LeadingAge Ohio

Palliative Care

a playbook for payers & providers in Ohio

Includes:

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This playbook was developed by LeadingAge Ohio in collaboration with Ohio hospice and palliative care providers, health plan partners, and other stakeholders. It is intended to serve as a practical guide for Medicaid managed care health plans and community-based providers seeking to contract for, deliver, and measure high-quality community-based palliative care.

Ohio's Medicaid managed care landscape is evolving. Health plans are increasingly aware that members with serious illnesses – cancer, heart failure, chronic obstructive pulmonary disease (COPD), dementia, advanced kidney and liver disease, and other life-limiting conditions – require more than what standard case management programs can offer.

Community-based palliative care is not hospice. It does not require a prognosis of six months or less. It can and should begin at diagnosis of a serious illness and be delivered alongside curative or disease-modifying treatment.

This document provides a framework for what good palliative care looks like – a gold standard model rooted in national clinical guidelines – and offers practical guidance for health plans navigating what to contract for, how to structure payment, how to measure outcomes, and how to think about access across Ohio's diverse urban, suburban, and rural counties. It also acknowledges the realities on the ground: Ohio's palliative care infrastructure is uneven, providers operate different delivery models, and access gaps exist particularly in rural areas. Where the gold standard cannot yet be met, this playbook offers guidance on bridging access responsibly.

This is not a regulatory document. It does not set prices or mandate contractual terms. It is a resource – a starting point for productive conversations between health plans and providers about what palliative care can and should look like in Ohio.

Purpose of This Playbook

This playbook is designed to be a practical, working resource – not a policy mandate. It is intentionally written for multiple audiences and can be used independently by any of the groups below.

For Health Plans

Ohio's Medicaid managed care plans are uniquely positioned to expand access to community-based palliative care by establishing clear contracting expectations, identifying qualified providers, and building payment structures that reward quality. This playbook helps health plans:

- Design contracting strategies that expand member access to community-based palliative care
- Identify program standards that distinguish high-quality palliative care from care management or disease management programs
- Develop sustainable payment models that support provider viability while driving toward accountability
- Understand the Ohio-specific landscape – where providers exist, where gaps remain, and how to think about rural access

For Providers

Hospice organizations, home health agencies, health systems, and independent palliative care programs seeking to develop or strengthen their palliative care programs can use this playbook to:

- Understand what health plans expect from contracted palliative care providers
- Benchmark their programs against the gold-standard model and NCP/CAPC guidelines

- Identify operational best practices for staffing, triage, access, and care planning
- Prepare for contracting conversations, including quality reporting and PMPM arrangements

For Stakeholders

Policy advocates, association staff, state agency partners, and community stakeholders engaged in expanding palliative care access across Ohio can use this playbook to:

- Develop strategies to address access gaps in rural and underserved communities
- Articulate the case for investment in community-based palliative care to payers and policymakers
- Identify where infrastructure development is most needed across Ohio's 88 counties
- Engage health plans in conversations about coverage standards and contracting expectations

Section 1: What Is Community-Based Palliative Care?

Definition and Scope

Palliative care is specialized medical care for people living with serious illness. It focuses on relief from the symptoms and stress of serious illness – with the goal of improving quality of life for both the patient and their family. Palliative care is provided by a team of clinicians who work alongside the patient's primary and specialty physicians.

Community-based palliative care serves a broad population, aiming to help people remain in their communities and avoid institutionalization. It provides support outside of hospitals by focusing on the needs of patients and their families in the home or community settings, such as clinics or long-term care facilities. Palliative care can serve anyone, regardless of age, living with a burdensome, serious, chronic, or traumatic illness, who would benefit from a layer of support:

- To manage physical symptoms
- Address psychosocial, emotional, and caregiving needs
- Support goals-of-care discussions and advance care planning
- To coordinate services across settings and providers
- Can be delivered concurrently with curative treatment

Key Distinction: Palliative Care vs. Hospice

Palliative care can be given at any stage of a serious illness and may accompany curative treatments, while hospice care is reserved for those nearing the end of life, focusing on comfort when life expectancy is six months or less.

Who Benefits

Community-based palliative care is appropriate for members with serious, chronic, or life-limiting conditions including but not limited to:

- Cancer (any stage, especially advanced or metastatic)
- Advanced heart failure, COPD, or other chronic cardiopulmonary conditions
- Advanced dementia or other progressive neurological conditions
- End-stage kidney or liver disease
- ALS and other progressive neurodegenerative disorders
- Stroke with significant functional impairment
- Other serious, chronic, or traumatic illnesses causing significant symptom burden, functional decline, or high utilization

Health plans should consider establishing member eligibility criteria that identify high-utilization members with serious illness who are most likely to benefit – using claims data, predictive analytics, or clinical referral pathways. Research shows that structured community palliative care programs, when targeted appropriately, reduce hospitalizations by 33%, reduce ICU admissions by 38%, and generate meaningful cost savings for health plans and providers.

The Evidence for Investment in Community-Based Palliative Care

The return on investment for community-based palliative care is well-supported in the literature and in real-world managed care experience:

Evidence Source	Finding
NASHP Actuarial Analysis (2022)	Estimated PMPM savings of $392– $1,289 for Medicaid members utilizing a palliative care benefit in the 6 months prior to hospice
Home Palliative Care Study (PMC, 2022)	16.7% gross reduction in total medical costs per member annually; 17.9% for those enrolled 6– 12 months
Community-Based Palliative Care, Medicare Advantage (PMC, 2019)	$619 PMPM cost reduction; 38% fewer ICU admissions; 33% fewer hospital admissions
Mount Carmel/Medigold, Columbus OH	Structured nurse and social work model reduced total medical costs and improved quality of end-of-life care in a Medicare Advantage population
Home-Based Palliative Care, ACO Study	$12,000 lower cost per patient in the final 3 months of life compared with usual care

Palliative care is not a cost center – it is a value driver. Evidence increasingly shows that well-designed palliative care programs can generate meaningful improvements in patient outcomes while reducing avoidable utilization. Health plans that contract high-quality palliative care are investing in better outcomes for their members and more sustainable utilization patterns.

