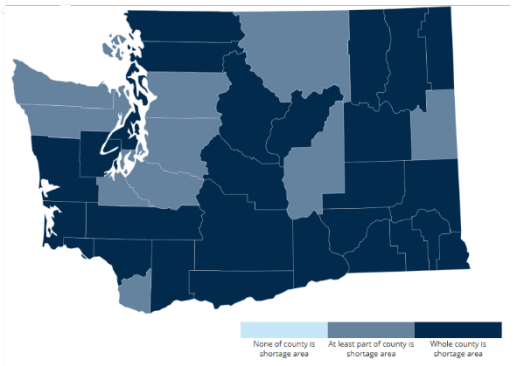
Professionals can obtain additional palliative care training or certification through several professional organizations. Training contributes to ensuring that providers have the skills needed to deliver high quality services to patients and their families. Professional growth opportunities for building palliative care competencies include single courses, annual continuing education requirements, advanced training, and board certification. Professional organizations

offering training include: American Academy of Hospice and Palliative Medicine (AAHPM); Center to Advance Palliative Care (CAPC); Education in Palliative and End of Life Care (EPEC); National Alliance for Care at Home (NACH); The National Institute on Aging; the Washington Rural Palliative Care Initiative; University of Washington Professional and Continuing Education; and the Washington State Hospice and Palliative Care Organization (WSHPCP).

Individually licensed practitioners, including physicians, advanced practice practitioners, nurses, social workers, and other members of the palliative team may also take advantage of continuing education requirements for their individual licenses and use state-accredited Continuing Education (CE) vendors to advance their learning.

## SHORTAGES IN WASHINGTON AND ACROSS THE US

Health care workforce shortages are a widespread issue across many regions of the United States. As observed in the 2023 *Washington Palliative Care Reimbursement Summary Report*, Washington is no exception to this challenge. The Washington State Medical Association recently noted that over half of the state's 7.8 million residents live in a "primary care health professional shortage area" with scarce access projected in the future.[24] The shortages are exacerbated by a decreasing number of individuals entering the health care workforce, particularly among nurses and medical assistants.




*Health Professional Shortage Areas: Primary Care, by County, January 2025*

Rural communities in Washington are most impacted by these shortages. Twenty-nine counties are currently designated as health professional shortage areas for primary care providers, in which the whole county is in a shortage area. The ten remaining counties have at least part of the county designated as a shortage area for primary care providers.[25]

To address these challenges, the Washington State Department of Health's Primary Care Office (PCO) works to improve access to primary care for medically underserved populations.[26] The PCO identifies and reduces barriers to health care services, which includes addressing shortages of palliative care providers. Other initiatives like the Washington Rural Palliative Care Initiative (WRPCI) also have been established to enhance palliative care services in rural areas by fostering public-private partnerships and providing technical assistance to local communities.[27] Currently, 19 rural communities are participating in this initiative, working collaboratively to improve access to quality palliative care. [28] [29] [30]

These shortages also may complicate the delivery of palliative care in the coming years. With 17% of the state's population ages 65 and over, the need for providers who can deliver a broad range of specialized palliative services will increase in the coming years.[31] [32]

According to the Center to Advance Palliative Care assessment of Palliative Care in Washington (February 2024), there are nearly 500 physicians, advanced practice registered nurses and registered nurses across the state that have received specialty certification in palliative care or pediatric palliative care.[33] This workforce can be augmented by existing home health and/or hospice agencies.

Addressing the shortage of primary care and certified palliative care providers in Washington requires a multifaceted approach, including policy reform, workforce development, and targeted initiatives to expand care in underserved rural communities. As demand for these services continues to rise, addressing workforce shortages through enhanced training, recruitment, and policy support will be critical to ensure that patients receive the holistic, compassionate care they need.

## PROVIDER TRAINING

To build and maintain a robust workforce that can support the needs of the patient population, it is essential to expand palliative training opportunities for physicians, advanced practice practitioners (e.g., advanced practice

registered nurses (APRNs)), nurses, social workers, pharmacists, and rehabilitation staff. With relevant, engaging, and timely training, providers can enhance their knowledge, build their clinical skills, and strengthen their ability to integrate palliative services with their professional specialty.[34] The sections above provide additional information on essential provider skills and training resources.

As part of a comprehensive strategy to expand palliative care service providers across the state, OIC, HCA, and the Department of Health will want to consider several key objectives:

- Strategically allocate limited resources: Align financial support to medically underserved areas or regions of the state where palliative care resources are scarce or unavailable.
- Use targeted grants to leverage local expertise to identify needs, best practices, and to deliver specialized training.
- Incentivize palliative care training. Dedicate resources to palliative fellowships, loan forgiveness, or support loan repayment efforts for physicians and advanced practitioners who seek board certification in palliative care. In underserved areas, this could include volume or subscription-driven tuition discounts for professionals who seek advanced palliative care training through the University of Washington, The Washington State Hospice and Palliative Care Organization, Eastern Washington University, or other resources.
- Work with existing centers of excellence and managed care providers to explore philanthropic approaches to advancing palliative care training in rural, frontier, and medically underserved areas.[35]

# Provider Staffing Models

### TEAM COMPOSITION

As Washington's Bree Collaborative highlights, both primary and specialty care providers can deliver palliative services.[36] The palliative care population is notably complex and benefits from an interdisciplinary approach to care due to multiple physical comorbidities, functional dependencies, frailty, cognitive impairments, and HRSNs. In an interdisciplinary team, roles are predicated on licensure, scope of practice, certification, and training. Although each team member's work is unique, their contributions are essential to delivering a comprehensive and coordinated approach to symptom management. [37] [38] [39] [40] [41] [42] Interdisciplinary teams that typically include physicians, advanced practice practitioners, nurses, pharmacists, rehabilitation therapists, psychologists, social workers, and clergy are the foundation of palliative care, ensuring that individuals receive the holistic, patient-centered care they need to address the physical, emotional, and financial challenges that can arise during a serious illness. By fostering collaboration between professionals, their combined expertise can meet the needs of diverse populations, improve quality of life, and provide dignity and comfort for patients and families.

### STAFFING MODELS

Palliative care staffing models are designed to promote individualized, person-centered treatment focused on relieving suffering from serious illness. These models encompass services offered in hospital and community settings, including telehealth, patient residences, nursing homes, and assisted living facilities. Cancer centers, dialysis clinics, and private medical practices can all provide palliative care services. The specific staffing models will vary based on the care setting and type of service provided. The three primary models are hospital-based, home-based, and clinic-based. Washington is considering a community-based palliative care benefit which encompasses home- and clinic-based palliative care models.

#### Home-Based Palliative Care

Receiving palliative care at home provides patients with clinical services in familiar surroundings, helping them to maintain as much functional autonomy as possible. For patients living in rural or underserved areas, home-based services may provide a more practical solution than skilled nursing or other facilities, allowing patients who live further from urban areas to access services more easily. Moreover, an evolving body of research indicates that home-based services may have the potential to reduce ED visits and hospitalizations, reducing avoidable spending while providing patients with greater comfort.[43]

Home-based palliative care typically employs one of the models discussed below. Please note that the caseloads are a typical range but may vary based on factors such as travel times, patient residence, complexity of HRSNs, and the availability of telemedicine or telehealth services. [44]

- Nurse practitioner (NP) led team with physician oversight: These teams can evaluate and diagnose the patient, manage a plan of care, and prescribe interventions such as medication, oxygen, or physical therapy. In the NP led model, one NP might manage 50-60 patients, with a social worker supporting between 250 – 300 patients. A single physician might provide oversight of 500 – 700 patients.
- Registered nurse (RN) led teams with physician or nurse practitioner oversight: RNs can assess patients but cannot diagnose or prescribe interventions. An RN-led model might assign 50-80 patients per nurse, 100-160 patients per social worker, and requires MD oversight of an estimated 500 – 700 patients.
- Mixed model: In a mixed model, teams may be based on patient acuity or clinical needs.

All home-based models require strong communication skills, clear documentation, and effective coordination with the patient's physicians. Similarly, all teams can leverage services such as telemedicine to expand access in rural regions. Using a validated patient risk stratification tool at intake and throughout the course of a patient's stay in palliative services may help to identify the optimal team structure.

**Clinic-Based Palliative Care**

Palliative services provided in either a community or an ambulatory clinic continue to serve the core mission of coordinating appropriate care to relieve suffering, manage symptoms, and promote functional independence and quality of life.[45] Clinic-based models may be standalone or integrated into existing clinical settings.

- Standalone palliative clinics: Standalone palliative care clinics operate independently, maintaining a dedicated staff that is exclusively designed to meet the needs of palliative patients. Funding sources for standalone clinics range but may include revenue from government-funded or commercial health plans, as well as philanthropic organizations. Researchers observe that standalone clinics may be more practical for larger volume programs that can maintain the staff needed to meet higher patient volumes.
- Integrated palliative care clinics: Functioning within existing primary or specialty care clinics, integrated palliative programs benefit from operational efficiencies and revenues drawn from non-palliative services co-located in the same clinic. Integrated or embedded programs may be more appropriate for smaller volume palliative programs.

**CONSIDERATIONS FOR EXPANDING ACCESS TO PALLIATIVE CARE SERVICES**

As the OIC evaluates palliative benefit expansion, there may be opportunities to allocate resources statewide. While individual providers and stakeholders ultimately make decisions that drive staffing models and team composition, it is imperative that the state foster equitable access to services. Equitable access ensures that all enrollees have the same opportunity to receive the timely services needed to reduce avoidable acute care utilization. It is important to ensure reimbursement structures are sufficient to attract and retain physicians, advanced practitioners, and other members of the IDT. In rural areas, these financial assistance structures should be mindful of travel time, limited economies of scale, and lower patient volumes.

# Options for Palliative Care Payment Models

In addition to design features such as clinical eligibility criteria, specification of palliative care services, appropriate staffing, and evaluation criteria and reporting requirements, the payment model identified for a palliative care benefit is critical to supporting robust access to high quality palliative care services that reduce the negative impact of disease on patients and their caregivers and improve their quality of life. The payment model also has implications for the cost of the benefit to patients and payers, as well as the reimbursement to palliative care providers. It has the potential to influence patient and provider behavior which, in turn, may impact the estimated cost of the new benefit.

In 2019, the Center to Advance Palliative Care (CAPC) completed a national initiative to identify palliative care programs providing services in community settings. Of the 76 unique home-based palliative care programs that responded, 86% of programs reported fee-for-service (FFS) billing as one of their top three sources of funding and

21% of programs reported contracted alternative payment arrangements, such as a fixed monthly payment per patient or a bundled payment covering a fixed number of months or weeks (i.e., periodic payment), as one of their top three funding sources.[46]

The following section compares and contrasts FFS and periodic payment models, describes potential associated pay-for-performance and shared risk features, and discusses common payer and provider perspectives on these payment methodologies.

## FEE-FOR-SERVICE PAYMENT MODEL

In a FFS model, providers would be reimbursed for each palliative care service they provide by billing specific Healthcare Common Procedure Coding System (HCPCS) codes to identify those services. These codes are usually designed to allow billing for all of the categories of services that are covered under the benefit. The payment amount for each service would typically be established by a fee schedule, which is a negotiated amount in an agreement between the provider and the payer.

### Fee-for-Service Payment Model Considerations

There are a number of potential benefits to a FFS payment model for a palliative care benefit. For decades, FFS has been the dominant U.S. reimbursement methodology and, therefore, both providers and payers have administrative systems in place to process this type of reimbursement. Therefore, the operational complexity of FFS payment models is low.

From a payer perspective, FFS payment models ensure that a payment is only made when a service described by the HCPCS code is provided. Considering the variation in patient complexity and palliative care service needs of eligible patients, this approach may be appealing to payers as reimbursement accurately reflects the variation in services provided to individual patients receiving palliative care services. With the availability of appropriate HCPCS codes to account for the time of personnel providing care coordination and other non-patient contact services, palliative care providers can be reimbursed for care based upon total staff time utilized, not limited to patient contacts. This approach requires that the palliative care provider carefully track the services provided and the associated resources used so they can appropriately bill for the palliative care services provided.

Traditionally, there have not been expectations for managing overall patient care or quality outcomes, including efficiency, in FFS reimbursement. However, without performance metrics, providers may be incentivized to provide more patient encounters, rather than expending resources in more effectively and efficiently managing overall patient care. Payer concerns about potential overutilization of palliative care services in a FFS payment model may be mitigated with prior authorization, utilization management, and/or quality performance requirements, although these strategies may have unintended consequences. For example, if a payer were to implement a utilization management program to cap the number of certain types of palliative care services a patient can receive (when wide variation is expected due to differences in patient need), there is a risk that not offering the lower cost service (e.g., a home visit from a palliative care team member) may result in a higher cost service such as an avoidable hospitalization. These types of administrative limits also may result in substantial payer and provider administrative burden.

