PALLIATIVE CARE

QUALITY IMPROVEMENT PROGRAM

DETAILED SPECIFICATIONS

2026

MEASUREMENT YEAR

Table of Contents

Partnership HealthPlan of California offers value-based programs in the areas of primary care, hospital care, specialty care, community pharmacy, extended care, and mental health. These value-based programs align with Partnership's mission to help our members and the communities we serve, be healthy.

In 2015, Partnership developed a pilot pre-hospice intensive palliative care program, called *Partners in Palliative Care*. The legislature of California passed a bill (SB 1004) in late 2015, requiring the development of a similar program as a statewide benefit for Medicaid. Implementation of this benefit occurred on January 1, 2018. In 2017, Partnership started the Palliative Care Quality Improvement Program (QIP) for providers.

Participation Requirements

To be eligible for this QIP program, intensive outpatient palliative care providers must have a signed Partnership QIP contract amendment no later than December 31, 2025, to be eligible for the 2026 measurement year which begins on January 1, 2026, Further, providers must remain contracted through December 31, 2026 (end of measurement year) to be eligible for payment.

Providers must be in good standing with state and federal regulators as of the month the payment is to be disbursed. Good standing means that the provider site is open, solvent, not under financial sanctions from the state of California or Centers for Medicare and Medicaid Services.

Partnership has the sole authority to determine if a provider is in good standing based on the criteria set forth below:

1. Provider is open for services for Partnership members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare and Medicaid Services (CMS). If a provider appeals a sanction and prevails, Partnership will consider a request to change the provider status to in good standing.
4. Provider is not pursuing any litigation or arbitration against Partnership.
5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with Partnership on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following Partnership policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement, or overbilling.
9. Provider is not conducting other activities adverse to the business interests of Partnership.

Patient Eligibility

Providers may earn incentives from the Palliative Care QIP based on care provided to Partnership eligible members, 18 years or older, who have an approved intensive outpatient palliative care treatment authorization request (TAR) on file. For more information about how members qualify for the program, please contact palliativeQIP@partnershiphp.org for a detailed policy.

Payment Methodology

The incentives provided through the Palliative Care QIP are separate and distinct from a palliative care provider site's usual reimbursement. Each provider site's earning potential is based on its volume of members approved for enrollment in the palliative care program. Please refer to the measure specifications for the incentive amount and payment calculation for each measure.

Payment Dispute Policy

Providers are strongly encouraged to review their preliminary reports during the designated preliminary review periods. If a provider does not notify Partnership of a calculation error during these periods, resulting in a potential underpayment or overpayment, the error may be corrected by Partnership post-payment through a formal appeal process. The formal appeal process is available for **up to 30 days after the provider has received their final payment statement**. Additionally, Partnership may recoup overpayments any time after payment is distributed. All formal appeal requests are reviewed by the Partnership's Executive Team.

Program Timeline

The Palliative Care QIP is administered in six-month measurement periods: Part I runs from January – June, and Part II runs from July – December. This document details the requirements and specifications for both Part I and Part II. Performance and payments are calculated at the end of each six-month period, and incentive payments are distributed three (3) months after the end of each measurement period. Partnership HealthPlan of California reserves the right to adjust QIP payment timelines due to holidays and extensive validation processes.

Measurement Period		Payment Distribution
Part I	January - June	September
Part II	July - December	March

Measure I. Avoiding Hospitalization and Emergency Room Visits

Description

The number of members enrolled in the Intensive Outpatient Palliative Care program who were not admitted to the hospital and did not have an emergency department (ED) visit.
One goal of palliative care is to improve quality of life for both the patient and the family. For members who have serious illnesses and are in the palliative care program, we expect the palliative care team to be the first point of contact, which in turn minimizes unnecessary hospitalizations and emergency department visits.

Measurement Period

Monthly, from January to June for Part I, and July to December for Part II.

Target

Zero admissions or ED visits per member per month.

Specifications

$240 per member enrolled in the Intensive Outpatient Palliative Care program per month, only if there are no hospital admissions or ED visits during that month.
Hospital admissions and ED visits are identified through data sources including encounters, claims, and treatment authorization requests (TARs) submitted to Partnership. Observation stays are included.

Refer to Appendix I for codes used to identify hospital admissions and ED visits.