Section 2: Why Health Plans Should Invest in Palliative Care

Community-based palliative care is one of the most well-evidenced interventions available to health plans managing a seriously ill population. This section makes the business and clinical case for investment – framed around the four value drivers most relevant to Medicaid managed care plans.

1. Improved Patient and Caregiver Experience

Serious illness creates enormous physical and emotional burdens – not just for patients, but for family members and caregivers who often provide unpaid, unsupported care at home. Health plan members with serious illness frequently report feeling overwhelmed, undertreated for symptoms, and unsupported in navigating complex medical decisions.

Community-based palliative care addresses this directly through:

- Proactive symptom assessment and management – addressing pain, dyspnea, nausea, anxiety, and other distressing symptoms before they escalate to crisis
- Goals-of-care discussions – helping patients and families understand their illness, clarify what matters most to them, and make informed decisions about treatment
- Caregiver education and support – equipping family members to provide care safely and recognize when to escalate
- Navigation support – connecting patients and families to community resources, specialist care, and social services

Patients enrolled in community palliative care programs consistently report higher satisfaction with their care than those receiving usual care alone.

2. Reduced Avoidable Utilization

Members with serious illness are among the highest-cost populations in any health plan. A significant portion of their costs – particularly emergency department visits and hospitalizations – are avoidable with the right support in place. Palliative care programs reduce avoidable utilization by:

- Managing symptoms proactively, before they reach crisis level
- Providing a direct clinical contact that patients and families can reach 24/7 before calling 911
- Coordinating care across providers to prevent gaps, duplication, and conflicting treatment plans
- Helping patients remain safely in their homes or preferred settings rather than escalating to inpatient care unnecessarily

As noted in Section 1, the evidence consistently shows 20– 38% reductions in hospitalizations and ICU admissions for enrolled members, with meaningful PMPM cost reductions across payer types.

3. Improved Hospice Transitions

One of the most significant and underappreciated benefits of community palliative care for health plans is its impact on hospice utilization. Members who receive palliative care earlier in their illness trajectory:

- Reach hospice with a clearer understanding of their prognosis and what hospice offers
- Transition to hospice in a timelier way – with longer lengths of stay and better end-of-life care quality
- Are less likely to die in the hospital or ICU

- Experience less aggressive, less costly care in the final weeks of life

For Medicaid health plans, which bear full cost of care for non-dual members through the end of life, the financial and quality implications of better hospice transitions are substantial. Palliative care programs often facilitate earlier and more informed discussions about hospice when appropriate.

4. Alignment with Value-Based Care

Community-based palliative care is a natural fit with the goals of value-based healthcare reform. It is inherently:

- Patient-centered – organized around the patient's goals, values, and preferences rather than provider-driven treatment protocols
- Proactive – focused on preventing crises and managing illness trajectories rather than reacting to acute episodes
- Coordinated – designed to bridge gaps across the fragmented healthcare system
- Accountable – measurable against clear quality outcomes (see Section 4)

Health plans building toward risk-based arrangements, ACO partnerships, or DSRIP-style population health programs will find community palliative care a high-leverage investment in their most complex, highest-cost member cohort.

Section 3: The Ohio Palliative Care Landscape

Ohio's palliative care landscape is actively developing, but uneven. Programs exist across a spectrum of delivery models:

- Home-based models – advanced practice providers (APPs) and nurses delivering care in the patient's residence
- Clinic-based models – palliative care delivered in outpatient settings, often affiliated with health systems or cancer centers
- Hospital-based models – inpatient palliative care teams with variable community follow-up
- Hospice-affiliated community programs – hospice organizations leveraging existing infrastructure to expand upstream into palliative care

Across Ohio programs, several common themes emerge: most programs are heavily driven by nurse practitioners and APPs, with physician oversight; interdisciplinary team members such as social workers and chaplains are engaged as needed rather than routinely; 24/7 availability is typically offered via telephone triage rather than in-person after-hours visits; and in-home delivery is significantly more costly than clinic-based care, particularly in rural counties where travel time creates substantial productivity barriers.

LeadingAge Ohio member organizations providing community-based palliative care currently serve the majority of Ohio's 88 counties, as illustrated in the provider coverage map below. Gray counties represent areas with identified access gaps where preferred-standard palliative care may not currently be available – areas where the safety-net access framework in Section 6 is most relevant.

Ohio Community-Based Home Palliative Care – Provider Coverage Map
Colored counties: Current LeadingAge Ohio member palliative care provider coverage (visit the interactive map to see specific providers by county)
Gray counties: Areas with limited or no current LeadingAge Ohio member palliative care coverage
Note: Coverage levels and specific provider capacity vary by county. Visit the interactive provider map at Ohio Palliative Care Provider Coverage Map to explore coverage by county. Sources: CSNO (Care Solutions Network of Ohio), Ohio's Hospice, Pure Healthcare, CAPC Palliative Care Provider Directory. Health plans should conduct direct outreach to confirm active program availability and enrollment capacity.

Visit Ohio Palliative Care Provider Coverage Map via the link or QR code below for full size, updated, interactive map. If there are updates that need to be made to this map, please email info@leadingageohio.org.

Section 4: The Gold Standard – Community-Based Palliative Care Model

This section defines the preferred model of community-based palliative care for contracting purposes. It is grounded in the National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care, 4th Edition (2018) and the Center to Advance Palliative Care (CAPC) Recommendations for Program Standards. Health plans are encouraged to prioritize contracting with providers who can meet these standards.