California's Medicaid program (Medi-Cal) is an example of a FFS payment model for palliative care services provided by providers that must meet certain credentialing and training requirements.[47] California uses existing HCPCS codes in its Physician Fee Schedule for palliative care provider billing for services under its palliative care benefit. Reimbursement varies by code and is maintained in Medi-Cal's fee schedule. For example, California providers can use the community-based interdisciplinary care team consult Current Procedural Terminology (CPT) code series (99341-99350) to bill for palliative care services, including care coordination, care plan development, patient assessment, and provider-to-provider consultations. California requires providers to meet performance standards and report information that Medi-Cal can use to monitor the provision of palliative care.[48] [49]

## PERIODIC PAYMENT MODEL

In a periodic payment model, providers would be reimbursed a fixed amount for palliative care services for a pre-defined time period. The time period may be a single day, 30 days, or an extended period such as six months, and the fixed reimbursement may vary based on prospectively estimated or retrospectively determined patient complexity. The provider being reimbursed assumes responsibility for distributing payment to other providers rendering palliative

care services, if applicable. Periodic payment models encourage palliative care team members to collaborate, coordinate care, and optimize resource utilization to provide care within the available reimbursement level. When fixed reimbursement is provided that is not directly linked to patient encounters, providers have confidence in the available reimbursement for the patient's palliative care services that, in turn, allows them the flexibility to provide the mix of services that best and most efficiently meets patient needs in the time period. For example, a patient being discharged from a hospital and stabilized at home might require several skilled nursing visits in a month, whereas another patient focused on improving quality of life might require more robust care coordination services across multiple treating providers in a month to develop and implement a cohesive treatment plan.

**Periodic Payment Model Considerations**

Periodic payment models are increasingly common for palliative care and other types of individualized multidisciplinary services, such as home health and hospice care. The operational complexity of this methodology is linked to the type of providers eligible for palliative care reimbursement, becoming more complex when the eligible provider type is not able to provide the full scope of palliative care services. In this scenario, the periodic payment model may require the palliative care provider (rather than the payer) to reimburse other providers who provide portions of the palliative care benefit.

In a periodic payment model, the palliative care provider controls the types and amounts of services provided, which allows them substantial flexibility in allocating resources efficiently (e.g., spending more or less staff time on patient contacts versus care coordination) to best meet the needs of individual patients. While the palliative care provider expects to allocate more resources for some patients and fewer resources for the care of others, on average, the fixed reimbursement is set to be sufficient for the provision of high quality palliative care services for the provider's patient mix. Providers that are able to develop staffing and service efficiencies often prefer periodic payment models, which typically yield more stable and predictable reimbursement that can support further infrastructure investment.

With fixed reimbursement under a periodic payment model, there may be an incentive for providers to underutilize services in order to maximize revenue in comparison to their resources used caring for patients, and this incentive increases if there are no quality expectations that impact reimbursement. For example, to maximize revenue, providers may gatekeep services or delay disenrollment when clinical eligibility criteria are no longer met. This may result in the payer overpaying, on average, for the palliative care services provided to a large proportion of patients. The magnitude of the potential overpayment is dependent upon the payment mechanism of the periodic payment model. For example, compared to a daily rate or monthly per patient per month payment, the potential for overpayment is greater if an upfront payment is made for six months of palliative care services. For this reason, monthly periodic payment of a fixed amount may be more attractive to a payer. While daily reimbursement is a common methodology for hospice care, where enrollment is often only for a short duration and patient needs may vary greatly from day-to-day, patients eligible for palliative care typically have more predictable needs for a longer duration of time, making monthly reimbursement a more common approach.

An example of a periodic payment palliative care model is the American Academy of Hospice and Palliative Medicine (AAHPM), Patient and Caregiver Support for Serious Illness (PACSSI) payment model.[50] This model provides tiered, equally weighted, monthly care management payments based upon patient complexity. The model includes a phased approach to performance measurement, including metrics to assess patient experience, completion of care processes, and utilization of health care services. The PACSSI model includes two tracks (track 1 and track 2) of performance accountability, varying from pay-for-reporting to shared financial risk based on total cost of care.[51]

Another example of a periodic payment palliative care model is the AAHPM, Palliative Care Support to a Medical Home (PCS) model. This model includes a larger, upfront fixed payment to cover assessment and planning, followed by lower, monthly support service payments. AAHPM recommends that both the upfront payment and monthly support service payment amounts be tiered based upon patient complexity.[52]

Periodic payment model payments can be adjusted based upon geography and/or the primary site-of-service (e.g., home versus facility). For example, in the PACSSI model, payments for facility-based patients are reduced by 20% to reflect the lower resource costs incurred in caring for such patients due to supportive care services provided by the facility.[53]

## LINKING PALLIATIVE CARE PAYMENT TO QUALITY AND VALUE

In both FFS and periodic payment models, direct financial incentives and/or financial risk for the palliative care provider's success in managing overall patient care and/or quality outcomes can be incorporated. Pay-for-reporting, pay-for-performance, and shared financial risk are three approaches to linking payment to cost and quality outcomes.

Pay-for-reporting provides positive or negative financial incentives to providers for reporting quality data. Because pay-for-reporting does not link payment to quality outcomes, these arrangements are usually time-limited and designed with the intention to evolve into a more advanced payment model.

As an example of pay-for-reporting in a periodic payment model, Washington Apple Health reduces hospice payments by two percent for providers in Washington state that fail to submit data required for the annual Medicare Hospice Quality Reporting Program.[54] The Medicare Hospice Quality Reporting Program includes, but is not limited to, measures related to the comprehensiveness of an admission assessment, utilization and gaps in skilled nursing visits, transitions in care, per-beneficiary spending, and patient satisfaction using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey.

Pay-for-performance financially rewards providers that perform well on quality metrics and/or penalizes providers that do not perform well, thus providing a link between payment and quality.[55] For example, providers may receive an adjustment to their fee schedule or a bonus if the rate of avoidable emergency room visits is reduced.

Shared risk is a more advanced payment model feature which evaluates provider performance against cost and/or quality benchmarks. The arrangement can be 'upside only' which means that providers have the opportunity to share in a portion of the savings they generate, and providers do not need to compensate payers for any losses (or increased cost) should targets not be met. Shared risk arrangements can also include 'downside' risk which allows payers to recoup any losses (or increased cost) from providers when cost and/or quality performance targets are not met.[56]

An example of a shared risk model is track 2 of the PASSCI fixed payment model.[57] Under this track, palliative care team quality and spending is directly linked to total cost of care for enrolled patients. Providers take on shared risk with the payer and may be paid a portion of any savings achieved or may need to pay back a portion of losses. Savings or losses are based on spending above a risk-adjusted total cost of care benchmark.[58]

# Evaluation Criteria and Reporting Requirements

## EVALUATION TYPES AND CRITERIA

As palliative services expand throughout Washington, establishing robust evaluation criteria and reporting requirements will be critical to understanding palliative care effectiveness. Data analysis, benchmarking, and reporting are essential to understanding how, where and when individuals are accessing available palliative care benefits, and the quality of the services they receive.

As outlined in the 2019 Bree Collaborative Report on Palliative Care, quality evaluations should focus on measures that are "feasible, under the control of those being measured," and be "reliable, and valid."[59]

Evaluations can include both quantitative and qualitative aspects. Quantitative evaluations leverage digital data that can be captured and transmitted electronically and may be used to perform quantitative reviews on measurable, numerical, and discrete categorical data. Some of the risks associated with quantitative methodologies include incomplete, inaccurate, or inadequate data sets that demonstrate biased conclusions or confounded results. Over-reliance on quantitative methods can lead to misrepresentation of scale and impact.

Qualitative reviews include the analysis of notes and observations made in medical charts. They may also include open-ended responses to surveys, interviews or focus groups. While it can add depth and dimension to quantitative evaluation, qualitative data is more difficult to generalize and extrapolate, can be time-consuming to complete, may produce a subjective final product, and can be difficult to replicate.[60]

At minimum, evaluation processes should consider statistical validity, demographic factors, delivery model, and care setting.

### Health Care Performance Measures

Structural measures describe the settings, facilities, and resources available for care. Examples could include the number of providers with board certification in palliative care or hospitals in a specific region with an inpatient palliative care team.

Process measures reflect the methods and procedures for delivering care through health care activities. This might provide evidence of person-centered communication or systems integration. Example measures might include the number of patients on a specific unit who are assessed for palliative care, records evidencing engagement with psychosocial services, or screening for pain, dyspnea, or treatment preferences prior to discharge.

Outcome measures determine the results of the intervention, or how the services impacted patients and caregivers. Metrics might include pain control, satisfaction with care, utilization of health care services, the costs of an episode of care, or for a defined palliative service bundle.

## SOURCES AND METHODS

Evaluating clinical services can include quantitative and qualitative measures that examine program and resource structures, processes that describe care delivery, and outcomes that evaluate the impact of the interventions.[61]

Program evaluation can be conducted using a variety of sources from payers and providers that include:

- Claims data to evaluate adherence to program standards and assess health outcomes;
- Chart audits to capture additional quantitative data as well as qualitative notes during medical care;
- Provider surveys to gather feedback, assess adherence to clinical best practices, identify barriers such as documentation challenges, and
- Participant surveys to understand a host of factors that can impact the overall patient care experience.

Using a variety of sources can help to provide comprehensive insights and drive continuous improvement for individual palliative care providers, teams, practices, and the systems where they work.

### Payer Reports

Medicaid managed care organizations and commercial payers will have access to claims data that can focus on issues related to the accessibility, efficiency, and quality of palliative services. This information can include:

- Demographic information: including race/ethnicity, gender, age, and location

- Provider data: including provider type/specialty, location, network, and institutional affiliations
- Diagnosis and comorbidities: identified in ICD-10 codes
- Procedures and treatments: identified in Common Procedure Terminology (CPT) codes for diagnostic, surgical and medical services, and procedures
- Utilization data: describing use of acute, primary, and specialty care as well as rehabilitation, home care, and other paid claims
- Pharmacy and durable medical equipment
- Medical management data: including service requests, approval, and denial data
- Spending or cost analyses: for aggregated or bundled services, value-based payments, individual, or unit costs

Payers should be capable of outlining the full range of palliative services encompassing all sites of care, including acute care, ambulatory services, home care vendors and provider networks. Regular reports, whether quarterly or annual, can highlight trends in service delivery, staffing, and patient outcomes. Payer reports will play a critical role in palliative care by providing valuable insights into utilization, costs, and resource allocation.

**Provider Reports**

Provider reports can be generated from provider networks, individual or group practices, or clinics. Unlike claims data, they can draw on clinical data stored in Electronic Health Records (EHRs). De-identified patient data can describe encounters and treatment plans and may also provide operational data that describes staffing and operations. Provider reports could include information describing:

- Assessments and clinical outcomes: related to physical and emotional symptoms, activities of daily living and functional independence
- Satisfaction measures: correlated to patient and family needs and experiences
- Care management and care coordination activities: describing how services are aligned to needs identified in an assessment and the person-centered treatment plan
- Advanced planning documents: iterating use of Advance Directives, Durable Power of Attorney, and the Washington Portable Orders for Life Sustaining Treatment form (POLST)[62] [63] [64]
- Interdisciplinary Team composition: describing referral and utilization metrics for social work, psychology, and chaplain services
- System integration: illustrating alignment with other providers and electronic referral tools, patient portals, or the use of health information exchanges (HIEs)
- Productivity and capacity: including efficiencies in documentation, patient throughput, accuracy in coding and billing, measures that describe appointment completion or no-shows, and consultation times

While advocacy groups, professional societies, and researchers have contributed to a growing collection of tools to evaluate palliative care, criteria will vary based on the care setting, the target population, the delivery system, and the demographic characteristics of the respondents. Notably, variability in patient populations can complicate comparisons across populations and programs, as differences between care settings, provider approaches to care, and data collection methodologies can lead to inconsistent data and unreliable evaluations. Before making reporting requirements or initiating analysis, researchers need to be aware that programs may vary significantly in the resources they have available to conduct high-quality evaluations.

Payer and provider program evaluations and reports are invaluable to palliative care programs, as they provide actionable data describing resource utilization, quality of care and patient outcomes. Each facilitates decision making to ensure that patients with serious illness have access to the services they need to maintain an optimal quality of life. By analyzing trends and outcomes, evaluations and reports ensure that program goals, quality standards and resources are aligned between payers, providers, and patients.