Example: For a member who is enrolled in the program on February 25, seen in the emergency room on March 9, admitted from April 23 through April 30, and dies on June 2 at home, the number of months with no hospital encounters or ED visits is three (February, May, and June). The palliative care provider site will be eligible for a total payment for avoiding hospitalization and ED visits of $720.

Reporting Guidelines

Reporting by palliative care provider sites to Partnership is not required. Partnership will send preliminary reports after the end of the measurement year and prior to payment to help providers confirm and correct performance data, if needed. Providers can also request member-level reports of admissions and ED visits on an ad hoc basis.

Measure II: Completion of a Signed POLST

Description

To align best practices, the Palliative Care QIP includes an incentive for the completion of a signed Physician Orders for Life Sustaining Treatment (POLST).

The POLST was designed for seriously ill patients with the goal of providing a framework for health care professionals so they can ensure the patient receives the treatments they want and avoids those treatments that they do not want.

Measurement Period

January to June for Part I, and July to December for Part II.

Specifications

$120 per member enrolled in the palliative care program per month upon:
Completion of a signed POLST.

Example: A member is enrolled from February 25 to May 30. A signed POLST was completed in February. The palliative care provider site will be eligible for payment for the months of February through May for a total incentive of $480 for completing a signed POLST.

Reporting Guidelines

Partnership will send palliative providers a report template containing a list of Partnership members enrolled in the palliative care program with their organization for the measure period. Palliative providers will use this report template to document all visit dates for their enrolled Partnership members, and which members completed a signed POLST. The palliative provider will submit the completed POLST template to the Palliative Care QIP team.

Measure III: Completion of a Standardized Patient Symptom Assessment

Description

The Palliative Care QIP includes an incentive for the completion of two (2) standardized patient symptom assessments each month. The assessments must be at least seven (7) days apart.

The goal is to comprehensively evaluate and improve the quality of palliative care provided to patients. Providers may use the Edmonton Symptom Assessment System (ESAS) or an equivalent symptom assessment form. The ESAS is a tool used to assess the severity of common symptoms experienced by patients, particularly in palliative care settings. It involves rating symptoms on a scale of 0 to 10, with 0 indicating no symptoms and 10 indicating the worst possible severity. The ESAS helps track symptom changes over time, facilitates communication between patients and healthcare professionals, and can be a valuable part of a holistic clinical assessment, particularly in identifying symptoms requiring further, more in-depth evaluation.

If an alternative assessment form is used, the following assessment elements are, at a minimum, required:

- Pain
- Fatigue
- Appetite
- Dyspnea
- Depression
- Anxiety
- Well-being

Measurement Period

January to June for Part I, and July to December for Part II.

Specifications

Up to $120 per member enrolled in the palliative care program per month upon:

At least two (2) patient encounters per month, completing a standardized symptom assessment tool within the designated thresholds for capturing required data elements per encounter, and documented using the ESAS tool (Appendix II) or an equivalent symptom assessment tool that includes the minimum assessment elements listed in the measure description above.

Please note: As per Partnerships Palliative Care Intensive Program policy: Palliative Care Intensive Program (Adult), enrolled members must have at a minimum one (1) in-person or video visit by an RN and one (1) in-person or video visit by a social worker every month. This requirement accounts for a minimum of two (2) encounters per month. Only a maximum of (2) encounters per month will be incentivized.

Example: For a member enrolled from February 25 to May 30, with at least two (2) visits documented with a patient symptom assessment form using the ESAS tool per visit completed within the designated thresholds for capturing required data elements each month, but completed in April and May, the number of months meeting this measure is 2 (April and May).

The palliative care provider site will be eligible for payment for completing a patient symptom assessment using the ESAS tool, if they are compliant with the reporting requirement per the designated thresholds:

Thresholds:

> 70% of data elements entered on assessments = Full points ($120 Per Member Per Month (PMPM))

50-69% of data elements entered on assessments = Partial points ($60 PMPM)

Threshold Benchmarks for Payment

Assessment 1	Assessment 2	Credit for Payment
70% or more	70% or more	Full credit ($120)
70% or more	Less than 69%	Partial credit ($60)
70% or more	No assessment	Partial credit (60)
50-69%	Less than 69%	Partial credit ($60)
50-69%	No assessment	Partial credit ($60)
Less than 50%	Less than 50%	No credit

Reporting Guidelines

Partnership will send palliative providers a report template containing a list of Partnership members enrolled in the palliative care program with their organization for the measure period. Palliative providers will use this report template to document which Partnership members who completed a patient symptom assessment using the ESAS tool. The palliative provider will submit the completed Patient Symptom Assessment template to the Palliative Care QIP team.