Guiding Framework: NCP & CAPC Standards

The National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care – published by the National Coalition for Hospice and Palliative Care and widely endorsed by The Joint Commission and CAPC – define eight domains of quality palliative care:

NCP Domain	What It Means in Practice
1. Structure & Processes of Care	Interdisciplinary team, care plan, continuity, quality improvement
2. Physical Aspects of Care	Symptom assessment and management (pain, dyspnea, nausea, etc.)
3. Psychological & Psychiatric Aspects	Anxiety, depression, delirium – assessed and treated
4. Social Aspects of Care	Caregiver support, community resources, social determinants of health
5. Spiritual, Religious & Existential Aspects	Chaplaincy or spiritual care, values clarification
6. Cultural Aspects of Care	Culturally responsive care, language access
7. Care of the Patient Nearing End of Life	Advance care planning, hospice transition, bereavement
8. Ethical & Legal Aspects of Care	Advance directives, POLST, surrogate decision-making

High-quality palliative care programs are designed to address all eight domains of care described in the NCP Clinical Practice Guidelines, though the specific structure of community-based programs may vary depending on staffing and setting.

Critical Components of the Preferred Model

Health plans seeking to contract for the preferred (gold-standard) community palliative care model should look for programs that meet the following minimum structural and operational criteria:

Interdisciplinary Team (IDT)

The interdisciplinary team provides care focused on individual physical, functional, psychological, social, spiritual and cultural needs. IDT members may be certified palliative care specialists in their discipline and/ or have additional training in palliative care.

Per NCP Guideline 1.1, palliative care is provided by a team of clinicians. The gold-standard community palliative care program includes at minimum:

- A certified prescriber: Physician, nurse practitioner (NP), or physician assistant (PA) with palliative care training – serving as the primary clinical driver of the program
- Registered nurse (RN): For assessment, care coordination, and between-visit follow-up
- Social worker (LCSW or MSW): For psychosocial assessment, caregiver support, community resource navigation, and advance care planning support
- Chaplain or spiritual care professional: For spiritual and existential support, engaged based on patient/family preference

Minimum Discipline Requirement
The gold-standard model requires a minimum three disciplines actively engaged in care delivery. This is consistent with CAPC program standards recommending interdisciplinary teams that include at least three disciplines including one prescribing clinician. A prescriber-only or prescriber-plus-nurse model, while clinically valuable, does not constitute comprehensive interdisciplinary palliative care as defined by NCP guidelines.
Note on current Ohio landscape: Most Ohio palliative care programs are predominantly APP/NP-driven, with social work and chaplain services engaged on an as-needed basis rather than routinely. Approximately 20% of patients in typical Ohio community programs receive social work or chaplain services. While this reflects current capacity constraints, the gold standard expects intentional IDT integration, with the prescriber actively tagging other disciplines into the care plan based on patient needs.

24/7 Access

Gold-standard programs provide 24/7 access to a palliative care clinician – meaning members and families can reach a knowledgeable palliative care team member at any hour of the day or night. At minimum, this means:

- 24/7 telephone availability with a palliative-care-informed clinician (not just a general nurse hotline)
- Protocols for after-hours assessment and triage
- Clear escalation pathways that can prevent unnecessary emergency department visits

Note: Most current Ohio community programs provide 24/7 coverage via telephone triage. After-hours in-home visits by palliative care staff are not standard. Telehealth is increasingly used to supplement after-hours support, particularly in rural areas, and represents an acceptable component of the 24/7 access model. Health plans should confirm that 24/7 coverage pathways are palliative-care-specific rather than general on-call pools.

Acuity-Based Visit Scheduling

Gold-standard programs use acuity-based scheduling to match visit frequency and intensity to patient need. A strong model includes:

- Standardized intake and acuity assessment at enrollment
- Tiered visit frequency: high-acuity patients seen within 2 business days; moderate within 5 days; low within 7 days
- Between-visit telephone or telehealth follow-up by a nurse or care coordinator

- Reassessment of acuity at each visit to adjust the care plan
- Identified minimal call and/or visit frequency

Advance Care Planning (ACP)

All enrolled members should receive advance care planning support, including:

- Goals-of-care conversation within the first two visits
- Documentation of healthcare proxy/power of attorney
- Completion or update of POLST (Physician Orders for Life-Sustaining Treatment) when appropriate
- Hospice education and warm referral pathways when the patient is eligible and interested

Care Coordination and Transitions

Palliative care teams should ensure continuity of care across settings by actively coordinating with:

- Primary care and specialty physicians
- Home health agencies
- Skilled nursing facilities and long-term care
- Hospice providers for transition when appropriate
- Social services, community organizations, and behavioral health providers

Telehealth Capability

Telehealth is an accepted and encouraged component of community palliative care delivery, particularly for:

- Rural members where travel time creates access barriers
- After-hours support and between-visit check-ins
- Members with mobility limitations or complex living situations

Telehealth does not replace in-person visits for initial assessment and relationship-building but should be integrated as a routine care delivery option.

Hospice Integration and Transition Pathways

Gold-standard programs maintain clear, warm referral pathways to hospice. This includes:

- Ongoing prognostic awareness – the palliative care team regularly reassesses whether the patient's condition has evolved to meet hospice eligibility criteria
- Proactive hospice education – patients and families understand what hospice is, when it is appropriate, and how to access it – before a crisis makes the conversation harder
- Warm hand-off protocols – a direct introduction to a hospice team rather than a referral that leaves families to navigate the transition alone
- Care nearing end-of-life-- the palliative care team establishes processes and structures to ensure appropriate care at end-of-life to include but is not limited to recognition of anticipatory grief and post death bereavement support.