## KEY PERFORMANCE DOMAINS FOR PALLIATIVE CARE

As the National Consensus Project for Quality Palliative Care outlines, performance measures for palliative care can be characterized within several key domains.[65] This approach is echoed in the Bree Collaborative and the Washington Palliative Care Reimbursement Project Summary Report. The key domains include:

- Structure and Process of Care – the Interdisciplinary Care Team
- Physical Aspects of Care
- Psychological and Psychiatric Aspects
- Social Aspects
- Spiritual, Religious, and Existential Aspects
- Cultural Aspects
- End of Life Care
- Ethical and Legal Aspects

Each of the domains includes essential indicators that provide critical insights to help inform policy, guide decision making, and optimize resource allocation. Stakeholders can use indicators in these domains to evaluate key performance metrics and ensure data-driven approaches to address State priorities. This process fosters accountability and continuous improvement across palliative services.

Using an organized framework to evaluate the performance of palliative care programs strengthens data capture and analysis, aids stakeholders in understanding the findings, and facilitates evidence-based decision making. This structured approach provides leadership the information they need to align resources to need and balance the complex requirements of patients, families, and systems.

## REPORTING REQUIREMENTS

Standardizing evaluations ensures transparency, bolsters accountability, and creates a cycle of continuous quality improvement. Regular reporting allows stakeholders to assess the efficiency of the program and whether it meets its intended goals and reaches its intended population.

### Global Considerations

Reporting teams or agencies will want to formulate their research questions before fully defining the reporting requirements. While considering the question or hypothesis, the analytics team will want to consider how best to ensure data integrity, reliability, and consistency. These steps will help produce reports that advance data integrity and consistency, demonstrate compliance with published requirements or program goals, and enhance the state's understanding of key performance metrics, including patient and family satisfaction, clinical outcomes, and process measures.

To align with state objectives and priorities, reports should further the objectives of the Washington Palliative Care Reimbursement Project and the 2019 Bree Collaborative Palliative Care Report. Both documents reflect a comprehensive range of performance measures that align with the key domains of palliative care and have been carefully considered in the context of overall state goals.[66]

Effective reporting requires close collaboration between state agencies, payers, and providers. An example of this collaboration is the Washington State HCA, which uses a robust data strategy to help policymakers and stakeholders make informed decisions about performance and resource allocation. The HCA's Analytics, Research, and Measurement (ARM) "dashboard suite" maintains several individual dashboards that include health care quality and social measures for the Washington Apple Health program, the Clinical Data Repository (CDR), and the Washington All Payer Claims Database (APCD). [67] To reduce redundancy and administrative burden, data populating these dashboards could be integrated with palliative care data to evaluate program performance.[68]

## CONSIDERATIONS FOR DEVELOPING EVALUATION CRITERIA AND REPORTING REQUIREMENTS

To track and trend palliative care availability and performance, the OIC should consider collaborating with stakeholders to jointly develop a Washington State Palliative Care Report Card that includes regional or institutional

benchmarking, tracking, and trending. Key reporting areas could include the performance standards described in the Bree Collaborative as well as accessibility and workforce metrics.

- To avoid overlap and minimize administrative burden for payers and providers, efforts to report on palliative care performance should consider measures already in use and explore opportunities to collaborate with the HCA's Performance Measures Coordinating Committee (PMCC).[69] [70]
- 2019 Bree Report quality performance metrics:
  - Acute care utilization comprising the number of emergency department visits, the number of hospital admissions and re-admissions, as well as admissions to intensive care units in the last 30 days of life.
  - Circumstances of death including deaths recorded in an acute care hospital or intensive care unit
  - Patient Quality of Life which accounts for measures such as advance care planning, review of medications, an assessment of patient's functional status and an assessment of pain.
- Accessibility and availability metrics
  - Program and program type within specific geographies, prioritizing rural and underserved areas
  - Payment measures
  - Telehealth service availability
- Utilization metrics including regional or population differences, disparities, or gaps
- Workforce development and growth
  - Board certified palliative care specialists
    - Primary or other specialty providers with specialized training in palliative care certificate program, specialized training, or palliative care continuing education units

### EVALUATION AND PERFORMANCE NEXT STEPS

There are multiple ways to design a new palliative care benefit and reimburse providers. Defining the providers eligible for payment and establishing minimum health and safety standards for palliative care providers to ensure the delivery of high-quality palliative care are key elements. Washington state currently faces a shortage of health care providers and the limited availability of specialized providers poses a potential challenge for a new palliative care beneft.[44] Regarding the potential payment models for a new palliative care benefit, it will be important for OIC and the work group to consider both the payer and provider capacity and readiness for implementation of the benefit.

## Clinical Eligibility Criteria and Services Included

### BACKGROUND, SOURCES, AND METHODS

The following three reports contain guidance around the clinical eligibility criteria used for and services to be included in a potential palliative care benefit:

- *Palliative Care*, published by the Robert Bree Collaborative
- *Washington State Palliative Care Reimbursement Summary Report*, published by the Health Care Authority and Oregon Health Sciences University
- *Payment Reforms to Improve Care for Patients with Serious Illness (PACSSI)*, published by the American Academy of Hospice and Palliative Medicine

At the direction of the OIC, we summarized the guidance provided in these reports and supplemented this guidance with additional diagnosis and procedure code information to provide specific claims-based eligibility criteria that can potentially be used to manage a palliative care benefit in the commercial and Medicaid markets. For example, we created claim-based rules to proxy for functional status limitation in alignment with the two standardized tools, Palliative Performance Scale (PPS) and Eastern Cooperative Oncology Group (ECOG) Performance Status Scale used in practice

We have also supplemented this guidance with additional data to provide lists of types of services to be included in the palliative care benefit and identified procedure codes for each service type to be used as a proxy to calculate service costs.

## CLINICAL ELIGIBILITY CRITERIA

The OIC and work group have generally been supportive of adult clinical eligibility criteria for the palliative care benefit in alignment with recommendations from the Bree Collaborative.[71] These clinical eligibility criteria for individuals insured by Medicaid and commercial insurance apply to individuals aged 21 and older with a diagnosis of a serious illness or multiple chronic conditions; functional limitations; and recent, unplanned acute care hospital-based health care utilization.

OIC and the work group also have generally been supportive of the pediatric clinical eligibility criteria for the palliative care benefit in alignment with the current criteria from Washington Apple Health (Medicaid).[72] These clinical eligibility criteria for commercially-insured individuals aged 20 or younger (children with WA Medicaid coverage are currently eligible for a palliative care benefit) apply to children who have a life-limiting medical condition with a complex set of needs requiring case management and coordination of medical services due to at least three of the following six circumstances:[7314]

- An immediate medical need during a time of crises
- Coordination with family member(s) and providers required in more than one setting (i.e., school, home, and multiple medical offices or clinics)
- A life-limiting medical condition that impacts cognitive, social, and physical development
- A medical condition in which the family is unable to cope
- A family member(s) or caregiver, or both, who needs additional knowledge or assistance with the client's medical needs
- Therapeutic goals focused on quality of life, comfort, and family stability

Note, the actuarial analysis identified eligible children using the life-limiting medical condition only as the circumstances above cannot all be identified using medical claims. Additional detail behind the clinical eligibility criteria can be found in Appendix A.

## PALLIATIVE CARE SERVICES

The OIC and the work group have generally been supportive of defining palliative care services for both adults and children in alignment with recommendations from the Bree Collaborative and specifications of the Washington Apple Health (Medicaid) existing palliative care benefit for children.[74] [75]

Palliative care for individuals aged 21 and older includes services from the following categories:

- An initial assessment
- Assessment and management of behavioral health/psychosocial needs
- Goals of care conversation(s)
- Caregiver support, if needed
- Advance care planning
- Pharmacy management
- Assessment of cognitive impairment
- Spiritual care needs
- Assessment and management of functional needs
- Ongoing management
- Assessment and management of symptoms/medical care
- 24/7 Telephone Support

Many of these service categories include the assessment and management of symptoms, which may include working with other health care providers to ensure the patient receives medically necessary services outside of the palliative care benefit. For example, palliative care services include assessment and management of functional needs, but the palliative care benefit does not include physical therapy, occupational therapy, or durable medical equipment. When medically necessary, those services would be covered outside of a palliative care benefit, consistent with their current coverage.

Palliative care for individuals aged 20 or younger includes care management and coordination services for similar needs.

# Financial Evaluation

Milliman developed a financial projection for the palliative care benefit on per member per month (PMPM) and cost per six-month episode bases for adults ages 21 and older (adults) and for enrollees 20 years and younger (pediatric). The analysis relies on the clinical eligibility criteria outlined in Appendix A.

Because the benefit does not yet exist, utilization rates for these services are not available. Assumed utilization for each type of palliative care service by episode complexity tier (moderate is tier 1 and high is tier 2) were developed in collaboration with the work group. The analysis assumes that each member who elects to utilize palliative care services receives all services, paid via a six-month bundled payment. Operationally, if payers pay per contact instead of via bundled payment, they will instead pay for what the patient receives, which may be different than the underlying bundle of services assumed in our analysis and result in higher or lower cost to the payer. The services included in each bundle are displayed in Exhibits 2 and 3.

**EXHIBIT 2: ASSUMED NUMBER OF PALLIATIVE CARE SERVICE UNITS PER 6-MONTH ADULT EPISODE**

| Adult Palliative Care Service Category | Tier 1 | Tier 2 |
|---|---|---|
| Initial assessment | 1.0 | 1.0 |
| Goals of care/advance care planning (30-60 minutes) | 2.5 | 2.5 |
| Cognitive assessment | 2.0 | 4.0 |
| Symptom management/medical care/pharmacy management (20-60 minutes) | 6.0 | 12.0 |
| Behavioral health/psychosocial assessment | 3.0 | 6.0 |
| Functional needs assessment | 2.0 | 4.0 |
| Ongoing care management (20-60 minutes) | 6.0 | 12.0 |
| 24/7 telephone support (11-20 minutes) | 6.0 | 12.0 |
| Spiritual care needs (15 minutes) | 6.0 | 10.0 |
| Caregiver support assessment | 2.0 | 4.0 |
| Other, as needed | 6.0 | 12.0 |

**EXHIBIT 3: ASSUMED NUMBER OF PALLIATIVE CARE SERVICE UNITS PER 6-MONTH PEDIATRIC EPISODE**

| Pediatric Palliative Care Service Category | Tier 2 |
|---|---|
| Visit with registered nurse, social worker or therapist | 6.00 |
| Noncomplex care management (60 minutes) | 19.80 |
| Complex care management (60 minutes) | 6.60 |

Additionally, not all enrollees eligible for palliative care benefits will use them. The analysis assumed 15% of eligible adult enrollees and 8% of eligible child enrollees use the palliative care benefit in 2027. The take-up rate is important because the calculation assumes that payments are made only for members who utilize palliative care services, and not necessarily all eligible members. The results of the analysis would vary to the extent that the actual take-up rates vary from the assumed take-up rates. The take-up rate may also increase in future years due to greater visibility, expanded provider coverage, and other factors. The results of the analysis for both 2027 and later years would vary to the extent that the actual take-up rates vary from the assumed take-up rates.

This analysis does not assume that expanded coverage for palliative care benefit will result in a net reduction in non-palliative medical spending. Studies evaluating palliative care and cost savings are often based on significantly varying populations, benefit designs, or sources of insurance. Palliative care may also result in earlier hospice use, shifting medical costs from hospital admissions and emergency department visits to hospice claims. Consequently, there is insufficient evidence to assume a palliative care benefit will result in savings from reduced non-palliative service spending. More information is available in the Methodology and Assumptions section.

However, there are some services currently utilized under the existing medical benefit that may explicitly overlap with the palliative care benefit, including certain advance care planning services, care management services, and office and home visits. Services received under the existing medical benefit are removed from the analysis such that the results are the marginal costs of offering a palliative care benefit for an enrollee with existing medical coverage.

More information is available in the Methodology and Assumptions section.

## COST OF COVERAGE AND MEDICAL COST PROJECTION RESULTS

Under the base scenario, eligibility for palliative care episodes for adults is based on age, serious illness or having at least three chronic conditions, evidence of functional limitations, and recent acute care hospital or emergency room care. Hospice care makes a member ineligible for the palliative care benefit while enrolled in hospital. The projected 2027 palliative care benefit allowed medical claim costs are approximately between $0.14 and $0.32 per member per month (PMPM), or $4,952,000 total allowed dollars for the commercial markets; and between $0.38 and $0.44 PMPM, or $8,925,000 total allowed dollars in the Medicaid market. These results are the marginal costs of offering a palliative care benefit with existing medical coverage and do not include the cost of palliative care services that are already utilized under the medical benefit.

Our analysis does not consider the potential impact of benefit designs, including cost sharing. Benefit design influences enrollee utilization and take-up rates. All costs are shown in allowed dollars. Member cost sharing was not considered but may be material for the commercial market.

Exhibit 4 shows the estimated allowed cost PMPM and total allowed dollars of palliative care by market category and region, Seattle Combined Statistical Area (CSA) and Outside of the Seattle CSA, for the original base scenario.