Payment Methodology Examples

Measure I. Avoiding Hospitalization and Emergency Room Visits

Hospital admission claims data, emergency department visit claims data, and palliative care TAR approval data are used to configure a provider's incentive payment for Measure I. These reports reflect data for the measure period being processed for payment.

Hospital admissions are identified by the "**ADMIT_DATE**" and "**DISCHARGE_DATE**" columns. These columns capture the duration of an inpatient stay.

Hospital Admissions '01jul2023'd and '31dec2023'd Based on Claims paid through 29MAR2024

CIN	HOSPITAL	ADMIT_DATE	DISCHARGE_DATE
MEMBER #1	NO HOSPITAL ADMISSIONS		
MEMBER #2	NO HOSPITAL ADMISSIONS		
MEMBER #3	CLEARLAKE ADVENTIST HLTH	29JUL2023, 15AUG2023, 04SEP2023. 27SEP2023	05AUG2023, 21AUG2023, 06SEP2023, 02OCT2023
MEMBER #4	NO HOSPITAL ADMISSIONS		
MEMBER #5	NO HOSPITAL ADMISSIONS		
MEMBER #6	NO HOSPITAL ADMISSIONS		

Emergency department visits are identified by the "**ADMIT_DATE**" column. This column captures the day the member was seen in the emergency department.

ED Admissions '01jul2023'd and '31dec2023'd Based on Claims paid through 25MAR2024

CIN	HOSPITAL	ADMIT_DATE
MEMBER #1	NO ED ADMISSIONS	
MEMBER #2	LAKESIDE HOSP SUTTER	26SEP2023
MEMBER #3	NO ED ADMISSIONS	
MEMBER #4	NO ED ADMISSIONS	
MEMBER #5	CLEARLAKE ADVENTIST HLTH	02SEP2023, 12OCT2023
MEMBER #6	NO ED ADMISSIONS	

Qualifying months for payment are identified by first looking at the TAR approval data for the member (highlighted in **gold above**). The TAR approval data determines the months the member had an approved TAR for palliative care within the measure period. Next, the measure period is reviewed to identify any hospital admissions and/or emergency department visits. There are six columns with the year and month which represent the measure period being processed for payment. Measure period months that are blank and are covered by a TAR approval qualify for payment (highlighted in **green below**). Measure period months that have a year and month noted indicate a hospital admission or emergency department visit and do not qualify for payment (highlighted in **red below**).

Examples:

Member #1 has TAR approval for the months September 2023 through December 2023. In looking at the measure period, Member #1 does not have any hospital admissions or emergency department visits from September 2023 through December 2023. The total number of months that qualify for payment is four months.

Member #3 has TAR approvals for the months of July 2023 through December 2023. There are hospital admissions and/or emergency department visits noted for the months of July 2023 through October 2023. Only November 2023 and December 2023 show no hospital admission or emergency department visits and only two months would qualify for payment.

UNIQUE_CINS	TAR Start Month	TAR End Month	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	Months eligible for Payment based on Start Month and End Month
MEMBER #1	202309	202312			No Hospital Admissions/ED Visits				4
MEMBER #2	202307	202312			202309				5
MEMBER #3	202307	202312	202307	202308	202309	202310			2
MEMBER #4	202307	202312							6
MEMBER #5	202307	202312			202309	202310			4
MEMBER #6	202307	202312							6

Measure II: Completion of a Signed POLST

Palliative care TAR approval data and POLST data submitted by palliative providers are used to configure a provider's incentive payment for Measure II. These reports reflect data for the measure period being processed for payment.

Palliative care TAR data is reviewed to identify a member's TAR approvals for palliative care during the measure period. The "**START_DATE**" column notes the TAR approval start date and the "**END_DATE**" column notes the TAR approval end date. These columns determine the duration of a TAR's approval.

IOPC APPROVED TARS			
MbrCIN	AuthorizationNbr	START_DATE	END_DATE
MEMBER #1	TAR	19Sep2023	11Dec2023
MEMBER #1	TAR	12Dec2023	4Mar2024
MEMBER #1	TAR	5Mar2024	27May2024

POLST data submitted by palliative providers is reviewed to determine the qualifying months for payment for each unique member (highlighted in **gold below**). POLST completion is shown in the column titled "**POLST**". An indication of (1) indicates the completion of a POLST and an indication of (0) documents when a POLST completion is not present. The column titled "**Visit_YrMnth**" indicates the months where a visit took place. "**POLST_Final**" column indicates the months that qualify for payment (highlighted in **green**).