Discharge and Transition Criteria

Programs should define clear criteria for when members graduate from palliative care services, including:

- Transition to hospice – member meets eligibility criteria and has elected the hospice benefit
- Stabilization – member's condition has stabilized sufficiently that ongoing specialist palliative support is no longer needed; care can be maintained by primary care with periodic palliative consultation
- Member preference – member chooses to discontinue palliative care services
- Loss of eligibility – member no longer meets the program's serious illness criteria

Note on Program Tenure

Ohio providers report that some members remain enrolled in palliative care programs for extended periods without clear clinical indication for continued specialty-level support. Health plans should expect contracted providers to conduct regular eligibility reassessment – typically every 90 days – to ensure members are receiving the appropriate level of care, whether that means continued palliative support, transition to hospice, or step-down to primary care management.

Section 5: Measurement and Accountability

Accountability precedes payment. Before establishing a payment relationship, health plans should define the metrics by which they will evaluate palliative care program performance. These measures protect the health plan's investment, ensure members receive quality care, and create meaningful incentives for program improvement.

Why Measurement Comes First

A PMPM payment model (see Section 7) works best when tied to clear accountability expectations. Without measurement, health plans cannot distinguish between a program delivering comprehensive IDT care and one delivering only phone-based medication management. Defining measures upfront also signals to providers that the health plan is a serious partner invested in quality – not just cost reduction.

Recommended Core Quality Measures

LeadingAge Ohio recommends that palliative care contracts include, at minimum, the following quality measures reported on a quarterly basis:

Measure	Description / Target
Palliative Care Referral Response Time	Time from referral receipt to first patient/family contact. Target: ≤ 3 business days for standard referrals; ≤ 2 business days for high-acuity
Advance Care Planning Completion Rate	% of enrolled members with documented ACP conversation and/or POLST within 30 days of enrollment. Target: ≥ 80%
Symptom Screening Completion	% of enrolled members with validated symptom assessment at each visit. Target: 100%
Hospice Transition Rate	% of enrolled members who transition to hospice. Baseline comparison to plan's general serious-illness population – not a quality metric in isolation, but a marker of appropriate care progression
Hospice Length of Stay (LOS) at Transition	Median LOS on Hospice for members who transition to hospice from palliative care. Programs with longer LOS on hospice after transition from palliative services indicate better preparation and earlier conversations. Target: median hospice LOS > 30 days
Emergency Department Utilization	All-cause ED visits per 1,000 member months for enrolled palliative care population vs. comparable non-enrolled population. Target: statistically meaningful reduction
Hospital Admissions	Hospital admissions per 1,000 member months for enrolled population. Target: reduction vs. baseline or comparable control group
Member/Family Satisfaction	Validated survey measure (e.g., FAMCARE or CAHPS equivalent). Target: ≥ 85% satisfied or very satisfied
30-Day Re-Enrollment Rate (if applicable)	If members disenroll, % re-enrolling within 30 days – a proxy for perceived value

Measurement and Incentive Structures

Health plans may structure palliative care contracts to incorporate performance incentives, including:

- Quality withholds: A percentage of PMPM held back and returned upon achievement of defined quality thresholds
- Shared savings arrangements: A portion of documented cost savings (vs. baseline or matched control) returned to the provider
- Reporting incentives: A per-member bonus for timely and complete quality reporting
- Patient engagement bonuses: Additional payment for achieving advance care planning completion above a threshold

The simplest approach – and the one most appropriate for emerging contracts – is a quality withhold with clear, achievable targets tied to the core measures above. As the relationship matures and data quality improves, health plans and providers can explore shared savings models.

Data Reporting Requirements

Contracts should specify minimum data reporting requirements, including:

- Quarterly reporting on all contracted quality measures
- Annual program description update (staffing model, service delivery changes, patient population served)
- Immediate notification of significant program changes (loss of key staff, change in coverage area, operational disruptions)
- Member-level data sharing agreement to allow health plan to conduct independent utilization analysis

Section 6: Safety-Net Access – When the Gold Standard Isn't Available

The preferred model described in Section 2 represents what health plans should seek in contracting. However, Ohio's palliative care infrastructure is still developing – particularly in rural and frontier counties. This section addresses what health plans and members can and should do when a preferred-standard provider is not available in a member's county.

The Safety-Net Principle

The safety-net framework is not a lower tier of palliative care. It is a geographic and access exception – a bridge to ensure members with serious illness have some level of specialized support while the health plan and provider community work to develop preferred-standard access in that area.

Critical Framing

The safety-net designation applies to access gaps, not to provider preference. Health plans should:

1. Prioritize contracting with preferred-standard (gold standard) providers wherever they exist
2. Use safety-net arrangements only when no preferred-standard provider serves a member's county
3. Actively work to develop preferred-standard access in safety-net counties over time
4. NOT use the safety-net framework to contract with lower-capacity providers in areas where preferred-standard providers exist

What Triggers Safety-Net Access

A safety-net arrangement is appropriate when:

- No preferred-standard palliative care provider (meeting the criteria in Section 2) operates in the member's county of residence
- Available providers in the area cannot meet minimum IDT requirements, 24/7 telephone access, or acuity-based scheduling
- The health plan has determined through outreach that no preferred-standard provider has available capacity for new members in that county

What Safety-Net Arrangements May Look Like

In areas without preferred-standard access, health plans may consider the following bridge arrangements:

Option A: Expanded Health System Partnership

Health systems with hospital-based palliative care teams may be contracted to extend outpatient follow-up services for members in adjacent rural counties. This may look like:

- Clinic-based palliative care visits at a satellite location
- Telehealth palliative care consultations supported by the health system's IDT
- Coordination with the patient's primary care provider for symptom management between visits