**EXHIBIT 4: BASE SCENARIO, ALLOWED COSTS BY MARKET AND AREA**

| Market | Source of Insurance | Region | Projected 2027 Membership | Total Palliative Expenditure | Allowed PMPM |
|---|---|---|---|---|---|
| Commercial | Individual | Seattle Region | 201,000 | $497,000 | $0.21 |
| Commercial | Individual | Outside Seattle Region | 121,000 | $467,000 | $0.32 |
| Commercial | Small Group | Seattle Region | 238,000 | $400,000 | $0.14 |
| Commercial | Small Group | Outside Seattle Region | 195,000 | $433,000 | $0.19 |
| Commercial | Large Group | Seattle Region | 397,000 | $689,000 | $0.14 |
| Commercial | Large Group | Outside Seattle Region | 532,000 | $999,000 | $0.16 |
| Commercial | PEBB | Seattle Region | 150,000 | $360,000 | $0.20 |
| Commercial | PEBB | Outside Seattle Region | 152,000 | $449,000 | $0.25 |
| Commercial | SEBB | Seattle Region | 137,000 | $323,000 | $0.20 |
| Commercial | SEBB | Outside Seattle Region | 139,000 | $335,000 | $0.20 |
| Medicaid | Medicaid | Seattle Region | 895,000 | $4,775,000 | $0.44 |
| Medicaid | Medicaid | Outside Seattle Region | 907,000 | $4,150,000 | $0.38 |
| **Total Commercial** | | | **2,262,000** | **$4,952,000** | **$0.18** |
| **Total Medicaid** | | | **1,802,000** | **$8,925,000** | **$0.41** |
| **Washington Total** | | | **4,064,000** | **$13,877,000** | **$0.28** |
| **Total State Programs*** | | | **2,380,000** | **$10,392,000** | **$0.36** |

*Total State Programs is defined as the combined total of PEBB, SEBB, and Medicaid. PEBB/SEBB are also included in the commercial subtotal.

Appendix B shows the development of the PMPM cost by market and region. For Medicaid, the above expenditures, $8.9 million, include both federal and state funded total allowed dollars. The state's share of allowable expenditures would vary according to the type of Medicaid enrollee utilizing the benefit, as the Federal Medical Assistance Percentage (FMAP) differs by Medicaid population. **The state's share of allowable Medicaid expenditures is estimated to be $2,677,500 to $4,462,500.**

### SCENARIO TESTING

In collaboration with the work group, Milliman has developed two alternate scenarios for the financial projection, each expanding benefit eligibility. Other scenarios that reduce eligibility or covered benefits could also exist but were not modeled in our analysis. The alternate scenarios listed below change the clinical eligibility criteria for the adult population from the base scenario. No alternate scenarios were analyzed for the pediatric population.

- The original base scenario follows requirements in the Clinical Eligibility Criteria section without deviation.
- Alternate scenario 1 removes the Functional Status Limitation from both tiers of the Clinical Eligibility Criteria.
- Alternate scenario 2 removes the unplanned hospital visit in the 12 months prior requirement.

**EXHIBIT 5: ALTERNATE SCENARIOS, ALLOWED COSTS BY MARKET**

| Market | Alternate Scenario 1 (Expenditure) | Alternate Scenario 1 (PMPM) | Alternate Scenario 2 (Expenditure) | Alternate Scenario 2 (PMPM) |
|---|---|---|---|---|
| Total Commercial | $9,379,000 | $0.35 | $8,531,000 | $0.31 |
| Total Medicaid | $14,439,000 | $0.67 | $12,534,000 | $0.58 |
| **Washington Total** | **$23,818,000** | **$0.49** | **$21,065,000** | **$0.43** |

For Medicaid, the above expenditures include both federal and state funded total allowed dollars. For scenario 1, the state's share of $14.4M allowable expenditures is estimated to be $4,331,700 to $7,219,500. For scenario 2, the state's share of $12.5M allowable expenditures is estimated to be $3,760,200 to $6,267,000.

### ELIGIBILITY REASSESSMENT

There are many other potential alterations to the palliative care benefit structure beyond those considered directly in our projections and scenarios. One notable example would be a relaxation of the palliative care benefit eligibility requirements for members during reassessment of those members who have already completed a palliative care episode. Depending on the aims of the program, it may be considered beneficial from an operational, policy, or other perspective to no longer require previously eligible members to continue to demonstrate functional status limitations or to continue to use acute hospital-based services in order to maintain eligibility.

The precise impact of relaxing standards for eligibility reassessment would depend on the benefit design. There may also be material second-order impacts, such as increased longer term take-up rates among surviving members given a less burdensome path to redetermined eligibility. However, it is realistic that a relaxation of eligibility requirements that applies only to eligibility reassessment would be less than the alternate scenario allowed cost PMPM values shown above as those relax eligibility standards for all episodes, not just for those episodes following eligibility reassessment.

## Actuarial Methodology and Assumptions

### OVERALL APPROACH

Milliman developed a cost model to estimate the cost of a palliative care benefit. The following steps describe the overall approach of the analysis.

1. A bundle of palliative care-related services was identified in collaboration with the Washington palliative care work group. These individual services were then grouped into service categories.

   The Washington All Payer Claims Database (APCD) was queried to identify historical experience for relevant service codes. This data was then summarized to estimate the average cost for each service category in 2022. Service codes absent from the APCD were supplemented with nationwide data sources.

2. Because the specific palliative care benefit being considered does not yet exist in Washington State, historical utilization rates for these service codes are not directly applicable. We developed assumed

utilization for each palliative care service category by episode and episode complexity (moderate is tier 1 and high is tier 2) in collaboration with the work group.

3. The cost per episode was calculated by multiplying the unit cost of each service category (developed separately by line of business and geographic area) by the assumed utilization rates for each episode complexity.
4. The number of enrollees that may qualify for the palliative care benefit was identified using the APCD. The eligibility criteria were determined in collaboration with the work group and are outlined in the Clinical Eligibility Criteria section.
5. Not all enrollees eligible for palliative care benefits will use them. Milliman estimated the number of enrollees who will use palliative care by multiplying the eligibility rate and an assumed take-up rate. We developed rates separately by insurance market and by palliative episode complexity.
6. The final estimated annual allowed cost of implementing the palliative care benefit was estimated by multiplying cost per episode by the number of people expected to utilize the benefit annually.
7. Two scenarios were analyzed by modifying the eligibility criteria.

**2027 WASHINGTON ENROLLMENT**

Projections of 2027 enrollment in individual, small group, and large group markets was calculated by trending 2022 enrollment data from the APCD to 2027 using population projections from the Washington Department of Finance. Public Employees Benefits Board ("PEBB") and School Employees Benefits Board ("SEBB") projected 2027 enrollment is equal to September 2025 enrollment. The 2027 Washington Apple Health ("Medicaid") enrollment projection is equal to May 2025 enrollment from the Kaiser Family Foundation.

**FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)**

To calculate the state share of total Medicaid expenditures we assumed an FMAP range of 50% to 70%. The 70% FMAP assumes traditional and Medicaid expansion enrollees use the palliative care benefit at the same rate. The 50% assumes the users of the palliative care benefit are traditional Medicaid enrollees.

**DEVELOPMENT OF ELIGIBILITY RATES**

To develop eligibility rates, we identified the population of adults aged 21 and above who met the three eligibility components – diagnosis of serious illness or multiple chronic conditions, functional status limitation and recent, unplanned hospital utilization. We also identified the population of pediatrics aged 20 and under who met less strict requirements. Alternate scenarios are noted in the Scenario Testing subsection above.

An additional adjustment to palliative care eligibility was made to Medicaid enrollees. We determined the number of Medicaid enrollees who were eligible for the palliative care benefit in the 2022 data and assumed a similar number of Medicaid enrollees would be eligible for the benefit in 2027. However, we did assume a reduction of 18% to the overall Medicaid population due to Medicaid eligibility redetermination, based on the Medicaid Enrollment and Unwinding Tracker from KFF.[76] Work requirements and 6 month eligibility review under H.R.1 could impact future palliative care eligibility rates but were not included in the assumptions because the impacts of these provisions are uncertain given the recent enactment of the law.

Based on the eligibility criteria in Appendix A and the data available through the APCD, we have estimated the eligibility rate in 2022 for all enrollees. We consider these claims-based eligibility rates to be reasonable values to use for baseline projections of population eligibility for this benefit. Eligibility rates by market and region are shown below in Exhibit 6 for all scenarios.

**EXHIBIT 6 –ESTIMATED PALLIATIVE CARE ELIGIBILITY RATES PER 100,000 MEMBERS**

| Market | Eligibility Scenario | Region | Tier 1 | Tier 2 | Pediatric |
|---|---|---|---|---|---|
| Commercial | All Clinical Criteria (Base) | Seattle Region | 39 | 70 | 135 |
| Commercial | All Clinical Criteria (Base) | Outside Seattle Region | 45 | 79 | 136 |
| Commercial | No Functional Limitation Requirement (1) | Seattle Region | 161 | 110 | |
| Commercial | No Functional Limitation Requirement (1) | Outside Seattle Region | 184 | 135 | |
| Commercial | No Unplanned Visit Requirement (2) | Seattle Region | 149 | 108 | |
| Commercial | No Unplanned Visit Requirement (2) | Outside Seattle Region | 156 | 114 | |
| | | | | | |
| Medicaid | All Clinical Criteria (Base) | Seattle Region | 117 | 358 | 490 |
| Medicaid | All Clinical Criteria (Base) | Outside Seattle Region | 119 | 323 | 506 |
| Medicaid | No Functional Limitation Requirement (1) | Seattle Region | 441 | 550 | |
| Medicaid | No Functional Limitation Requirement (1) | Outside Seattle Region | 414 | 498 | |
| Medicaid | No Unplanned Visit Requirement (2) | Seattle Region | 309 | 509 | |
| Medicaid | No Unplanned Visit Requirement (2) | Outside Seattle Region | 295 | 430 | |

Actual eligibility rates may differ from our estimated rates because patients may meet eligibility requirements through data sources other than claims (e.g., electronic health record documentation). It is therefore possible that the eligibility criteria used in our analysis may be more stringent than those used in practice, which could materially increase the eligibility rates as compared to our projections; it is also possible that relevant patterns of practice change as a result of this benefit such that more people become eligible.

### TAKE-UP RATES

Not all enrollees who are eligible for palliative care may use the benefit. We have observed multiple sources with significantly different take-up rates in our research, including:

- A National Academy for State Health Policy (NASHP) palliative care report indicated that successful home-based palliative care programs cite an engagement rate of 35%.[77]
- An American Cancer Society study indicated that rate of eligible patients in Medicaid who received palliative care increased to 18.9% in Medicaid expansion states and 16.7% in non-expansion states.[78]
- The CMS Medicare Care Choices Model (MCCM) report noted that less than 1% of eligible beneficiaries who lived in participating hospices' market areas enrolled.[79]
- A CAPC post about hospital palliative care that noted that pediatric palliative care had significantly lower penetration (slightly over half the rate) than adult palliative care. [80]
- A JPSM article on community-based palliative care for children.[81]

**Given this observed range in take-up rates for palliative care benefits, we have estimated a year-one take-up rate of 15% for all adults 21+ in both commercial and Medicaid, and a year-one take-up rate of 8% for all children 20 or younger in both markets.** The take-up rate is applied to the eligibility rate to determine the number of enrollees utilizing palliative care benefits.

We expect that in subsequent years, the take-up rate would increase, potentially significantly. This could in turn increase costs for the state and health plans over the course of this program. We also note that the actual year one take-up rate may be substantially dependent upon the awareness of the benefit offering, availability of palliative care providers, and referral rates to palliative care providers.

### DEVELOPMENT OF UNIT COST BY SERVICE TYPE AND PER EPISODE UTILIZATION

For each service category, HCPCS codes were identified for use as a proxy for palliative care services included in the bundle. For service categories such as 24/7 telephone support, a single HCPCS code was used to calculate the unit cost. For service categories that should consider mixes of setting, duration of care or provider types, multiple HCPCS codes were used and weighted to account for an appropriate service mix.

Average charge estimates were developed using 2022 data from Washington's All Payer Claims Database (APCD), calculated separately by service category, region, and insurance market. We assigned claims in the APCD data to

“Seattle” or “Non-Seattle” areas based on their ZIP codes. Seattle area ZIP codes were assigned using the Seattle Combined Statistical Area (CSA), excluding any ZIP code with no attributed Metropolitan Statistical Area (MSA).

We evaluated all commercial and Medicaid market claims data in 2022 for the HCPCS associated with services to be covered under the palliative care benefit and calculated the average unit cost per service by HCPCS for members of any age. We also separately evaluated claims for Seattle, Non-Seattle, and statewide data.