Name	Visit_YrMnt	DOB	POLST	TarStatus	POLST_Final
MEMBEBER #1	2024-07	11/2/1990	1	ValidTar	1
MEMBEBER #1	2024-08	11/2/1990	1	ValidTar	1
MEMBEBER #1	2024-09	11/2/1990	1	ValidTar	1
MEMBEBER #1	2024-10	11/2/1990	1	ValidTar	1

Examples:

Member #1 has confirmed visit dates from July to October of the measure period (highlighted in **gold**). The "**POLST**" column shows a one (1) indicating there is a signed POLST (highlighted in **blue**). This member has a valid TAR that covers the measure period being processed for payment under the "**TARStatus**" column (highlighted in **orange**). The total number of months that qualify for payment is four months (highlighted in **green**).

Name	Visit_YrMnt	DOB	POLST	TarStatus	POLST_Final
MEMBEBER #1	2024-07	11/2/1990	1	ValidTar	1
MEMBEBER #1	2024-08	11/2/1990	1	ValidTar	1
MEMBEBER #1	2024-09	11/2/1990	1	ValidTar	1
MEMBEBER #1	2024-10	11/2/1990	1	ValidTar	1

Member #2 has confirmed visit dates from July to December of the measure period (highlighted in **gold**). The "**POLST**" column shows a (1) indicating there is a signed POLST beginning in September (highlighted in **blue**). This member has a valid TAR that covers the measure period being processed for payment under the "**TARStatus**" column (highlighted in **orange**). The total number of months that qualify for payment is four months (highlighted in **green**).

Name	Visit_YrMnt	DOB	POLST	TarStatus	POLST_Final
MEMBER #2	2024-07	2/25/1976	0	ValidTar	0
MEMBER #2	2024-08	2/25/1976	0	ValidTar	0
MEMBER #2	2024-09	2/25/1976	1	ValidTar	1
MEMBER #2	2024-10	2/25/1976	1	ValidTar	1
MEMBER #2	2024-11	2/25/1976	1	ValidTar	1
MEMBER #2	2024-12	2/25/1976	1	ValidTar	1

Measure III: Completion of Standardized Symptom Assessment

Palliative care TAR approval data and palliative care survey data submitted by palliative providers is used to configure a provider's incentive payment for Measure III. These reports reflect data for the measure period being processed for payment.

Palliative care TAR data is reviewed to identify a member's TAR approvals for palliative care during the measure period. The "**START_DATE**" column notes the TAR approval start date and the "**END_DATE**" column notes the TAR approval end date. These columns determine the duration of a TAR's approval.

IOPC APPROVED TARS			
MbrCIN	AuthorizationNbr	START_DATE	END_DATE
MEMBER #1	TAR	19Sep2023	11Dec2023
MEMBER #1	TAR	12Dec2023	4Mar2024
MEMBER #1	TAR	5Mar2024	27May2024

Qualifying visit months are identified by looking for at least (2) visits within a month (highlighted in **gold below**). Completed assessments are identified for each qualifying visit month (highlighted in **orange below**). Please note, the assignment of "**Final_FirstAssessment**" and "**Final_SecondAssessment**" indicates the order that the assessments were completed for the qualifying visit month. The "**Ratio**" tab shows the percentage of required elements captured on the assessment (see the list of required data elements using the ESAS tool (Appendix II). The percentage under the "**Ratio**" tab is noted under the appropriate threshold column: "**70% or more**", "**50-69%**" and "**Less than 50%**", **No Assessment** (highlighted in **green**).