Option B: Infrastructure Leverage Model

Larger palliative care organizations – such as OHI or Reserve Care – may contract with health plans to serve broad geographic territories and then subcontract with smaller local providers to deliver hands-on care. In this model:

- The primary contract holder provides clinical oversight, care coordination, and quality infrastructure
- Local providers (home health agencies, smaller hospices) serve as the field-based team
- This approach allows a single contract to cover counties the primary organization cannot directly serve

Option C: Enhanced Primary Care with Palliative Consultation

In areas where no structured palliative care program exists, health plans may arrange for:

- A palliative care specialist available for telephone consultation with the member's primary care provider
- CAPC training and support for primary care providers to integrate primary palliative care skills
- Goals-of-care facilitation through the health plan's care management team, supported by palliative care consultation

Note on Naming

When arrangements do not meet the full standards of community-based palliative care as defined in this playbook, health plans and providers should consider using the term 'complex care management' or 'serious illness care coordination' or ‘supportive care’ rather than 'palliative care.' This distinction protects the integrity of the palliative care brand and ensures members understand the level of support they are receiving.

Telehealth as a Rural Bridge

Telehealth is particularly valuable in safety-net contexts. Key considerations for rural and frontier settings:

- Telehealth can extend the reach of urban-based palliative care teams into underserved counties
- Phone and video-based assessments can substitute for some in-person visits, reducing provider travel burden
- Telehealth cannot fully replace the hands-on clinical assessment needed for complex symptom management – in-person visits should be maintained at key junctures (enrollment, significant clinical change, transition planning)
- Health plans should confirm that contracted telehealth palliative care includes clinical team access, not just telephonic care coordination

Section 7: Payment Models

This section outlines the recommended payment structure for community-based palliative care contracts in Ohio. The goal is to incentivize health plans to contract with the highest-quality providers available while providing a sustainable financial framework for those providers to deliver comprehensive care.

The Recommended Model: Per Member Per Month (PMPM)

LeadingAge Ohio recommends that health plans contract for community-based palliative care using a per member per month (PMPM) payment model. A PMPM structure:

- Provides predictable revenue for providers – enabling sustained investment in IDT staffing and program infrastructure
- Aligns payment with population management – encouraging proactive engagement rather than reactive visit-by-visit care
- Decouples payment from fee-for-service coding complexity – eliminating barriers created by the inability to bill for chaplain visits, care coordination, and team consultation
- Creates a single, clear contract metric for health plans to evaluate provider performance against cost

Incentive Design Principle

The PMPM should be set at a single standard rate, not tiered by service level. This design intentionally incentivizes health plans to seek out and contract with providers offering the most comprehensive care – because the payment is the same regardless of whether the provider offers a full IDT or a prescriber-only model. Plans get more for their money when they contract with gold-standard providers.

PMPM Rate Guidance

Specific PMPM rates are negotiated between health plans and individual providers based on local market conditions, program scope, geographic coverage, and member acuity. LeadingAge Ohio does not set rates. However, the following data points from comparable markets provide useful context:

Reference	Payment Context
California Medi-Cal MCOs (CHCF/Compassionate Care Coalition survey)	Uniform PMPM payments most common; specific amounts negotiated by plan; some plans add reporting or patient engagement incentives on top of base PMPM
NASHP Actuarial Analysis (2022)	Palliative care benefit estimated cost-neutral to cost-saving at the program level for Medicaid; savings of $392– $1,289 PMPM for the 6-month pre-hospice window for Medicaid-only members
Ohio in-home vs. clinic-based programs	In-home delivery is materially more costly than clinic-based care – providers report travel time of 30– 45 minutes per visit in rural areas as a primary cost driver

Reference	Payment Context
Rural add-on consideration	Providers serving rural members with in-home delivery may warrant an enhanced PMPM or a rural/travel add-on to reflect lower productivity and higher per-visit cost

Program Vignettes

The following anonymized vignettes illustrate how Ohio palliative care programs are currently structured and financed. They are intended to give health plans a realistic picture of the range of models operating in Ohio today – not to set market rates.

Vignette A: In-Home, NP-Driven Program (Mid-Size Organization)

A mid-size hospice-affiliated palliative care program operates exclusively in-home across a multi-county service area. The program is driven almost entirely by nurse practitioners (approximately 98% NP-delivered care), with physician medical director oversight. Social work and chaplain services are available but engaged selectively – approximately 20% of patients receive social work or chaplain support, triggered by specific clinical needs identified by the NP. The program uses an acuity-based scheduling model: high-acuity patients are seen within 2 business days of enrollment; moderate within 5 days; low within 7 days. After the initial NP assessment, an LPN handles scheduling and routine between-visit contact. 24/7 access is provided through the affiliated hospice's on-call line – telephone triage only, not in-home palliative visits after hours. Current census: approximately 65 patients. Program is financed through a PMPM arrangement with a Medicaid managed care plan. In-home delivery creates significant cost pressure, particularly with rural travel time of 30-45 minutes per visit.

Vignette B: Health System-Affiliated, Multi-Site Program (Larger Organization)

A larger health-system-affiliated palliative care program serves a broader census (approximately 66 patients per quarter) with referrals coming primarily from physician offices and cancer centers. The care model includes an NP as the primary clinician, with a nurse providing follow-up phone calls between visits. Visit frequency averages every 8-12 weeks, with acuity driving frequency adjustments. The program participates in an ACO and reports three quality measures: percentage of members transitioning to hospice, referral source tracking, and palliative referral response time. Approximately 8 of 66 members per quarter transition to hospice. Contracting is handled through a third-party credentialing and contracting entity. The program operates within an integrated health system with access to specialist consultation, inpatient palliative care team backup, and care coordination infrastructure.

