



## Hawai'i's Palliative Care Benefit: Design and Stakeholder Input

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## Objectives

- Review elements of proposed Medicaid palliative care for Hawaii
- Review processes used to gather stakeholder input, to inform benefit design and implementation plans
- Consider the pros and cons of adopting elements in the Hawaii model that go beyond the minimums required for Medi-Cal palliative care
- Consider benefits of gathering stakeholder input, to identify opportunities to improve accessibility/acceptability/value of current PC programs

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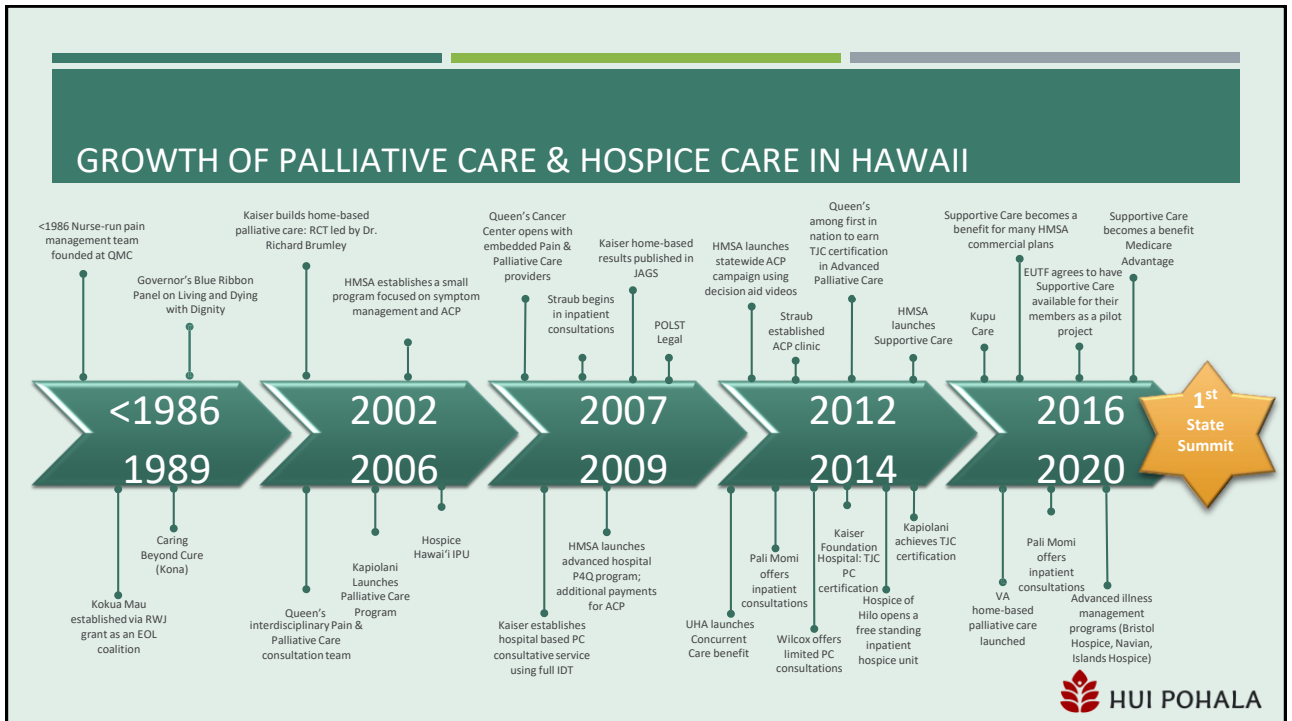
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# Formalizing a Palliative Care Benefit with the Center for Medicaid Services: Hawaii