**Unit Cost for Service Codes Without Credible Experience**

The APCD did not have credible claims data for some service codes. For these service codes, we performed additional research on national commercial claims using Milliman’s Consolidated Health Cost Guidelines™ Sources Database (CHSD). We adjusted the average charge by applying geographical relativities using the Milliman Health Cost Guidelines™ (HCGs) in order to reflect the Washington commercial market. We then developed an assumed cost for Medicaid by applying the average ratio of Medicaid to commercial unit costs from other service lines.

**Trend Assumptions**

The unit costs were trended to 2027 to model the projected cost of the first year of the palliative care benefit. These trends were developed separately for the commercial and Medicaid markets.

For the commercial market, we relied on Milliman Health Cost Guidelines™ (HCGs) and Milliman Health Trend Guidelines™ (HTGs) to determine annual trends from 2022 to 2027 to select a 5.25% unit cost trend. The HTGs contain historical statewide trends. Comparing Washington trends to nationwide averages shows that Washington was approximately 1.5% greater than nationwide average trends.

For Medicaid, we relied on publicly available data from Medicaid and CHIP Payment and Access Commission (MACPAC) on annual growth in Medicaid Enrollment and Spending[82]. We estimated annual cost trend by comparing the annual growth in total spending divided by the annual growth in enrollment from 2014 through 2023. On average, the annual growth rate in Medicaid expenditure per enrollee was 1.9%. For our projections, we have assumed a 2.0% annual cost trend for Medicaid services, including palliative care services.

The palliative care unit cost trend assumptions used for each market are shown in Exhibit 7 below.

**EXHIBIT 7: ANNUAL PALLIATIVE CARE UNIT COST TRENDS BY MARKET CATEGORY**

| Market | Unit Cost Trend |
|---|---|
| Commercial | 5.25% |
| Medicaid | 2.00% |

Exhibit 8 shows the estimated 2027 total allowed cost per palliative care episode by market category, region, and episode complexity tier with overlapping services accounted for. Tier 1 denotes episodes of moderate complexity and tier 2 denotes episodes of high complexity.

**EXHIBIT 8: ALLOWED PER EPISODE COSTS BY MARKET AND AREA**

| Market | Region | Tier 1 | Tier 2 | Pediatric |
|---|---|---|---|---|
| Commercial | Seattle Region | $5,830 | $10,537 | $5,421 |
| Commercial | Outside Seattle Region | $6,096 | $11,088 | $5,650 |
| Medicaid | Seattle Region | $3,308 | $6,209 | $3,624 |
| Medicaid | Outside Seattle Region | $2,938 | $5,423 | $3,517 |

Appendices C through F show the development of the cost per episode by market and region.

## ADJUSTMENTS FOR CURRENTLY PROVIDED SERVICES

Some services utilized under the existing medical benefit could be directly replaced by services within the proposed palliative care benefit developed with the work group. These services include care management, advance care planning, and some types of home/office visits and are projected to be between $5 and $70 on average over the

course of an episode in 2027, depending on the market and the complexity. These services were removed from our estimates for all scenarios to avoid double counting.

## POTENTIAL COST SAVINGS

An important assumption influencing the overall cost of a palliative care benefit mandate is whether, and to what extent, such a benefit could reduce medical claim costs in areas such as acute inpatient admissions or emergency room visits. While performing independent research on this question was outside the scope of our analysis, we were asked to consider the existing research on this topic while developing an assumption around the appropriateness of assuming medical cost savings that could, in whole or in part, offset the cost of the new palliative care benefit as part of our projection.

We performed an independent review of existing research, including but not limited to numerous sources provided by members of the work group. The research we reviewed included, but was not limited to, the following studies:

- Rao, Karthik, et al. 2024. "Effects of Primary Care-Led, Integrated Palliative Care for Medicare Patients in a Value-Based Model." Journal of Pain and Symptom Management 67, no. 3: 195–203.
- Washington Health Care Authority. *Washington Palliative Care Reimbursement Project Summary Report*. Published March 2023. https://www.hca.wa.gov/assets/program/palliative-care-reimbursement-project-summary-report-2023.pdf.
- Gordon, M. J., Le T., Lee E. W., and Gao A. "Home Palliative Care Savings." *Journal of Palliative Medicine* 25, no. 4 (2022): 591–595. https://doi.org/10.1089/jpm.2021.0142.
- Baxter, Kelly E., Therese Rochon, and Kate M. Lally. "Providing Palliative Care Across the Continuum to Reduce Readmissions in Community Settings." HMP Global Learning Network, February 2018. https://www.hmpgloballearningnetwork.com/site/altc/articles/providing-palliative-care-across-continuum-reduce-readmissions-community-settings.
- Kranker, Keith, Matthew Niedzwiecki, R. Vincent Pohl, Arnold Chen, Marlena Luhr, Lauren Vollmer Forrow, and Valerie Cheh. *Medicare Care Choices Model: Fourth Annual Report.* Submitted by Mathematica to the Centers for Medicare & Medicaid Services, April 2022. https://www.cms.gov/priorities/innovation/data-and-reports/2022/mccm-fourth-annrpt.
- Centers for Medicare & Medicaid Services. *Medicare Care Choices Model: Fifth Annual Report.* n.d. Accessed July 31, 2025. https://www.cms.gov/priorities/innovation/data-and-reports/2023/mccm-fg-fifthannrpt.
- Gordon, Marvin J., Tao Le, and Emmet W. Lee. "Home Palliative Care Savings." Journal of Palliative Medicine 25, no. 4 (March 30, 2022): 547–552. https://doi.org/10.1089/jpm.2021.0142.
- Hua, Meng, Yiyun Lu, Xueqin Ma, R. Sean Morrison, Guohua Li, and Hannah Wunsch. "Association Between the Implementation of Hospital-Based Palliative Care and Use of Intensive Care During Terminal Hospitalizations." *JAMA Network Open* 3, no. 1 (2020): e1918675. https://doi.org/10.1001/jamanetworkopen.2019.18675.
- Sheridan, Paige E., Wendi G. LeBrett, Daniel P. Triplett, Eric J. Roeland, Andrew R. Bruggeman, Heidi N. Yeung, and James D. Murphy. "Cost Savings Associated with Palliative Care among Older Adults with Advanced Cancer." *American Journal of Hospice and Palliative Medicine* 38, no. 10 (October 2021): 1250–1257. https://doi.org/10.1177/1049909120986800.
- May, Peter, Charles Normand, J. Brian Cassel, et al. "Economics of Palliative Care for Hospitalized Adults with Serious Illness: A Meta-analysis." *JAMA Internal Medicine* 178, no. 6 (2018): 820–829. https://doi.org/10.1001/jamainternmed.2018.0750.

Over the course of this review, we identified numerous challenges associated with developing credible and reliable estimates of palliative care cost offsets. This includes the question of whether any material savings from non-hospice, non-end of life palliative care exists, as well as estimating what such an amount might be in practice.

In the interest of brevity and clarity, we discuss general observations from the available research and studies on the subject in terms of potential applicability to the palliative care benefit under consideration for Washington, in lieu of a more detailed source-by-source discussion. Not all of these observations apply to all sources, but collectively they

summarize a body of work that, while interesting, does not provide a clear and reliable basis for assuming medical savings due to the addition of a palliative care benefit similar to the one Washington is considering.

**Limitation 1: Hospice Focus**

Some studies on palliative care are focused on programs that aim to increase hospice usage or are structured in a way that increased hospice usage becomes a significant effect of the palliative care intervention. This is not necessarily a limitation of the programs with respect to their own aims but cannot be compared to Washington's palliative care benefit. Washington's benefit is a non-hospice benefit, focused beyond end-of-life care, and is structured to terminate if and when members transition to hospice care.

A discussion of the potential medical cost impact of earlier or more frequent transitions to hospice care is beyond the scope of this report, but we do note that significant observed savings in many cited studies are linked directly to hospice usage. Our understanding is that the purpose of Washington's benefit is not to incentivize or direct hospice usage, and we have therefore not considered any potential savings that could potentially derive from such outcomes in our projections. To the extent that the state considers earlier or more frequent hospice care usage an explicitly desired policy goal, it may be appropriate to revisit the question of potential savings that could result from earlier or more frequent hospice care usage.

**Limitation 2: Significant Population Differences**

Many studies on palliative care focus on a Medicare or end-of-life population. This population is different from the population that is being considered for Washington's palliative care benefit. This limitation is intertwined with the hospice focus discussed above, but it is important to also consider that the overall utilization profile of a Medicare population may differ from the utilization profile of the commercial or Medicaid populations, even beyond specific hospice implications.

**Limitation 3: Credibility Concerns**

The credibility of the results can be challenged for many studies on palliative care. Credibility concerns are primarily related to small study populations derived from a small starting population, low take-up rates of the palliative care benefit being studied, or both. Significant variations in results between cohorts (such as by line of business) can also lead to credibility concerns.

**Limitation 4: Lack of Documentation Around Study Details**

The work group provided and/or discussed study results that are not publicly available. There was insufficient information available to validate their design and potential applicability. This does not constitute an issue with the analyses themselves but does prevent us from reasonably relying on any of the conclusions from any studies which were described in general terms or where the information about design, population, or other study characteristics was not available.

**Limitation 5: Significant Differences in Benefit Structure**

Some of the studies on palliative care focused specifically on hospital interventions, often with a focus on readmission rate reductions. This type of benefit is significantly different from the benefit under consideration for Washington. To the extent that Washington may have interest in a palliative care benefit focused on hospital interventions, it may be worthwhile to revisit these studies.

**Limitation 6: Reversion to the Mean**

In this context, reversion to the mean references the tendency of members to experience lower costs of care after high-cost events. This tendency is difficult to measure and is one of the reasons why many studies use a control group of some form. Some of the studies we reviewed did not have such a control group, and instead directly measured apparent savings from palliative care or hospice interventions, reducing the reliability and applicability of their results.

Other studies did use a control group, but in many cases it was unclear exactly how the control group was created or whether it sufficiently and appropriately adjusted for the potential impact of reversion to the mean after high-cost care.

Other potential concerns would include selection bias or publication bias, as well as the potential for palliative care to result in cost increases for some service categories, such as pharmacy expenses for pain management.

**Given the limitations of research and available studies in this area, we believe the most appropriate and supported assumption is that a palliative care benefit would neither increase nor decrease medical costs outside of the palliative care benefit. However, there would be a net increase in cost from adding a palliative care benefit.** However, despite the discussion above, we note that a lack of strong evidence supporting savings is not the same as strong evidence of no savings. There exist other studies which suggest that there may at least be the potential for cost offsets and perhaps outright savings. The HCA's 2023 Palliative Care Reimbursement Project Summary Report quoted studies suggesting cost reductions, but also noted "The degree to which cost savings manifest will depend on the how closely the eligibility and service model in Washington resembles the populations and services provided in the studies. Lastly, barriers to care such as workforce constraints and stigma will mute both the direct and indirect effects. Eligibility policy will have an effect on the magnitude of these effects as well."[83]

Additional research into this topic may eventually lead to a more conclusive estimate about medical cost savings (beyond the impact of moving members to hospice sooner) due to increased palliative care services. We also discuss additional considerations around potential cost savings in the Actuarial Analysis Considerations and Limitations section.

# Actuarial Analysis Considerations and Limitations

- The state of Washington currently does not offer palliative care coverage for adult members enrolled in Medicaid or mandate a palliative care benefit in the commercial market. However, in our analysis of claims data through the All Payers Claims Database (APCD), we observed some evidence of utilization of procedures (such as care management, advance care planning, and some types of home/office visits) that may overlap with the services that would be offered under the palliative care benefit. We reduced the cost of the palliative care benefit to avoid double counting these procedures.
- We consider claims-based eligibility rates, based on identification of functional status limitations and unplanned hospital stays for determining palliative care eligibility, to be reasonable values to use for baseline projections of population eligibility for this palliative care benefit going forward and have incorporated these assumptions into our projections. However, eligibility rates may differ in practice as patients may meet eligibility requirements through means other than claims (e.g., electronic health record documentation). The cost of the palliative care benefit may be significantly different than projected in this analysis to the extent that the actual eligibility rate varies from the claims-based eligibility rate assumed for the analysis.
- The actual benefit to be offered by the state may have different eligibility requirements than those modeled in this report. We have discussed alternate scenario testing around potential variation in eligibility requirements
- In our modeling, we excluded all members with 2022 hospice claims from program eligibility estimates. In practice, there may be members who are eligible for this benefit and transition to hospice during their eligibility period; there may also be members who are ineligible for this benefit due to incurring hospice claims prior to the year of eligibility. This may cause the cost of the benefit to vary as compared to the current modeled values.
- In our review of existing research, take-up rates for palliative care vary. The cost of the palliative care benefit may vary from the results presented in this analysis to the extent that the actual take-up rate for the Washington state palliative care benefit varies significantly from the 15% adult and 8% pediatric take-up rates we have assumed in this analysis.
- Our analysis does not consider the potential impact of benefit designs, including cost sharing. Benefit design influences enrollee utilization and take-up rates. All costs were shown in allowed dollars. Member cost sharing was not considered but may be material for the commercial market.
- Costs for this benefit may vary significantly by rate group for Medicaid, which could materially change the distribution of Medicaid members by rate group. An analysis of these implications is outside the scope of our report. Should this benefit be implemented for Medicaid, we recommend additional analysis to ensure that shifts in membership due to H.R.1 (2025-2026)[84] and any other factors are fully considered.