Example:

Member #1 has a valid TAR approval for palliative care for the measure period being processed for payment. Two visits are identified in the months of July, August, September, October, November and December. Each month has (2) assessments that were completed with 100% of the required data elements. The assessments for each month fall under the "**70% or more**" threshold. The total number of months qualifying for the full incentive is (6) months (see Benchmark Thresholds for Payment Table)

Assessments	Member_Name	Visit Months	Ratio	TarStart	TarEnd	TAR_Validation	First_70% or more	First_50-69%	First_Less than 50%	No Assessment
Final_FirstAssessment	MEMBER #1	July	1	7/30/2024	1/20/2025	Valid	1	0	0	
Final_SecondAssessment	MEMBER #1	July	1	7/16/2024	1/6/2025	Valid	1	0	0	
Final_FirstAssessment	MEMBER #1	August	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_SecondAssessment	MEMBER #1	August	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_FirstAssessment	MEMBER #1	September	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_SecondAssessment	MEMBER #1	September	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_FirstAssessment	MEMBER #1	October	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_SecondAssessment	MEMBER #1	October	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_FirstAssessment	MEMBER #1	November	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_SecondAssessment	MEMBER #1	November	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_FirstAssessment	MEMBER #1	December	1	10/11/2022	5/12/2025	Valid	1	0	0	
Final_SecondAssessment	MEMBER #1	December	1	10/11/2022	5/12/2025	Valid	1	0	0	

Appendix I: Table of Hospital Admissions and Emergency Department Codes

CLAIM TYPE	LOCATION CODE	SERVICE PROVIDER TYPE	DESCRIPTION	TYPE
H, HX	3		INPATIENT HOSPITAL	Admissions
H, HX	21		INPATIENT HOSPITAL	Admissions
H, HX	51		INPATIENT, PSYCHIATRIC FACILITY	Admissions
H, HX	61		INPATIENT, REHAB	Admissions
M, MX	23		EMERGENCY DEPARTMENT	ED
M, MX		15	COMMUNITY HOSP OUTPATIENT DEP	ED
M, MX		61	COUNTY HOSP OUTPATIENT DEP	ED

Edmonton Symptom Assessment Scale (ESAS) Tool

Name: _____ Phone Number: _____

Address: _____ Completed By:_____

Please circle a number that best describes how you feel:

0 1 2 3 4 5 6 7 8 9 10

No pain — *Worst possible pain*

0 1 2 3 4 5 6 7 8 9 10

Not tired — *Very tired*

0 1 2 3 4 5 6 7 8 9 10

No nausea — *Very nauseous*

0 1 2 3 4 5 6 7 8 9 10

Not depressed — *Very depressed*

0 1 2 3 4 5 6 7 8 9 10

Calm — *Very anxious*

0 1 2 3 4 5 6 7 8 9 10

Not drowsy — *Very drowsy*

0 1 2 3 4 5 6 7 8 9 10

Normal appetite — *No appetite*

0 1 2 3 4 5 6 7 8 9 10

Best feeling of well-being — *Worst possible feeling of well-being*

0 1 2 3 4 5 6 7 8 9 10

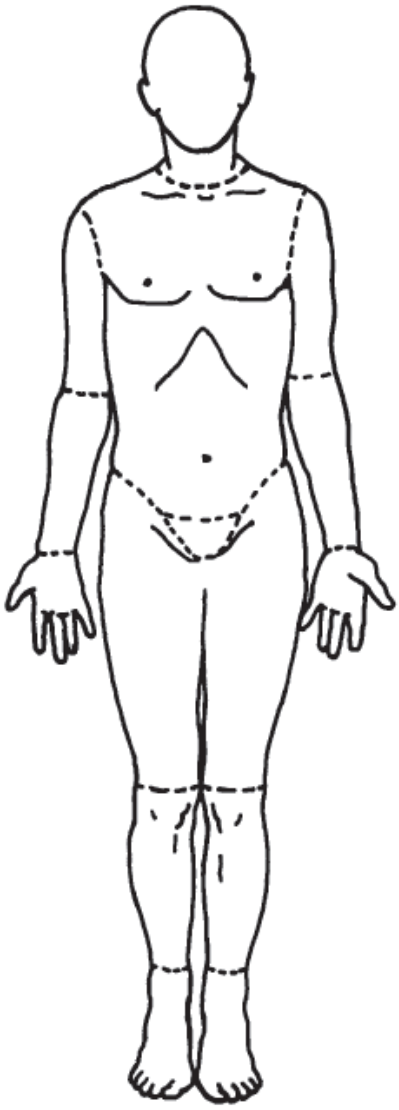
No shortness of breath — *Very short of breath*