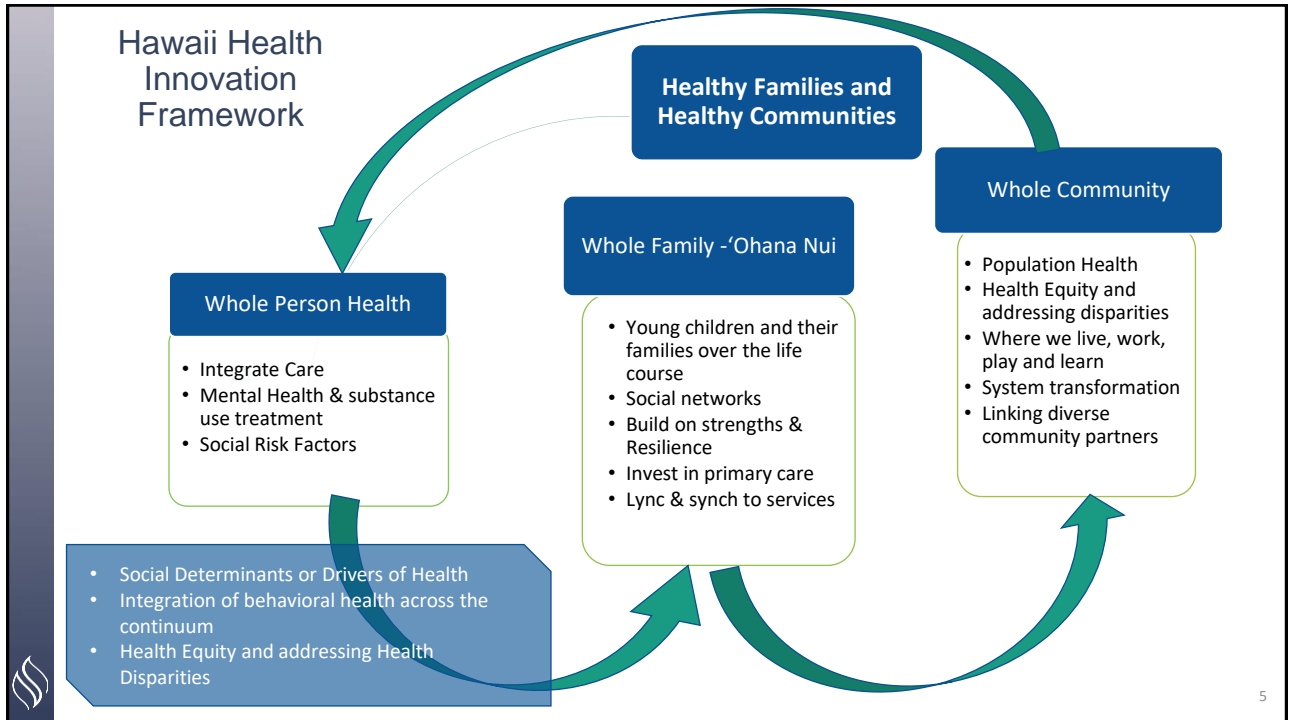
Torrie Fields, MPH

April 2023

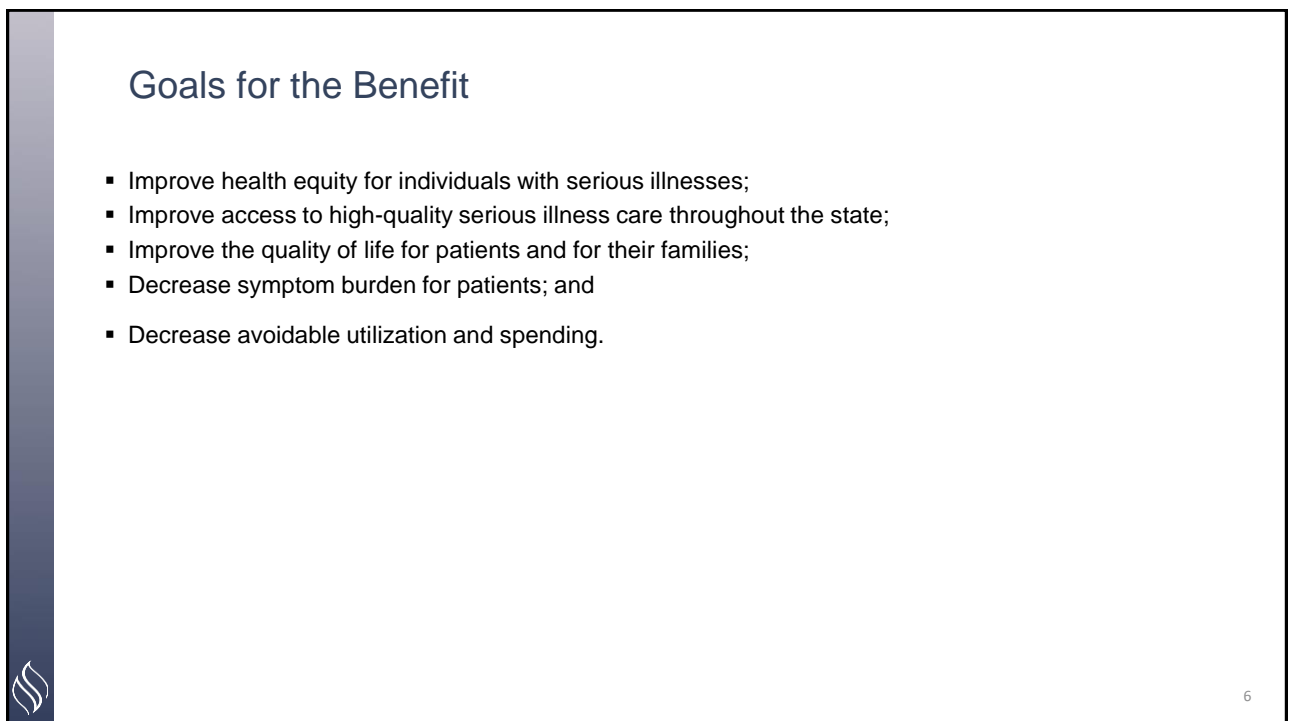
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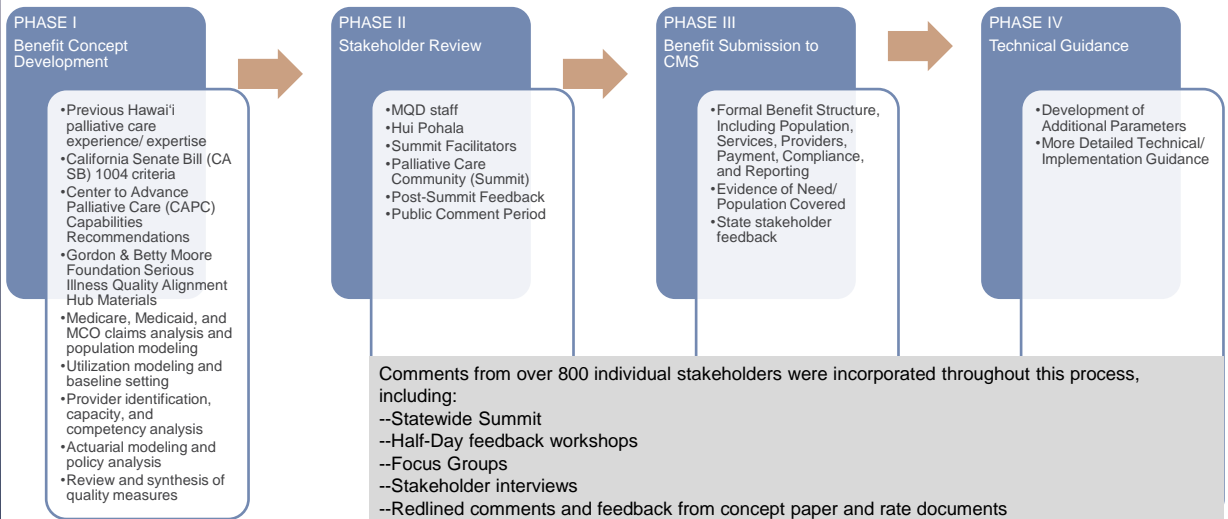
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## Evidence & Experience Making up the Model

The Stupski Foundation, John A Hartford Foundation, and Gordon & Betty Moore Foundation and private funders have provided funding to gather the **best evidence** to inform the design of a **core set of services** that Medicaid beneficiaries and their families can access when facing serious illness.



