Technical Brief: Financing Specialist, Team-Based Palliative Care with Equity Embedded

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Executive Summary

Specialist, team-based palliative care—as defined by the National Quality Forum (NQF) and the National Consensus Project (NCP)—improves patient experience, reduces avoidable utilization, and supports families across the trajectory of serious illness. Yet the United States lacks a coherent **payment architecture** that funds the **full interdisciplinary team** and ties dollars to outcomes and equity. Over the past decade, the field pursued broad messaging ("everyone with serious illness needs specialist palliative care") while **under-investing in financing mechanics**. High-profile policy experiments (e.g., Medicare Advantage hospice carve-in) were terminated, and promising proposals (e.g., AAHPM's PACSSI) were never scaled nationally, leaving programs dependent on fee-for-service billing and philanthropy. This brief proposes a practical, testable payment model—the **Serious Illness Care Management Benefit (SICMB)**—paired with a **Serious Illness Team Standard (SITS)** certification, a **parsimonious core measure set** with **equity action triggers**, and governance that centers impacted communities. While the scope of this brief is on payment architecture, we certainly can't ignore the huge workforce shortage facing the field.

Key recommendations:

- Establish **SITS certification** (clinical + cultural/structural competence) as the gateway to enhanced payment and to build the pathway to training interprofessional specislists
- Implement a **risk-adjusted PMPM** SICMB for certified teams; **allow concurrent hospice** and **standardize eligibility triggers**
- Tie dollars to a **Core Set** of patient-reported and utilization measures with **equity disaggregation** and **corrective action thresholds**
- Fund **equity-forward adjustments** (bonus PMPMs, redistributive pools) to reach high-SDI/low-resource geographies and close subgroup gaps
- Embed **environmental metrics** linking avoided high-emission encounters to decarbonization targets

Background and Problem Statement: The Model We Claim vs. The Money We Provide

NQF's framework and NCP's 4th edition define quality palliative care as **interdisciplinary, person- and family-centered**, delivered across settings with eight domains (structure/processes; physical; psychological; social; spiritual; cultural; care of the imminently dying; ethical/legal). Hospital availability has grown: 83.6% of hospitals with 50+ beds report specialist palliative services; however, **for-profit** and **rural** hospitals lag

(49.0% and 34.5. Staffing breadth and depth remain uneven; many programs do not include all core disciplines, reflecting **payment misalignment** rather than only operational deficits.

Workforce and Access Constraints

In addition to being smaller than we need and shrinking faster than we can replace, the specialist workforce is **maldistributed**. In 2022, 8,935 board-certified HPM physicians and NPs were active; >90% practice in metropolitan areas, with fewer clinicians in high-deprivation regions. Broader physician shortages through 2037, particularly in **nonmetro** areas, compound access.

Policy Instability and the Payment Vacuum

CMS's **Medicare Advantage hospice carve-in** (VBID) ended December 31, 2024, after declining participation and **low utilization** of palliative/transitional services, highlighting the consequences of unclear benefit design and weak funding flows. AAHPM's **PACSSI** proposal earned PTAC recommendation for limited testing in 2018 but was never implemented. CMS's 2026 **TEAM** model coordinates post-surgical episodes, not palliative benefits, leaving serious-illness care unfunded as a team-based service.

Conclusion: Absent a national, team-based serious-illness benefit with equity requirements, programs rely on fee-for-service billing (E/M, ACP, PCM) and patchwork contracts, underfunding nonbilling roles (pharmacist, nursing, social work, chaplaincy) central to NQF/NCP fidelity.

Objectives

1. **Finance** the NQF/NCP interdisciplinary model via a **risk-adjusted PMPM benefit** that explicitly funds the **whole team**.
2. **Measure** outcomes that matter to patients and families, with equity disaggregation and enforcement.
3. **Ensure** geographic and socioeconomic equity through payment adjustments and transparent reporting.
4. **Integrate** environmental metrics to capture co-benefits of avoided high-emission utilization.

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The Proposed Model

1) **Serious Illness Team Standard (SITS) — Certification as the Payment Gateway**
   Definition: Programs seeking enhanced payment must meet **SITS**, which combines the NQF/NCP clinical blueprint with **cultural and structural competence** requirements.
   - **Clinical standard:** Minimum FTEs across **APP, nursing, pharmacist, physician, spiritual care, and social work**; continuity across settings; after-hours access; caregiver support; social needs navigation aligned to the eight quality domains.
   - **Equity standard:** Documented language access, culturally respectful spiritual care, community partnerships with organizations serving marginalized populations, and (minimally) annual staff training in antiracism. Use tiered certification (provisional/full) with development pathways for smaller or rural programs.
   - **Incentive:** Only SITS-certified programs qualify for **SICMB** PMPM payments; non-certified teams remain in fee-for-service for professional services.
   - **Bonus**: Since we can't hire folks for a team that doesn't exist, we need conditional PMPM bonuses tied to training partnership agreements to build the path toward a skilled, specialist, interprofessional workforce.
   - **What I'm glossing over**: Who should certify and how. I envision a federated certification model likely housed under a new SITS Council within the NCP with surveys outsources to TJC (adding a new SITS component to their specialty palliative care certification) and ACHC or CHAP for community programs (with a similar SITS addendum), but obviously this is a big, multistakeholder question.