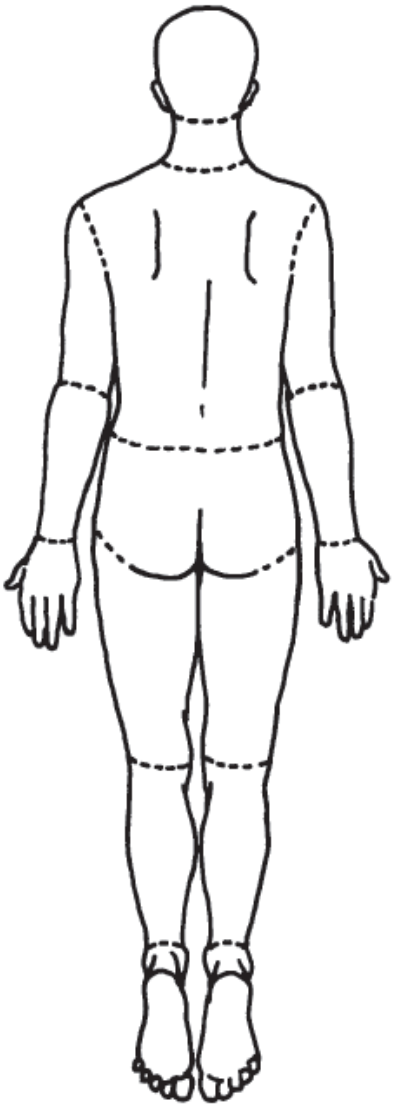
0 1 2 3 4 5 6 7 8 9 10

Other problem

Please mark on these pictures where you feel pain or discomfort.

Right





Right

Edmonton Symptom Assessment Scale (ESAS)

The Edmonton Symptom Assessment Scale (ESAS) is a valid and reliable tool to assist in the assessment of nine common symptoms experienced by cancer patients.

PURPOSE OF THE ESAS

This scale is designed to help assess pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well-being, and shortness of breath. The blank scale can be used to assess "other problems" as needed. Each symptom's severity at the time of assessment is rated from 0 to 10; 0 meaning the symptom is absent and 10 being the worst possible severity.

The ESAS was designed so you or your family/caregiver could self-assess symptoms, and use this tool to better understand your symptoms. Your opinion of the severity of your own symptoms is the gold standard for symptom assessment.

The ESAS provides a clinical profile of symptom severity over time as well as a context for understanding symptoms. However, it is not a complete assessment in itself. For comprehensive symptom management, the ESAS must be used as one part of a holistic clinical assessment.

HOW TO DO THE ESAS

Take a moment to reflect on your symptoms and choose the most appropriate number to indicate where the symptom lands on the scale. You can then write it onto the ESAS Log.

Some symptoms may be harder to vocalize or understand. Below are similar words that may help you better understand the symptom.

- **Depression** – Feeling sad or blue most of the time
- **Anxiety** – Feeling nervous or restless
- **Tiredness** – Having lower energy but not necessarily tired
- **Drowsiness** – Feeling sleepy
- **Well-being** – Reflect on your overall comfort, both physical and otherwise. Truthfully answer the question "How are you?"

If you are in pain, the Body Diagram can be used to find out where you hurt specifically.

WHO SHOULD COMPLETE THE ESAS

Ideally, each person fills out their own ESAS. However, if needed it should be completed with assistance by the caregiver (a family member, friend) or a health professional closely involved with your care. If you cannot participate in the symptom assessment, the ESAS is completed by the caregiver or professional.

The method in which the ESAS is completed must be indicated on the client log as follows: by client, caregiver assisted, by caregiver, or by health professional.

NOTE:

When the caregiver or professional completes the ESAS alone, the subjective symptom scales are left blank (i.e. tiredness, depression, anxiety, and well-being) while the caregiver assesses the remaining symptoms as objectively as possible (i.e. pain is assessed based on knowledge of pain behaviours, appetite is interpreted as the absence or presence of eating, nausea as the absence or presence of retching or vomiting, and shortness of breath as laboured or accelerated breaths that appear to cause the patient distress).

WHEN TO DO THE ESAS

The ESAS should be completed at every visit to the doctor. It is good practice to complete the ESAS at the same time of day, prior to your scheduled visit. The ESAS should only be completed on a daily basis for those receiving more than one nursing visit per day; however, there may be a symptom(s) requiring reassessment more than once a day. For example, if your pain is at a 10 on the morning visit, you can call your doctor and they may suggest some tools to better manage the symptom. The case manager authorizes visits twice a day for pain control, and at the second visit you reassess the pain.

WHERE TO DOCUMENT THE ESAS

The ESAS results should be documented within your medical record system.