## Benefit Development Process



## Palliative Care Definitions

### Hawaii:

Palliative care specializes in the management of physical symptoms, including nausea, pain, fatigue, and shortness of breath, as well as the emotional and spiritual distress caused by serious, chronic, or terminal conditions; and

Palliative care is defined by the World Health Organization as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

### Federal:

Medicare regulations define “palliative care” as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice ([42 CFR 418.3](#)). Palliative care is at the core of hospice philosophy and care practices and is a critical component of the Medicare hospice benefit.

1. Hawaii: 2018 SCR 142, HD 1
2. Federal Register: [42 CFR 418.3](#)



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## Proposed Eligibility Criteria: Serious Illness Diagnoses

Serious Illness Diagnoses
Advanced cancer, Stage 3 or 4, locally advanced or metastatic cancer; leukemia or lymphoma
Congestive Heart Failure (CHF), New York Heart Association (NYHA) Class III or IV criteria
Chronic Obstructive Pulmonary Disease (COPD)
End Stage Liver Disease or Cirrhosis
Chronic Kidney Disease Stage III or IV or End Stage Renal Disease (ESRD)
Neurologic Disorders, such as motor neuron disease, Parkinson's Disease, Muscular Dystrophy, Multiple Sclerosis, or another progressive neurologic disorder
Alzheimer's Disease
Other Dementias

Beneficiaries must also demonstrate progressive, ongoing decline in function through an evidence-based screening tool for function, such as the Karnofsky Scale, Palliative Performance Scale, and FAST.

**\*\*Note:** Palliative care for children have additional diagnoses and services allowable but will follow a similar benefit design.



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## Proposed Services Included in Palliative Care

The community-based palliative care benefit would need to include the following services when medically necessary, aligned with patient goals for care, and directed on behalf of the patient and family:

1. Assessment
2. Clinical Services through an interdisciplinary team, addressing a person's holistic needs and the needs of their caregiver
3. Care Coordination and Communication

Palliative care is delivered by an appropriately trained and prepared interdisciplinary team, the members of which have demonstrated competency in palliative care. The interdisciplinary team should, at minimum, consist of the following disciplines, as designated in the National Consensus Project Clinical Practice Guidelines and provide 24/7 availability of services:

- Physician (medical doctor, doctor of osteopathy), board certified in a related field. The physician role must direct clinical care and program oversight. At least one prescribing clinician on the interdisciplinary team must have specialty certification in hospice and palliative care. For physicians, the Hospice Medical Director Certification Board (HMDCB) can be used.
- Registered nurse
- Licensed clinical social worker
- Spiritual care professional
- Child-Life Specialist (CLS) – Only Required for Pediatrics



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## Proposed Reimbursement and Billing Structure

The Palliative Care Services benefit emphasizes value-based reimbursement. Enrolled palliative care members will continue to be eligible for existing services as appropriate under their health plan.

Care through the community-based palliative care benefit will be covered through a flexible reimbursement model that can be tracked as separate from the hospice benefit.

Because most palliative care services are delivered through existing hospice agencies, reimbursement is aligned with administrative billing processes that can feasibly be administered by providers.

These value-based payments include the following:

- Assessment and referral to Palliative Care Services
- Reassessment for services during defined intervals
- Per enrolled member-per month case rate to cover all palliative care services and providers included in the palliative care team

Beneficiaries must qualify for services through the assessment and must consent to services prior to enrollment.