These vignettes illustrate just a small fraction of the diversity of current Ohio models. Health plans should not assume all programs claiming to offer "palliative care" provide the same level or scope of services. Due diligence – including reviewing staffing models, IDT composition, 24/7 coverage pathways, and quality reporting capability – is essential before contracting.

Payment Add-Ons to Consider

In addition to a base PMPM, health plans may consider the following supplemental payment structures:

Add-On Type	Rationale and Design
Rural / In-Home Travel Add-On	Compensates for lower productivity and higher per-visit cost in rural settings. Could be structured as: (a) a flat per-member-per-month increment for members in rural counties, or (b) a per-visit mileage supplement above a defined threshold

Add-On Type	Rationale and Design
High-Acuity Enrollment Supplement	A one-time payment per new member enrollment to cover the time-intensive intake, assessment, and care planning activities at the start of a palliative care relationship
Quality Performance Bonus	A per-member per-quarter payment tied to achievement of contracted quality metrics (see Section 7)
Reporting Compliance Incentive	A flat quarterly payment contingent on timely and complete quality data submission

What This Playbook Does Not Recommend

This playbook intentionally does not recommend fee-for-service payment structures for palliative care. Fee-for-service billing for palliative care services creates several problems:

- It disadvantages non-billable IDT members (chaplains, care coordinators) who provide significant value but cannot generate billable charges
- It incentivizes volume – more visits – rather than value – better outcomes with appropriate resource utilization
- It creates billing complexity for palliative care teams, diverting clinical capacity to coding and documentation
- It does not support the population management approach that makes palliative care cost-effective for health plans

Health plans should structure contracts to move away from fee-for-service and toward PMPM arrangements – even if incrementally. A hybrid model (reduced PMPM plus FFS for specific services) may be appropriate as a transitional arrangement for providers not yet fully prepared for capitated payment.

Section 8: Rural Considerations

Rural and frontier Ohio counties present unique challenges for community-based palliative care delivery. Access gaps, workforce shortages, travel costs, and limited local provider infrastructure require both adapted care models and adapted payment structures.

Understanding the Rural Challenge

Rural palliative care delivery is materially different from urban or suburban delivery:

- Travel time: In-home visits in rural counties can require 30– 45 minutes of drive time each direction – consuming NP productivity with non-clinical time
- Lower patient density: Fewer patients per geographic area means higher per-member cost for the same quality program
- Workforce shortages: Rural areas have fewer qualified APPs, social workers, and chaplains with palliative care experience
- Limited program infrastructure: Fewer hospice-affiliated or health-system-affiliated organizations with existing palliative care infrastructure in rural counties
- Specialized program gaps: Pediatric palliative care, for example, is largely absent from rural Ohio – those programs tend to be concentrated in urban health systems

Payment Adjustments for Rural Access

Health plans contracting for palliative care in rural areas should consider the following payment adjustments to ensure programs are financially sustainable:

- Enhanced PMPM for rural members: A standard rural differential – similar to what Medicaid uses in other program areas – to offset higher per-visit cost
- Travel/mileage supplement: A per-mile or per-visit travel allowance for in-home visits beyond a defined distance threshold (e.g., 25 or 30 miles round trip)
- Telehealth substitution credit: Recognizing telehealth visits as equivalent to in-person visits for payment purposes reduces the cost pressure on rural providers

Health plans should also recognize that requiring full in-person visit frequencies in rural areas may simply not be financially viable for providers without payment adjustment. Programs serving rural members will necessarily rely more heavily on telehealth, telephone follow-up, and extended visit intervals – and contracts should be designed to accommodate this reality.

Contracting Strategies for Rural Access

When standard palliative care providers do not operate in a member's rural county, health plans can consider the following contracting strategies:

Leverage Urban Provider Infrastructure

Larger palliative care organizations in Ohio's urban centers are increasingly willing to contract for rural coverage by subcontracting with local providers. This model – where a large organization provides quality oversight, care coordination, and clinical backup while local "hands and feet" deliver in-home care – can extend access significantly. Health plans should structure contracts to accommodate and incentivize this approach.

Expand Telehealth Palliative Care

Telehealth palliative care – delivered by a qualified NP or physician via video – can dramatically extend reach into rural counties. Health plans should:

- Accept telehealth visits as meeting program standards for routine follow-up care
- Require in-person visits for initial assessment and at key care transitions
- Ensure contracted telehealth programs include IDT access (not just solo NP video visits)

Partner with Existing Rural Infrastructure

Home health agencies, hospices, and rural health clinics already operating in underserved counties can serve as delivery partners for palliative care programs based in larger markets. Health plans can facilitate these partnerships by:

- Including subcontracting provisions in primary palliative care contracts
- Requiring primary contractors to demonstrate rural outreach plans
- Connecting prospective rural delivery partners with established palliative care programs for clinical support and training

Section 9: Service Area and Contracting Guidance

Understanding the Ohio Palliative Care Landscape

Before contracting, health plans should conduct a service area assessment to understand where palliative care capacity exists and where gaps remain. The provider coverage map (referenced in Section 1) provides a baseline view of current member-organization coverage. However, coverage on a map does not equal active program capacity – health plans should directly confirm:

- Active program status (is the program currently accepting new patients?)
- Enrollment capacity (how many new members can the program accept per month?)
- Delivery model (in-home, clinic-based, telehealth, or hybrid?)
- IDT composition (who is on the team and in what roles?)
- Geographic service boundaries within the county
- Existing payer relationships and PMPM experience

Sample Contracting Checklist for Health Plans

When evaluating a palliative care provider for contract, health plans should assess the following:

Contracting Element	What to Ask / Verify
Program Accreditation or Certification	Is the program accredited by The Joint Commission or ACHC for community-based palliative care? Does it align with NCP guidelines?
IDT Composition	Who are the team members? What are their palliative care credentials? Is a prescriber (NP, PA, or physician) directing the clinical program?
24/7 Access	How is 24/7 coverage provided? Who answers after-hours calls? Is there a direct palliative care line or a general on-call pool?
Geographic Coverage	Which specific counties does the program serve? What is the average distance to members' homes?
Quality Reporting Capability	Can the provider report the measures identified in Section 3? What data systems are in use?
Telehealth Infrastructure	Is telehealth available? What percentage of visits are conducted via telehealth? What platform is used?
Rural Delivery Experience	Does the provider have experience serving rural members? What adaptations have been made?
Hospice Transition Pathways	Does the provider have a formal hospice transition protocol? Does it include warm hand-offs?
Sample Contract / Prior Agreements	Can the provider share a de-identified example of a prior PMPM contract for reference?
Financial Sustainability	Is the program financially viable at the proposed PMPM? What is the current payer mix?

Sample Contract Framework Elements

A palliative care contract between a health plan and a community-based provider should include, at minimum, the following elements. (Note: Full contract language should be developed with legal counsel. This is a framework, not model contract language.)

- **Program description:** Definition of covered services, eligible member criteria, and excluded services
- **Eligible member definition:** Diagnosis criteria, functional status thresholds, or utilization-based triggers
- **Payment structure:** PMPM rate, effective date, rate adjustment schedule, and any add-on payments
- **Quality requirements:** Required measures, reporting frequency, and performance standards
- **Data sharing:** HIPAA-compliant data exchange requirements for quality reporting and utilization analysis
- **Access standards:** Response time, visit frequency minimums, 24/7 coverage requirements
- **Provider qualifications:** Required credentials, training, and certification for team members
- **Termination provisions:** Notice requirements, transition of care responsibilities, member notification
- **Geographic scope:** Service area definition, county-level coverage commitments

CSNO, CareSource, and OASN may have de-identified sample palliative care contracts available for reference. Health plans and providers are encouraged to reach out to these organizations directly.

Section 10: Future Directions

The field of community-based palliative care is evolving rapidly. This section highlights emerging models and innovations that represent the next horizon for Ohio health plans and providers – areas worth watching and potentially piloting as the infrastructure matures.

Direct Admission from Palliative Care to Post-Acute Settings

One of the most promising future directions is a structured pathway allowing palliative care teams to directly admit members to skilled nursing facilities or inpatient hospice – bypassing the emergency department. Currently, most acute care transitions for seriously ill patients flow through the ED. A palliative care team with direct admission authority could:

- Prevent unnecessary hospitalizations by facilitating timely transitions to the appropriate level of care
- Reduce the trauma of ED visits for members with complex symptom needs
- Lower total cost of care through avoided inpatient admissions

This model requires collaborative agreements between palliative care programs, SNFs, and hospital systems – but it is achievable and worth pursuing as a contractual innovation.

Broader Integration of Dual-Eligible Populations

Many seriously ill Ohioans are dually eligible for Medicare and Medicaid. Coordinated palliative care arrangements that span both payers – potentially through Dual Special Needs Plans (D-SNPs) – represent a significant opportunity to reduce fragmentation and total cost of care. California's 2024 guidance binding D-SNPs to the same palliative care standards as Medi-Cal MCOs provides a useful model.

PMPM Plus Outcomes-Linked Escalation

As measurement infrastructure matures, health plans and providers may be well-positioned to move toward payment models that escalate PMPM payments based on demonstrated outcomes – with a floor for minimum program operation and upside sharing tied to measurable improvements in quality and cost. This represents the natural evolution of the measurement-first framework described in Section 5.

Pediatric Palliative Care

Pediatric community palliative care is an area of significant unmet need in Ohio. This playbook has not addressed pediatric considerations in depth, as the care models, eligibility criteria, and provider landscape differ substantially from adult palliative care. LeadingAge Ohio anticipates developing a supplemental addendum on pediatric palliative care as provider and health plan capacity in this area develops.

Ohio Palliative Care Policy Developments

Ohio has not yet established a comprehensive Medicaid community palliative care benefit – placing it among the majority of states still developing this infrastructure. As of early 2025, only five states (California, Colorado, Hawaii, Maine, and Oregon) include community-based palliative care as a covered Medicaid benefit, with seven additional states actively developing such benefits.

LeadingAge Ohio will continue to monitor state and federal policy developments and update this playbook accordingly. Health plans with interest in advocating for a formal Ohio Medicaid palliative care benefit are encouraged to engage with the Palliative Care Workgroup.

Appendix: Resources and References

Key National Organizations and Resources

Organization / Resource	Relevance
Center to Advance Palliative Care (CAPC) – capc.org	Program standards, clinician training, payment resources, data tools
National Coalition for Hospice and Palliative Care – nationalcoalitionhpc.org	Publisher of NCP Clinical Practice Guidelines, 4th Edition (2018)
National Academy for State Health Policy (NASHP) – nashp.org	State Medicaid palliative care policy, payment models, actuarial data
Hospice and Palliative Care Association of Ohio – hpcao.org	Ohio-specific provider network, advocacy, education
Care Solutions Network of Ohio (CSNO)	Ohio member organization network; service area coverage data
OASN (Ohio Association of Senior Network)	Potential source for sample contracts and palliative care agreements

Key Citations

- National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018.
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- NASHP. Paying for Palliative Care. October 2023.
- PMC. Effects of a Population Health Community-Based Palliative Care Program on Cost and Utilization. Mount Carmel/Medigold, Columbus, OH. 2019.
- PMC. Home Palliative Care Savings. 2022.
- Hospice News. Covering the Costs of Palliative Care Via Medicaid. May 2025.
- Oregon Health Authority. Payment for Community-Based Palliative Care in Oregon: Environmental Scan. March 2024.