- The projected costs for the pediatric Medicaid benefit was not offset by the current cost of palliative care coverage, which we understand to be very small based on discussions with OIC and the work group. If a specific estimate of the cost of the current benefit to the state is available, it would likely be appropriate to incorporate a corresponding reduction to our projections for the pediatric Medicaid population.
- Provider shortages were not explicitly considered in the estimate of the cost of the palliative care benefit. Results may vary due to members being unable to find palliative care providers.

# Variability of Results

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this report. It is almost certain that actual experience will not conform exactly to the assumptions used in this report. Actual amounts will differ from projected amounts to the extent that the actual experience is better or worse than expected.

# Model and Data Reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the cost of a palliative care benefit. We have reviewed this model, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- Enrollment and Claims Data from Washington's All Payer Claims Database
- All other sources mentioned inline and in references.

The models, including all input, calculations, and output may not be appropriate for any other purpose.

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency.

We have not found material defects in the data. If there are additional material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

# Qualifications to Perform Analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Matthew Smith and Casey Hammer are members of the American Academy of Actuaries and meet the qualification standards for performing this analysis. Milliman does not provide legal advice and Washington State should seek appropriate counsel relating to any of the provisions discussed in this report.

# Distribution and Usage

This report has been prepared for the OIC and HCA for the purpose providing a landscape of palliative care, outlining considerations when designing a palliative care benefit, and providing a cost estimate of a palliative care benefit so that these entities can decide whether to implement a palliative care benefit. Milliman recognizes that this report will be public record subject to disclosure to third parties. To the extent that the information contained in this report is provided to any third parties, the report should be distributed in its entirety. We do not intend this information to benefit, or create a legal liability to, any third party, even if Milliman consents to the release of its work product to such third party. Similarly, third parties are instructed to place no reliance upon this report prepared by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any recipient of this report to make an independent determination as to the adequacy of the proposed results for their organization.

# Appendix A – Clinical Eligibility Criteria and Development of Eligibility Rates

**ADULT CLINICAL ELIGIBILITY CRITERIA**

The adult clinical eligibility criteria used in our analysis are listed below:

- **Age** – only members aged 21 and above are eligible for this benefit under this specific criterion.
  - Pediatric members aged 20 and under are eligible with a modified version of this criterion, as discussed later in the Appendix.
- **Conditions** – members must have a serious illness or at least 3 chronic conditions based primarily on diagnosis codes reported on healthcare claims
  - Relevant diagnosis codes must be present on qualifying claims on at least two different dates of services within a 3-month period
  - Additional qualifying criteria apply for serious illnesses Heart Failure and Advanced Pulmonary Disease
- **Functional Status Limitation** – a member must have one or more claims indicating a functional status limitation, including any of the following:
  - **Institutionalized** - Five out of six months prior to the condition indicator with claims for institutionalized care, or:
  - **Hospital bed, wheelchair, or oxygen** – one or more claims with a Healthcare Common Procedure Coding System (HCPCS) code for durable medical equipment (DME) intended to address functional limitations, or:
  - **Bed confinement or impaired level of consciousness** – one or more claims with a diagnosis code indicating bed confinement or impaired level of consciousness, or:
  - **Other limitations** – two or more claims on different dates of service with a diagnosis code for other limitation
  - Both claims must be for the same limitation – one claim each for two distinct limitations would not qualify
- **Healthcare utilization** – a member must have one of the following claims looking back 12 months from when the patient meets the conditional and functional status requirements:
  - **ED visits or observation stays** – as identified by claims where first two digits of Bill Type are “13” and the claim has one or more relevant HCPCS or revenue codes
  - **Inpatient admits**
    - As identified by claims where the first two digits of Bill Type are “11” and the claim has one or more lines with an inpatient revenue code
    - Exclude non-acute and planned admissions
- **Hospice care** – when an individual transitions to hospice care, they become ineligible for the remainder of a palliative care benefit period
  - Hospice care does not retroactively remove eligibility for palliative care, only prospectively
  - If an individual leaves hospice care, they are eligible for future palliative care benefit episodes
- **Episode start date** and duration assignment
  - The first month that an eligible member has a condition and functional status limitation (flagged within prior six months) is the start of a potential episode
  - A member must also have had relevant healthcare utilization (IP, ED, observation) within the prior 12 months
  - If the utilization criterion is not met, evaluate each subsequent month where the member continues to meet the condition and functional status limitation criteria
  - Initial episodes last six months (that first month plus five more), and member may be eligible for subsequent 6-month palliative care episodes
- **Episode complexity assignment**

- Episodes are assigned Tier 1 (moderate) or Tier 2 (high) complexity. Complexity assignments are based on the below logic (each criterion listed trumps those subsequent):
  - **Dementia** – Members with serious illness of dementia but no other serious illness flags and fewer than three chronic condition flags are assigned Tier 1
  - **Tier 2 Assignments**
    - **Multiple hospital visits** – Members with an unplanned inpatient admission and at least one other unplanned hospital visit (IP, ED, or Observation)
    - **Multiple unique functional status limitations –** Members with two or more unique functional status limitations
    - **Bed confinement or impaired level of consciousness**
    - **Institutionalized status**
  - All other episodes are assigned Tier 1

For adults, individual episodes were assigned using the eligibility criteria discussed above according to the following methodology:

**Step 1: Identify the population with a serious illness and/or chronic conditions**

Adult members were identified as having any of the following serious illnesses or chronic conditions based on relevant diagnosis codes.

**SERIOUS ILLNESSES - ADULT**

- Advanced Pulmonary Disease
- Brain cancer
- Cachexia
- Advanced Dementia
- Gastrointestinal cancer
- Advanced Heart Failure
- Hematologic cancers
- Hip Fracture
- Lung cancer
- Metastatic Cancer
- Ovarian cancer
- Pancreatic cancer
- Progressive Neurologic Disorder
- Protein-Calorie Malnutrition

**CHRONIC CONDITIONS**

- Mild-Moderate Pulmonary Disease
- Cancer (types not identified as serious illness)
- Mild-Moderate Heart Failure
- Coronary Artery Disease
- Mild-Moderate Dementia
- Diabetes
- Renal Disease
- Peripheral Vascular Disease

Separately for each serious illness and/or chronic condition, members were flagged as having the serious illness or chronic condition for every month following the first flag assignment.

Flags are only assigned when there is evidence of two qualified claims on different dates of service within a three-month period with a relevant diagnosis code (on any position in claim). Qualified claims include medical claims that are not filed for the purpose of lab or radiology only.

Note that if the member does not have a serious illness flag, the member must have at least three different chronic condition flags to qualify for a palliative care episode, though these flags do not all need to originate from the same month of data.

To differentiate the severity of illness, additional logic was applied for Heart Failure and Advanced Pulmonary Disease:

- Heart Failure – To be considered eligible based on this serious illness flag, members must meet one of the following:
  - At least two qualified claims with a diagnosis code of end-stage heart failure ('I5084') in any diagnosis code position within a three-month period
  - A claim with a diagnosis code for dialysis encounter/dependence reported in any diagnosis code position
  - An outpatient hospital-based or independent renal dialysis center facility claim with Type of Bill 72X (any Type of Bill code starting with "72"), a home dialysis HCPCS code, or a dialysis revenue code
  - A claim with a left ventricular assist device (LVAD) related HCPCS or ICD Procedure code
- Advanced Pulmonary Disease – To be considered eligible based on this serious illness flag, members must have evidence of oxygen dependence.

**Step 2: Exclude members with hospice related care**

For each member identified in step 1, we excluded any members with evidence of hospice care as identified based on revenue code, HCPCS, bill type, or place of service code indicating hospice. These exclusions applied to the entire calendar year 2022.

**Step 3: Identify functional status limitation**

Members were identified as having at least one functional status limitation based on relevant HCPCS, revenue codes, or diagnosis codes. Once a functional status limitation was identified, it was assumed to be present for the duration of the analysis period.

Specific identifications of categories included:

- Hospital Bed, Wheelchair, Oxygen – identified based on one or more claims with a relevant durable medical equipment (DME) order.
- Institutionalized – identified based on relevant HCPCS and/or non-acute inpatient revenue codes. To be counted, there must be a consecutive six-month period where at least five of the six-months have claims evidence (a gap month inside a six-month period is allowed, but a five-month period is not). This six-month period must exist between six-months prior and six-months after the first identified month with a serious illness flag or at least three chronic condition flags.
- Bed Confinement or Impaired Level of Consciousness – identified based on one or more claims with a relevant diagnosis code
- Other Functional Status Limitations – identified based on two or more claims on different dates of service with a diagnosis code of the same limitation, in any position within a three-month period. The following limitations can qualify:

**FUNCTIONAL STATUS LIMITATIONS**

- Aphagia
- Ataxia
- Bed Confinement
- Cognitive deficit
- Colostomy status
- Dental
- Gastrostomy status
- Hearing deficit
- Ileostomy status
- Language deficit
- Level of consciousness
- Memory deficit
- Mobility
- Nutrition
- Oxygen
- Pressure ulcer
- Renal dialysis
- Toileting
- Tracheostomy status
- Ventilator dependent
- Vision deficit

Members without a functional status limitation were excluded from palliative care episode eligibility.

**Step 4: Identify unplanned hospital visits**

Members must have at least one unplanned acute hospital visit, which can be an inpatient admission, emergency room visit, or observation stay.

- Acute Inpatient Admission – hospitalizations are identified by bill type and inpatient revenue code. Non-acute stays are identified based on revenue code, and planned stays are identified based on "always planned" procedure codes (anywhere on claim) or diagnosis codes (primary diagnosis code on claim).
  Additional exclusions apply to admissions based on claim with potentially planned procedure codes and acute or complication principal diagnosis codes.[85]
- Emergency Room Visits and Observation Stays – ER visits and observation stays are identified based on bill type and HCPCS or revenue codes.

Members without an unplanned hospital visit are excluded from palliative care episode eligibility.

**Step 5: Create Palliative Care Episodes**

Look for the first month a patient has a functional limitation flag as well as either a serious illness or at least three chronic condition flags. If there was at least one unplanned hospital visit in the previous 12 months, the utilization threshold is also met, and a six-month palliative care episode should be assigned.

Note that additional or adjusted criteria may apply for future episodes. As we focused on 2022 APCD data, we did not adjust our approach for future episodes. However, in practice there may be adjusted criteria for future or follow-up episodes after the initial six-month period expires.

**Step 6: Assign Episode Complexity**

Episodes were assigned to tier 1 (moderate complexity), or tier 2 (high complexity) as follows:

- Episodes flagged with the dementia serious illness without any other serious illness flags or 3+ other chronic condition flags are assigned to tier 1
- Episodes are assigned to tier 2 if one or more of the following apply:
  - Evidence of one unplanned inpatient admission and a second unplanned hospital visit of any type (IP, ER, Observation)
  - Evidence of two or more unique limitations at any time in the prior six-month period or first month of the palliative care episode (do not need to apply in the same month)
  - Evidence of bed confinement or impaired level of consciousness at any time in the prior six-month period or first month of palliative care episode
  - Evidence of institutionalized status
- All other episodes are assigned to tier 1

## PEDIATRIC ELIGIBILITY

The pediatric clinical eligibility criteria used in our analysis are listed below:

- Only members aged 20 and under are eligible for this benefit under this specific criteria.
- Members aged 20 and under were identified as having any of the serious illnesses listed below based on relevant diagnosis codes, and do not have a requirement for a functional limitation or hospital visit within 12 months.
- Members receiving hospice services are ineligible for the benefit.
- Pediatric episodes are only one level of complexity.

### SERIOUS ILLNESSES - PEDIATRICS

- Brain/spinal injury
- Neonatal cerebral disorders

- Cancer
- Cerebral Palsy
- Certain chromosomal disorders (Trisomy 13/18)
- Chromosomal disorders
- Cystic fibrosis
- Extreme prematurity
- Heart disease
- Myopathies
- Progressive metabolic disorders
- Renal failure
- Respiratory failure
- Severe brain malformations
- Severe immunodeficiencies
- Severe liver disease
- Severe osteogenesis
- Severe short gut/TPN dependent

Flags are only assigned when there is evidence of two qualified claims on different dates of service within a three-month period with a relevant diagnosis code (on any position in claim). Qualified claims include medical claims that are not filed for the purpose of lab or radiology only.