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## Monitoring Outcomes & Performance Measures

- MQD will require health plans to report data on a regular basis that will ensure program integrity and allow for continual quality improvement that include referrals, enrollment, disenrollment, and length of time receiving the benefit
- MQD will measure outcomes from the benefit that include member satisfaction, clinical quality, utilization, and cost



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## Proposed Outcomes Measures

Category	Type	Quality Measure/Measurement Area
Satisfaction	Patient Reported Outcome Measure	Patients' experience of care
Advance Care Planning	Process	Rates of patients who have an advance care plan or surrogate decision maker documented in the medical record or other documentation of advance care planning taking place
Clinical Quality	Process	Proportion of patients with pain screening or assessment (and/or with pain plan of care)
Clinical Quality	Process	Proportion of patients with functional assessment (ability to perform activities of daily living and instrumental activities of daily living)
Clinical Quality	Process	Proportion of patients with their caregiver burden formally assessed
Utilization	Outcome	Rates of avoidable hospital and/or emergency department utilization; risk-adjusted as appropriate
Utilization	Outcome	Days at home: number of days a patient remains outside of an institutional care setting during a standardized time period
Utilization	Process	Appropriate hospice utilization (e.g., hospice referral rate or hospice length of stay (LOS) for those referred or proportion of hospice LOS less than seven days or more than 180 days for those referred)



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A slide with a white background and a blue decorative border on the left and bottom. The C-TAC Innovations logo is in the top right corner. The main title is in a large, bold, blue sans-serif font. Below the title, the name and title of the speaker are listed in a smaller, black sans-serif font.

**C-TAC Innovations**

# Planning CBPC Benefit Implementation: Stakeholder Engagement

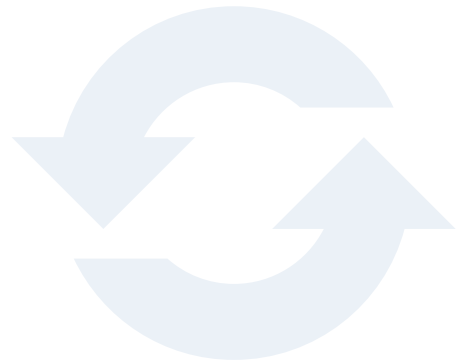
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Executive Director

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## Engagement Philosophy

- › Breadth of Perspectives:  
Expand the Team 360°
- › Flip the 80:20 Rule



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## Organizing Framework for Recommendations

- › Messaging and Communication
- › Workforce Assessment
  - Capacity
  - Capability
  - Competency
- › Overarching

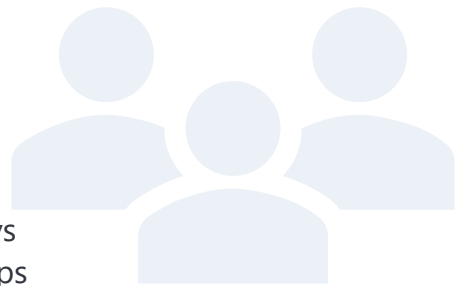


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## Engagement Strategies and Activities

- › Steering Committee
- › In-person Visit
- › Advisory Council
- › Communication and Messaging
  - Patient/Caregivers: In-person Surveys
  - Current CBPC Providers: Focus Groups
  - Providers Caring for Med-QUEST Patients
- › Workforce
  - Electronic Survey
  - Focus Groups/Interviews



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## Surveys and Focus Groups

### Organization Types for Survey

Communication: 155 people, 16 locations from 2 islands - 73 responses  
Workforce: 105 Sent; 47% response rate; Respondents from 6 Islands

- Palliative Care and Hospice Organizations
- Native Hawaiian Health Centers
- Federally Qualified Health Centers
- Specialty care providers/hospital-based services
- Community-based organizations
- Home Health/Home care agencies
- Residential settings/Residential Care
- Cultural or Faith-based Organization

### Focus Group Types

Communication: 20 Doctor/Nurse Practitioner Interviews  
 7 of 11 CBPC Provider Interviews  
Workforce: 62 Participants