Glossary

Term	Definition
PMPM	Per Member Per Month – a fixed monthly payment per enrolled patient, regardless of number of visits or services delivered
IDT	Interdisciplinary Team – the multi-disciplinary clinical team delivering palliative care, including prescribers, nurses, social workers, and chaplains

Term	Definition
NCP Guidelines	National Consensus Project Clinical Practice Guidelines for Quality Palliative Care – the nationally recognized standard for palliative care quality, 4th edition (2018)
CAPC	Center to Advance Palliative Care – a national organization providing training, tools, and resources for palliative care programs
ACP	Advance Care Planning – the process of documenting a patient's wishes for future care, including healthcare proxy designation and POLST completion
POLST	Physician Orders for Life-Sustaining Treatment – a medical order documenting patient preferences for life-sustaining treatment, valid across care settings in Ohio
CSNO	Care Solutions Network of Ohio – an Ohio network of hospice and palliative care member organizations
APP	Advanced Practice Provider – nurse practitioners (NPs) and physician assistants (PAs) serving as primary clinicians in palliative care programs
Safety-Net Access	As used in this playbook: a geographic/access exception framework for areas where preferred-standard palliative care is not available
D-SNP	Dual Eligible Special Needs Plan – a Medicare Advantage plan designed to serve members who are eligible for both Medicare and Medicaid

Appendix A: CAPC / NCP Standards Crosswalk

Community-based palliative care programs across Ohio operate in a variety of settings and organizational structures. The table below demonstrates how the recommendations in this playbook align with nationally recognized standards, while reflecting operational realities reported by Ohio providers. It is intended to help health plans and providers identify where Ohio programs currently stand and where development is needed.

CAPC / NCP Standard	Playbook Application (Preferred Model)	Ohio Operational Reality	Implications for Health Plans
Interdisciplinary Team Structure	Preferred model includes an IDT with at least three disciplines, including one prescribing clinician	Many Ohio programs are APP-led, with physicians providing oversight and additional disciplines involved as needed	Health plans should prioritize contracting with programs that build interdisciplinary support while recognizing that many programs are currently APP-driven
Access to a Prescribing Clinician	Patients should have 24/7 access to a prescribing clinician with access to the medical record	Most programs provide after-hours clinical access through phone triage, often leveraging hospice on-call infrastructure	Plans should ensure contracted providers maintain reliable after-hours clinician access for patients
Comprehensive Assessment	Programs should perform comprehensive	Providers report structured intake processes and acuity-	Plans may include referral response time expectations in

CAPC / NCP Standard	Playbook Application (Preferred Model)	Ohio Operational Reality	Implications for Health Plans
	assessments addressing symptoms, functional status, cognitive status, caregiver burden, and social needs	based triage, typically scheduling initial visits within 2– 7 days	contracts to support timely access
Symptom Management	Programs should provide pharmacologic and non-pharmacologic symptom management across serious illness conditions	Symptom management is the core function of most Ohio palliative programs, typically delivered by APPs	Plans should ensure contracted providers have appropriate clinical expertise for complex symptom management
Goals-of-Care and Advance Care Planning	Programs should facilitate ongoing discussions about goals of care, prognosis, and treatment preferences	Providers report that goals-of-care conversations are a major component of every visit	Plans should recognize advance care planning as a key value driver for palliative care – and include ACP completion as a contracted quality metric
Psychosocial and Spiritual Support	Programs should ensure access to social work and spiritual care services when needed	Many programs use consult-based social work or chaplain support rather than routine interdisciplinary visits; approximately 20% of patients receive these services	Plans should allow flexibility in how interdisciplinary services are delivered while ensuring patient access when clinical need is identified
Care Coordination Across Settings	Programs should coordinate care with hospitals, specialists, primary care providers, and hospice programs	Coordination commonly occurs with oncology practices, primary care, and hospice providers	Plans should support palliative care programs that improve care coordination across the healthcare system
Crisis Planning and Symptom Escalation	Programs should establish clear plans for addressing urgent symptom escalation or caregiver crises	Many programs rely on clinical triage protocols and escalation pathways through affiliated hospice on-call lines	Plans should expect programs to maintain clear, palliative-care-specific pathways for urgent clinical needs – not just general nurse hotlines
Hospice Transitions	Programs should support timely referral and warm transition to hospice when appropriate	Providers report tracking hospice transition rates as a quality metric; some note that patients occasionally remain on palliative services longer than clinically appropriate	Plans should view palliative care as an important pathway to appropriate hospice utilization and build hospice transition rate and LOS into quality contracts
Patient and Caregiver Education	Programs should educate patients and caregivers about disease progression, symptom management, and care options	Education commonly occurs during home visits and follow-up phone calls	Plans should recognize caregiver education as a core component of palliative care value – not an optional add-on

CAPC / NCP Standard	Playbook Application (Preferred Model)	Ohio Operational Reality	Implications for Health Plans
Program Evaluation and Quality Measurement	Programs should evaluate performance using clinical outcomes and patient experience measures	Providers report tracking metrics such as referral response time, hospice transitions, and referral sources; data systems vary in sophistication	Plans should consider incorporating quality metrics into palliative care contracts and building toward shared data infrastructure over time
Discharge and Transition Criteria	Programs should define when patients are stable, no longer appropriate for palliative care, or ready for hospice transition	Some Ohio providers noted that patients may remain on palliative services longer than clinically appropriate without clear reassessment triggers	Plans may support clearer transition guidelines and periodic eligibility reassessment requirements to ensure appropriate care progression

LeadingAge Ohio Palliative Care Playbook

This is a living document. Sections will be updated as Ohio's palliative care landscape evolves, new research emerges, and stakeholder feedback is incorporated.
For questions or feedback, contact the LeadingAge Ohio.

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