Similar to the adults, pediatric members meeting the eligibility criteria were assigned to a six month palliative care episode. Note that additional or adjusted criteria may apply for future episodes. As we focused on 2022 APCD data, we did not adjust our approach for future episodes. However, in practice there may be adjusted criteria for future or follow-up episodes after the initial six-month period expires.

# Appendix B – Development of Benefit Cost Projections

This appendix illustrates the development of the projected 2027 allowed cost per member per month of the proposed palliative care benefit. For Medicaid, the cost per episode and cost per member per month includes both state and federal expenditures.

| Market | Source of Insurance | Region | Complexity Tier | Eligible Members per 100,000 | % of Eligible who Utilize | Utilizers per 100,000 | Cost per Episode | Cost per Member per Month |
|---|---|---|---|---|---|---|---|---|
| Commercial | Individual | Seattle Region | Tier 1 | 54 | 15.0% | 8 | $5,830 | $0.04 |
| Commercial | Individual | Seattle Region | Tier 2 | 106 | 15.0% | 16 | $10,537 | $0.14 |
| Commercial | Individual | Seattle Region | Pediatric | 70 | 8.0% | 6 | $5,421 | $0.03 |
| Commercial | Small Group | Seattle Region | Tier 1 | 31 | 15.0% | 5 | $5,830 | $0.02 |
| Commercial | Small Group | Seattle Region | Tier 2 | 55 | 15.0% | 8 | $10,537 | $0.07 |
| Commercial | Small Group | Seattle Region | Pediatric | 120 | 8.0% | 10 | $5,421 | $0.04 |
| Commercial | Large Group | Seattle Region | Tier 1 | 33 | 15.0% | 5 | $5,830 | $0.02 |
| Commercial | Large Group | Seattle Region | Tier 2 | 53 | 15.0% | 8 | $10,537 | $0.07 |
| Commercial | Large Group | Seattle Region | Pediatric | 137 | 8.0% | 11 | $5,421 | $0.05 |
| Commercial | PEBB | Seattle Region | Tier 1 | 44 | 15.0% | 7 | $5,830 | $0.03 |
| Commercial | PEBB | Seattle Region | Tier 2 | 90 | 15.0% | 13 | $10,537 | $0.12 |
| Commercial | PEBB | Seattle Region | Pediatric | 133 | 8.0% | 11 | $5,421 | $0.05 |
| Commercial | SEBB | Seattle Region | Tier 1 | 36 | 15.0% | 5 | $5,830 | $0.03 |
| Commercial | SEBB | Seattle Region | Tier 2 | 64 | 15.0% | 10 | $10,537 | $0.08 |
| Commercial | SEBB | Seattle Region | Pediatric | 234 | 8.0% | 19 | $5,421 | $0.08 |
| | | | | | | | | |
| Commercial | Individual | Outside Seattle Region | Tier 1 | 101 | 15.0% | 15 | $6,096 | $0.08 |
| Commercial | Individual | Outside Seattle Region | Tier 2 | 159 | 15.0% | 24 | $11,088 | $0.22 |
| Commercial | Individual | Outside Seattle Region | Pediatric | 59 | 8.0% | 5 | $5,650 | $0.02 |
| Commercial | Small Group | Outside Seattle Region | Tier 1 | 39 | 15.0% | 6 | $6,096 | $0.03 |
| Commercial | Small Group | Outside Seattle Region | Tier 2 | 70 | 15.0% | 10 | $11,088 | $0.10 |
| Commercial | Small Group | Outside Seattle Region | Pediatric | 151 | 8.0% | 12 | $5,650 | $0.06 |
| Commercial | Large Group | Outside Seattle Region | Tier 1 | 34 | 15.0% | 5 | $6,096 | $0.03 |
| Commercial | Large Group | Outside Seattle Region | Tier 2 | 58 | 15.0% | 9 | $11,088 | $0.08 |
| Commercial | Large Group | Outside Seattle Region | Pediatric | 128 | 8.0% | 10 | $5,650 | $0.05 |
| Commercial | PEBB | Outside Seattle Region | Tier 1 | 50 | 15.0% | 7 | $6,096 | $0.04 |
| Commercial | PEBB | Outside Seattle Region | Tier 2 | 111 | 15.0% | 17 | $11,088 | $0.15 |
| Commercial | PEBB | Outside Seattle Region | Pediatric | 141 | 8.0% | 11 | $5,650 | $0.05 |
| Commercial | SEBB | Outside Seattle Region | Tier 1 | 39 | 15.0% | 6 | $6,096 | $0.03 |
| Commercial | SEBB | Outside Seattle Region | Tier 2 | 65 | 15.0% | 10 | $11,088 | $0.09 |
| Commercial | SEBB | Outside Seattle Region | Pediatric | 209 | 8.0% | 17 | $5,650 | $0.08 |
| | | | | | | | | |
| Medicaid | Medicaid | Seattle Region | Tier 1 | 117 | 15.0% | 18 | $3,308 | $0.05 |
| Medicaid | Medicaid | Seattle Region | Tier 2 | 358 | 15.0% | 54 | $6,209 | $0.28 |
| Medicaid | Medicaid | Seattle Region | Pediatric | 490 | 8.0% | 39 | $3,624 | $0.12 |
| Medicaid | Medicaid | Outside Seattle Region | Tier 1 | 119 | 15.0% | 18 | $2,938 | $0.04 |
| Medicaid | Medicaid | Outside Seattle Region | Tier 2 | 323 | 15.0% | 48 | $5,423 | $0.22 |
| Medicaid | Medicaid | Outside Seattle Region | Pediatric | 506 | 8.0% | 41 | $3,517 | $0.12 |

# Appendix C – Palliative Episode Allowed Costs for the Commercial Market in the Seattle Region

| Palliative Care Service Category | Tier 1 Utilization per Episode | Tier 1 Average Charge | Tier 1 Cost per Episode | Tier 2 Utilization per Episode | Tier 2 Average Charge | Tier 2 Cost per Episode | Pediatric Utilization per Episode | Pediatric Average Charge | Pediatric Cost per Episode |
|---|---|---|---|---|---|---|---|---|---|
| Initial assessment | 1.00 | $322 | $322 | 1.00 | $322 | $322 | | | |
| Goals of care/advance care planning | 2.50 | $222 | $555 | 2.50 | $222 | $555 | | | |
| Cognitive assessment | 2.00 | $336 | $672 | 4.00 | $336 | $1,343 | | | |
| Symptom management/medical care/pharmacy management | 6.00 | $156 | $933 | 12.00 | $156 | $1,867 | | | |
| Behavioral health/psychosocial | 3.00 | $354 | $1,062 | 6.00 | $354 | $2,125 | | | |
| Functional needs assessment | 2.00 | $215 | $429 | 4.00 | $215 | $859 | | | |
| Ongoing management | 6.00 | $99 | $596 | 12.00 | $99 | $1,191 | | | |
| 24/7 Telephone Support | 6.00 | $58 | $348 | 12.00 | $58 | $696 | | | |
| Spiritual care needs | 6.00 | $113 | $679 | 10.00 | $113 | $1,132 | | | |
| Caregiver support* | 2.00 | $4 | $7 | 4.00 | $4 | $14 | | | |
| Other, as needed | 6.00 | $42 | $251 | 12.00 | $42 | $502 | | | |
| Visit with registered nurse, social worker or therapist | | | | | | | 6.00 | $144 | $864 |
| Noncomplex care management (60 minutes) | | | | | | | 19.80 | $182 | $3,600 |
| Complex care management (60 minutes) | | | | | | | 6.60 | $151 | $995 |
| **Total Episode Cost** | **42.50** | | **$5,854** | **79.50** | | **$10,605** | **32.40** | | **$5,458** |
| Cost of Services Currently Overlapping Proposed Benefit | | | $24 | | | $68 | | | $38 |
| **Final Palliative Care Expenditure Impact** | | | **$5,830** | | | **$10,537** | | | **$5,421** |

*Caregiver support is an assessment of caregiver stress, capacity, and support. The fee schedules observed are consistent with this being offered as an add-on service, such as during an E&M visit.

# Appendix D – Palliative Episode Allowed Costs for the Commercial Market outside the Seattle Region

| Palliative Care Service Category | Tier 1 Utilization per Episode | Tier 1 Average Charge | Tier 1 Cost per Episode | Tier 2 Utilization per Episode | Tier 2 Average Charge | Tier 2 Cost per Episode | Pediatric Utilization per Episode | Pediatric Average Charge | Pediatric Cost per Episode |
|---|---|---|---|---|---|---|---|---|---|
| Initial assessment | 1.00 | $270 | $270 | 1.00 | $270 | $270 | | | |
| Goals of care/advance care planning | 2.50 | $235 | $589 | 2.50 | $235 | $589 | | | |
| Cognitive assessment | 2.00 | $340 | $679 | 4.00 | $340 | $1,359 | | | |
| Symptom management/medical care/pharmacy management | 6.00 | $173 | $1,036 | 12.00 | $173 | $2,073 | | | |
| Behavioral health/psychosocial | 3.00 | $343 | $1,029 | 6.00 | $343 | $2,058 | | | |
| Functional needs assessment | 2.00 | $209 | $418 | 4.00 | $209 | $835 | | | |
| Ongoing management | 6.00 | $103 | $617 | 12.00 | $103 | $1,234 | | | |
| 24/7 Telephone Support | 6.00 | $74 | $446 | 12.00 | $74 | $892 | | | |
| Spiritual care needs | 6.00 | $121 | $726 | 10.00 | $121 | $1,210 | | | |
| Caregiver support* | 2.00 | $8 | $16 | 4.00 | $8 | $33 | | | |
| Other, as needed | 6.00 | $48 | $289 | 12.00 | $48 | $578 | | | |
| Visit with registered nurse, social worker or therapist | | | | | | | 6.00 | $126 | $754 |
| Noncomplex care management (60 minutes) | | | | | | | 19.80 | $194 | $3,849 |
| Complex care management (60 minutes) | | | | | | | 6.60 | $161 | $1,063 |
| **Total Episode Cost** | **42.50** | | **$6,116** | **79.50** | | **$11,130** | **32.40** | | **$5,666** |
| Cost of Services Currently Overlapping Proposed Benefit | | | $20 | | | $42 | | | $17 |
| **Final Palliative Care Expenditure Impact** | | | **$6,096** | | | **$11,088** | | | **$5,650** |

*Caregiver support is an assessment of caregiver stress, capacity, and support. The fee schedules observed are consistent with this being offered as an add-on service, such as during an E&M visit.

# Appendix E – Palliative Episode Allowed Costs for the Medicaid Market in the Seattle Region

| Palliative Care Service Category | Tier 1 Utilization per Episode | Tier 1 Average Charge | Tier 1 Cost per Episode | Tier 2 Utilization per Episode | Tier 2 Average Charge | Tier 2 Cost per Episode | Pediatric Utilization per Episode | Pediatric Average Charge | Pediatric Cost per Episode |
|---|---|---|---|---|---|---|---|---|---|
| Initial assessment | 1.00 | $112 | $112 | 1.00 | $112 | $112 | | | |
| Goals of care/advance care planning | 2.50 | $88 | $219 | 2.50 | $88 | $219 | | | |
| Cognitive assessment | 2.00 | $446 | $891 | 4.00 | $446 | $1,782 | | | |
| Symptom management/medical care/pharmacy management | 6.00 | $88 | $529 | 12.00 | $88 | $1,058 | | | |
| Behavioral health/psychosocial | 3.00 | $170 | $510 | 6.00 | $170 | $1,020 | | | |
| Functional needs assessment | 2.00 | $67 | $134 | 4.00 | $67 | $269 | | | |
| Ongoing management | 6.00 | $59 | $354 | 12.00 | $59 | $708 | | | |
| 24/7 Telephone Support | 6.00 | $30 | $180 | 12.00 | $30 | $360 | | | |
| Spiritual care needs | 6.00 | $39 | $236 | 10.00 | $39 | $394 | | | |
| Caregiver support* | 2.00 | $2 | $3 | 4.00 | $2 | $7 | | | |
| Other, as needed | 6.00 | $24 | $147 | 12.00 | $24 | $294 | | | |
| Visit with registered nurse, social worker or therapist | | | | | | | 6.00 | $52 | $314 |
| Noncomplex care management (60 minutes) | | | | | | | 19.80 | $127 | $2,519 |
| Complex care management (60 minutes) | | | | | | | 6.60 | $120 | $795 |
| **Total Episode Cost** | **42.50** | | **$3,316** | **79.50** | | **$6,222** | **32.40** | | **$3,629** |
| Cost of Services Currently Overlapping Proposed Benefit | | | $7 | | | $13 | | | $5 |
| **Final Palliative Care Expenditure Impact** | | | **$3,308** | | | **$6,209** | | | **$3,624** |

*Caregiver support is an assessment of caregiver stress, capacity, and support. The fee schedules observed are consistent with this being offered as an add-on service, such as during an E&M visit.