- Medical Specialties
- Primary Care
- Care Managers/CCMAs
- Hawai'i Primary Care Association/Federally Qualified Health Centers
- Caregivers
- Native Hawaiian Physician Group
- Faith/Spiritual Groups
- Home Health Providers
- Health Plan Care Coordinator Teams
- Pediatric Physicians
- Emergency Physicians
- Educators
- Community Health Workers
- Advisory Council

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## Focus Group Question Examples: Messaging and Communication

- › What is your current level of experience and comfort in identifying, discussing, and referring to CBPC services?
  - What communication style/approach works best? What words/language do you avoid?
- › What successes and challenges have you experienced in engaging patients and family members in PC?
- › In thinking about the ethnic/cultural diversity of people living in Hawaii, tell me about any cultural variation in PC engagement you have experienced (if any).

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## Focus Group Question Examples: Capacity, Capability, Competency

- › How well do you feel your care providers listened to your and your loved one's needs? And how well do you think your care providers took action toward your loved one's care?
- › How would you assess and manage care for people with serious illness with limited resources (e.g., no caregiver and/or social risk factors such as access to nutritional foods, safe housing, language/literacy barriers, transportation, etc.)?
- › What is your #1 recommendation to improve care for this population?

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## Prioritizing Recommendations

- › Foundational to Begin
- › Necessary to expand to vulnerable population
- › Optimization/Enhancements



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# Thank you!

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## Core Element Comparisons

Element	Medi-Cal PC (SB 1004)	Hawaii Model
Eligibility	4 diseases, detailed general and disease-specific criteria (71% plans expanded)	Added renal diseases, neurologic disorders, Alzheimer's Disease, other dementias; paired with functional assessment (only)
Services	<ul style="list-style-type: none"> <li>• Advance Care Planning</li> <li>• PC Assessment &amp; Consultation</li> <li>• Plan of Care</li> <li>• Interdisciplinary PC Team</li> <li>• Care Coordination</li> <li>• Pain and symptom management</li> <li>• Provide or refer to mental health and social services</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment</li> <li>• Clinical Services through an IDT, addressing a person's holistic needs and <i>the needs of their caregiver</i></li> <li>• Care Coordination and Communication</li> <li>• <i>24/7 availability required</i></li> </ul>
Provider qualifications	<ul style="list-style-type: none"> <li>• Qualified providers for palliative care based on the setting and needs of a beneficiary</li> <li>• DHCS recommends using providers with current palliative care training and/or certification</li> </ul>	<ul style="list-style-type: none"> <li>• Appropriately trained and prepared IDT, "demonstrated competency in palliative care"</li> <li>• At least one prescribing clinician on the IDT must have specialty certification in hospice and palliative care</li> </ul>
Reimbursement and billing structure	APL silent; 67% plans using PEMPM, 25% offer assessment fee	<ul style="list-style-type: none"> <li>• Payment for assessment and referral</li> <li>• PEMPM case rate to cover all PC services and providers included in the palliative care team</li> </ul>

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## Reflections and Reactions: Program Design

What are potential pros and cons (from plan and provider perspectives) of adopting or adapting features of Hawaii model that go beyond minimums specified in California APL?

- Additional diseases and fewer criteria for eligible population
- Specific reference to assessing and addressing caregiver needs
- Specific requirement that at least one prescribing clinician have specialty certification in PC
- PEMPM payment mechanism with separate reimbursement for assessment and referral

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## Reflections and Reactions: Stakeholder Input

Is there a potential benefit for California Medi-Cal managed care plans and palliative care provider organizations to gather input from stakeholders?

- Could we better understand what patients/families/other treating clinicians want/need from palliative care?
- Is there an opportunity to review processes and practices, in particular for communication and messaging, to promote accessibility and acceptability of PC services?

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## Reactor Panel

**Lena Beker**

CEO and Founder  
Roze Room

**Tao Le, MD**

Regional Medical Director  
Health Net of California

**Jill Mendlen**

CEO, LightBridge Hospice and Palliative Care  
& LightBridge Medical Associates

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