OIC Palliative Care Survey Questions
Submitted August 7, 2020

The Office of the Insurance Commissioner (OIC) requested the Association of Washington Healthcare Plans (AWHP) assist in fulfilling the directives of the Specialty Palliative Care Workgroup contained in the 2020 budget by surveying member health plans regarding palliative care coverage and benefits. AWHP agreed to do so and developed a mutually approved list of questions with the OIC. Many member plans responded, and the answers below summarize the range of responses to each question.

1. **Do your plans provide a palliative care benefit?**

   AWHP: All plans provide coverage for medically necessary palliative care services, though some do so as part of other benefit types such as medical, pharmacy or hospice, as opposed to a stand-alone palliative care benefit. The Medicaid program has a specific "Pediatric Palliative Care" benefit outlined in the Health Care Authority's (HCA) Hospice Services billing guide.

2. **Do your plans use the standard definition of palliative care developed by the National Consensus project? If not, please provide the definition your plans use.**

   AWHP: The majority of plans do use the current National Consensus project standard definition of palliative care. A minority of plans do not use a standard definition.

   The HCA has a definition in its Hospice Services billing guide: "Palliative – Medical treatment designed to reduce pain or increase comfort, rather than cure. (WAC 182-551-1010)" and some additional information in the HCA Integrated Managed Care contract.

3. **If you provide a palliative care benefit, what would be the triggering event? Is a medical necessity criterion used to determine access to the benefit?**

   AWHP: For plans with a specific palliative care benefit, triggering events and medical necessity criteria vary but generally begin with an order from an authorized physician. For plans without a specific palliative care benefit, the triggering event and medical necessity criteria would be tied to the specific benefit being requested, such as hospice care criteria.

4. **Please provide a description of your palliative care benefit, how it is structured and any associated coverage/payment criteria:**

   AWHP: Plan responses varied. For those that do not include stand-alone palliative care benefits, the services are structured as part of the larger benefit of which they are part (such as hospice or home health). For those that do use a stand-alone palliative care benefit, common coverage structures include case management, home health, counseling and advance planning conversations.

a. Is palliative care treated as primary or specialty care?

AWHP: Most plans treat as specialty but indicate that for cost-sharing it does not fall into primary or specialty care.

b. Do your plans use a baseline set of diagnosis and criteria for provisions of palliative care aligned with the National Consensus Model definition?

AWHP: Only one responding plan uses a set of diagnosis and criteria.

c. Does it include the use of telemedicine or tele-monitoring care for seriously ill patients, as defined by RCW 74.09.325/RCW 74.09.658?

AWHP: All responding plans indicate that telemedicine is covered.

d. What types of providers can be reimbursed for palliative care services?

AWHP: All responding plans indicate that any in-network provider whose scope allows for palliative care treatment covered by the plan will be reimbursed.

e. Are there setting restrictions for the palliative care benefit?

AWHP: No plans indicated use of setting restrictions.

f. What are the typical plan limits, including financial limits?

AWHP: Some plans indicated that if the palliative care service is being provided as part of a larger benefit – such as hospice or home health – any applicable quantity limitations for that benefit would apply. For stand-alone palliative care benefits, some plans report benefit limitations in covered monthly contacts and service intensity add-on payments to providers.

5. How are providers reimbursed for providing palliative care? Please describe if reimbursement is on a fee for service basis or if any value-based reimbursement models are used.

AWHP: Plan responses varied. It was noted that these services can be billed by a variety of provider types. Generally, how a provider is reimbursed depends on the specific provider's contract and the member's benefit contract. Most plans indicated that reimbursement is on a fee-for-service basis, but a few did indicate select use of alternative payment models.