The cost per episode and cost per member per month includes both state and federal expenditures.

# Appendix F – Palliative Episode Allowed Costs for the Medicaid Market outside the Seattle Region

| Palliative Care Service Category | Tier 1 Utilization per Episode | Tier 1 Average Charge | Tier 1 Cost per Episode | Tier 2 Utilization per Episode | Tier 2 Average Charge | Tier 2 Cost per Episode | Pediatric Utilization per Episode | Pediatric Average Charge | Pediatric Cost per Episode |
|---|---|---|---|---|---|---|---|---|---|
| Initial assessment | 1.00 | $164 | $164 | 1.00 | $164 | $164 | | | |
| Goals of care/advance care planning | 2.50 | $87 | $218 | 2.50 | $87 | $218 | | | |
| Cognitive assessment | 2.00 | $258 | $516 | 4.00 | $258 | $1,031 | | | |
| Symptom management/medical care/pharmacy management | 6.00 | $78 | $468 | 12.00 | $78 | $936 | | | |
| Behavioral health/psychosocial | 3.00 | $165 | $496 | 6.00 | $165 | $993 | | | |
| Functional needs assessment | 2.00 | $75 | $149 | 4.00 | $75 | $299 | | | |
| Ongoing management | 6.00 | $48 | $285 | 12.00 | $48 | $571 | | | |
| 24/7 Telephone Support | 6.00 | $42 | $255 | 12.00 | $42 | $509 | | | |
| Spiritual care needs | 6.00 | $36 | $215 | 10.00 | $36 | $359 | | | |
| Caregiver support* | 2.00 | $1 | $3 | 4.00 | $1 | $5 | | | |
| Other, as needed | 6.00 | $29 | $175 | 12.00 | $29 | $349 | | | |
| Visit with registered nurse, social worker or therapist | | | | | | | 6.00 | $84 | $503 |
| Noncomplex care management (60 minutes) | | | | | | | 19.80 | $116 | $2,296 |
| Complex care management (60 minutes) | | | | | | | 6.60 | $110 | $725 |
| **Total Episode Cost** | **42.50** | | **$2,944** | **79.50** | | **$5,434** | **32.40** | | **$3,523** |
| Cost of Services Currently Overlapping Proposed Benefit | | | $5 | | | $10 | | | $6 |
| **Final Palliative Care Expenditure Impact** | | | **$2,938** | | | **$5,423** | | | **$3,517** |

*Caregiver support is an assessment of caregiver stress, capacity, and support. The fee schedules observed are consistent with this being offered as an add-on service, such as during an E&M visit.

The cost per episode and cost per member per month includes both state and federal expenditures.

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October 27, 2025

Nico Janssen
Senior Health Policy Analyst
Washington State Office of the Insurance Commissioner

Re: Response to Milliman Draft Report on Washington State Palliative Care Benefit

Dear Nico,

The Washington State Hospice & Palliative Care Organization (WSHPCO) and the Home Care Association of Washington (HCAW), want to express our appreciation for having been able to participate in the OIC's Palliative Care Benefit Work Group in response to SSB 5936 over the past 16 months.

Rural hospital systems and palliative care providers in Washington state are already providing palliative care in rural communities and have a proven track record of reducing costs, as is evidenced by the correspondence submitted for the Office of the Insurance Commissioner Palliative Care Workgroup Report. Our associations would like to help expand these existing programs and are looking at ways to streamline and eliminate barriers to provide more palliative care in their communities.

Much of the work has been done through the Washington Rural Palliative Care Initiative (WRPCI), an effort to better serve patients with serious illness in rural communities. This public-private partnership is led by the Washington State Office of Rural Health at the state Department of Health involving over 24 organizations. This work aims to assist rural health systems and communities to integrate palliative care in multiple settings, such as emergency department, inpatient, skilled rehabilitation, home health, hospice, primary care, and long-term care.

We are researching specific ways to extend the current system of palliative care in Washington state that would be cost effective and at the very least cost neutral for our rural providers. We may be proposing future legislation that would assist in eliminating barriers to palliative care that are in current state law.

We hope that the results of the Milliman Report, which only focused on larger statewide data, does not preclude our efforts to assist smaller rural health care systems with a proven track record for cost savings associated with the practice of palliative care to patients in their communities.

Respectfully submitted,

Barbara Hansen, MA, RN

Barbara Hansen, MA, RN

Executive Director, WSHPCO

Debra Strom, MSN, RN, CPHQ
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Nico Janssen
Palliative Care Workgroup
Office of the Insurance Commissioner

Re: Response to Milliman Draft Report on Washington State Palliative Care Benefit

Dear Mr. Janssen and Members of the Palliative Care Workgroup,

As Chief Executive Officer of Heartlinks, I write to provide formal comment on the September 2025 Milliman Draft Report regarding the development of a Washington State palliative care benefit. Heartlinks has provided nonprofit community-based palliative care for over a decade, and pediatric palliative care for more than 15 years, serving both rural and urban populations in Benton and Yakima counties.

While we appreciate the report's thoroughness, Heartlinks must respectfully disagree with several of its conclusions - particularly (1) the assumption that palliative care does not reliably reduce emergency department (ED) visits and hospitalizations, and (2) the implied preference for fee-for-service or episodic payment models over a per-day rate structure. We also have concerns about the report's framing of eligibility criteria, its emphasis on physician shortages without addressing team-based care, its reliance on general hospital metrics, and its financial modeling assumptions.

**1. Real-World Evidence Contradicts the "No Savings" Assumption**
The Milliman report assumes "no net reduction in non-palliative medical spend" due to palliative care. This conclusion is inconsistent with both our direct experience in Washington's rural/urban settings and the broader peer-reviewed evidence.

Importantly, the draft report acknowledges that its actuarial analysis relied on claims-based modeling rather than data from existing Washington palliative care providers. In effect, the report did not collect or analyze real-world utilization data from providers like Heartlinks that are already delivering palliative care. As a result, the assumption that palliative care has no impact on hospitalization or emergency department use in Washington lacks a local evidence base and does not reflect actual practice.

In our service region, palliative care consistently reduces ED visits and hospitalizations. Many patients stabilized at home avoid preventable acute escalations. National research demonstrates

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that palliative care reduces hospital admissions, readmissions, and emergency visits, while shortening length of stay and lowering per-day hospital costs. Large meta-analyses have shown that early palliative care consultations reduce direct hospital costs by thousands of dollars per admission, and national surveys of hospital programs have found reductions in readmissions of nearly 50% and declines in ED use of more than one-third.

These findings are consistent with our outcomes in Benton and Yakima counties, where rural access challenges make palliative interventions particularly effective in averting hospital use. To disregard this evidence risks underestimating both the clinical and financial value of palliative care.

**2. Payment Methodology: Why a Daily Rate is Preferable**
The Milliman draft emphasizes fee-for-service and periodic (monthly or episodic) models. Heartlinks believes this approach is flawed.

A per-day (per diem) rate, similar to the hospice reimbursement structure, is the most sustainable and equitable option for community-based palliative care in Washington:

- A daily rate supports continuity and allows the interdisciplinary team to flex intensity as patient needs fluctuate, without administrative barriers to billing each discrete service.
- In rural areas, long travel times and unpredictable care patterns make FFS models administratively burdensome and financially unsustainable. Daily rates mitigate this.
- Hospice daily rates have long demonstrated feasibility and accountability, with clear quality reporting. Extending this logic to palliative care ensures consistency across serious illness care.
- Daily rates can include tiering for acuity, performance adjustments tied to outcomes, and reporting requirements to avoid misuse.

By contrast, episodic or FFS models risk incentivizing fragmented care, under-service in rural settings, and misalignment between provider effort and reimbursement.

**3. Eligibility Criteria Should Be Broader**
The report proposes eligibility that requires adults to have functional limitations and recent unplanned hospital use. This design is too restrictive and counterproductive. By requiring a hospitalization to qualify, the model forces patients to experience a crisis before they can access care that might have prevented it.

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Eligibility criteria should focus on the presence of serious illness and the need for supportive care, not prior acute utilization. For children, the criteria should also be broadened to reflect the realities of families managing complex needs in multiple care settings. Palliative care should be proactive, not reactive.

**4. Workforce Capacity Must Include Interdisciplinary Teams**

We agree with the report's recognition of provider shortages, particularly in rural areas. However, the report overemphasizes the physician workforce and underestimates the capacity of interdisciplinary teams. Heartlinks has successfully delivered palliative care for years, utilizing a model that incorporates nurse practitioners, registered nurses, social workers, chaplains, and other specialized professionals.

A sustainable benefit must support the reimbursement of interdisciplinary teams, not just physician services. Payment and credentialing must reflect the reality that palliative care relies on coordinated, team-based care that extends beyond physician availability.

**5. Evaluation and Reporting Must Use Palliative-Specific Metrics**

The draft report recommends adapting the State Common Measure Set to evaluate palliative care. While this offers a starting point, the proposed measures are insufficient to capture the full impact of palliative care. Metrics must include palliative-specific indicators such as symptom relief, caregiver outcomes, timeliness of advance care planning, and alignment with patient and family goals.

Relying solely on claims-based hospital utilization or generic patient experience scores misses the holistic value that palliative care provides. Any statewide benefit must incorporate robust, palliative-specific reporting that reflects the whole-person and family experience.

**6. Financial Modeling Underestimates Value and Demand**

We are concerned that the financial projections in the draft underestimate the value of palliative care and overestimate its cost. The analysis assumes only 15% of eligible adults would use the benefit, which is unrealistically low given rising demand and the documented need in our communities. It also assumes no offsetting savings from avoided hospital use, despite extensive national and local evidence to the contrary.

By excluding potential savings and limiting take-up projections, the report presents an incomplete financial picture. A more accurate analysis would model both utilization reductions

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and higher participation rates and would consider regional differences between urban and rural service delivery.

**Conclusion and Recommendations**

Heartlinks strongly supports the establishment of a statewide palliative care benefit, but we urge the Workgroup to reconsider the conclusions of the Milliman report. Based on our experience, we recommend:

1. Recognizing that palliative care reduces hospital and ED utilization when delivered effectively.
2. Adopting a per-day payment model, with risk-adjusted tiers and quality safeguards.
3. Broadening eligibility criteria to include patients with serious illness before acute crises occur.
4. Supporting reimbursement for interdisciplinary team-based models of care.
5. Establishing palliative-specific evaluation metrics that reflect the outcomes patients and families value most.
6. Revising financial assumptions to reflect realistic take-up rates and potential cost offsets.

We stand ready to provide data, share lessons from our ten years of program experience, and participate in piloting models that will ensure Washington patients and families have access to the high-quality palliative care they deserve.

Respectfully,

Shelby Moore, MPA, CFRE
Chief Executive Officer, Heartlinks

Cc: Palliative Care Workgroup Members

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Nico Janssen
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Re: Response to Milliman Draft Report on Washington State Palliative Care Benefit

Dear Nico,

On behalf of the Washington State Hospice & Palliative Care Organization, I want to express my appreciation for having been able to participate in the OIC's Palliative Care Benefit Work Group in response to SSB 5936 over the past 16 months. I know the OIC has worked very hard to convene meetings and to gather information, data and feedback during our meetings. I have learned a great deal from having served on this Work Group.

I have reviewed the Milliman Draft Report "Washington Palliative Care Analysis Prepared for the Washington State Office of Insurance Commissioner". I continue to disagree with the Key Assumption number 3 on page 2 in the Executive Summary section of the report:

3. Claims Savings - Given the limitations of research and available studies in the area of palliative care, we believe the most appropriate and supported assumption would be no net reduction in non-palliative medical spend due to the addition of a palliative care benefit.

I believe this Key Assumption ignores the findings and experiences of many current Palliative Care Providers in Washington State and elsewhere. It also ignores the findings of the CMS Fifth and Final Annual Evaluation Report (2016 – 2021) from the Medicare Care Choices Model, although this model was not truly a "palliative care model" (link: https://www.cms.gov/priorities/innovation/data-and-reports/2023/mccm-fg-fifthannrpt ):

- Among enrollees who died before the model ended, net expenditures (Medicare Part A and B expenditures plus MCCM payments) **decreased by $7,604 per MCCM enrollee** (13%) between enrollment and death, on average, relative to a matched comparison group.
- **Inpatient admissions decreased by 26%.** Reduced inpatient expenditures drove overall Medicare savings.
- **Outpatient emergency department visits and observation stays decreased by 12%**.

It seems to me that a dependent clause could be added at the end of Key Assumption #3: "although there are studies which demonstrate a decrease in inpatient admissions and emergency department visits." Thank you for consideration of my comments.

Respectfully submitted,

Barbara Hansen, MA, RN
Executive Director, WSHPCO