2) **Serious Illness Care Management Benefit (SICMB) — Risk-Adjusted PMPM**

   Scope: A **national benefit** initially for Medicare Advantage, ACO REACH, and state Medicaid, designed to finance team-based serious illness care and reduce avoidable acute utilization.

   - **Payment: Risk-adjusted PMPM** tiers based on clinical severity, functional status, caregiver complexity, and social risk (e.g., SDI). PMPM explicitly funds **nurse, pharmacist, spiritual care, and social work** time and infrastructure.
   - **Concurrent hospice:** Allowed by default, with standardized transitions and technical assistance to avoid VBID's low uptake problem which was partially a problem of definitional and benefit-design failure but also an operational

problem of claims processing, network contracting, data sharing between MA plans and hospices. Claims routing, attribution handoffs, shared care plan standards (FHIR-based), and network adequacy requirements for MAOs and ACOs contracting with hospices will all need to be detailed. (More details in Appendix F)

- **Eligibility triggers:** Common rules (diagnosis + utilization + functional decline) to **prevent cherry-picking** and ensure uniform identification; publish plan- and provider-level uptake.
- **Care-in-the-home:** Required proactive home visits/telehealth cadence; caregiver training and respite support; after-hours coverage to arrest avoidable ED/hospital use.
- **Development Pathway**: to be clear, our problem here is much deeper because we don't even know how to adjust for risk in such a payment model. We need researchers to use existing datasets (CAPC Registry, state Medicaid claims, ACO REACH attribution files) and work with institutional partners (ASPE, RAND EPC, actuarial firms) to build a methodology. Until then, early phases of SICMG implementation will likely require simplified two- or three-tier structures pending validation.

3) **Scope Detail**: **Why limit the initial rollout to MA, ACO REACH, and state Medicaid?**

These segments have the strongest, near-term levers for value and equity.

- **MA now enrolls a majority of Medicare beneficiaries**—54% in 2025—so contracting and benefit design changes in MA immediately touch a large senior population and can be implemented through plan contracts and model participation, not new statute.
- **ACO REACH** explicitly centers equity in original Medicare, with built-in compliance, quality withholds, risk caps, and PY2026 updates that strengthen sustainability and beneficiary protections. It's the fastest "pathway" to embed serious-illness benefits for FFS populations via an existing model.
- **State Medicaid** already funds community-based palliative care in multiple states via managed care, state plan options, or waivers, and is adding equity-oriented benefit design (e.g., CA SB1004 and D-SNP integration). Medicaid beneficiaries carry disproportionate social risk, so equity-tied payment yields the largest marginal gains.

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CMS infrastructure and momentum support a rapid start.

- CMS continues to evolve the APM portfolio (e.g., ACO REACH updates, TEAM) and is actively promoting **multi-payer alignment** tooling and concepts—making MA + Medicare + Medicaid alignment technically and operationally feasible.
- MA's scale and operational concentration (United + Humana ≈ 46% of MA lives) allows faster diffusion of standardized serious-illness benefits through a smaller number of national platforms.

Equity and accountability can be embedded in contracts immediately.

- REACH increases the quality withhold and adjusts risk methodologies in 2026; these mechanics can tie dollars to your Core Set and Equity Action Threshold without new law.
- Medicaid managed care contracts routinely include equity conditions; states are expanding palliative benefits and can adopt your certification (SITS) plus PMPMs quickly.

Why not "all payors" on day one?

- **Legal/friction: ERISA preemption limits states' ability to mandate uniform benefits in self-insured employer plans.** ERISA broadly preempts state laws that "relate to" employee benefit plans; while some state insurance mandates reach fully insured products, **self-funded ERISA plans** are shielded, creating non-uniform adoption unless employers opt in.
- **Commercial heterogeneity and readiness.**
    - Commercial value-based payment is growing, but still mixed: **39.2%** of payments in commercial lines flowed through VBC in 2023; adoption of downside risk is increasing, yet operational barriers remain.
    - Execution—not concept—is the bottleneck; many systems lack the data and alignment to take risk quickly, particularly for specialty team-based care.
- **Avoid model churn.** CMS has recently **terminated or restructured** several models to save costs; limiting the first phase to segments with established program rules reduces policy risk while you validate outcomes and cost offsets.

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The Path to all payors

If your strategic goal is national normalization, the path is **phased all-payer alignment**, not an immediate mandate.

- **Use AHEAD to drive multi-payer alignment at the state level (on cost and quality).** The **AHEAD** all-payer, total-cost-of-care model gives states tools to align MA, Medicaid, and **commercial plans** around common payment and equity standards, including cost-growth caps, primary care investment targets, and hospital global budgets. Your serious-illness PMPM can be added as a state alignment "module."
- **Publish an "All-Payer Alignment Specification."** CMS already articulates multi-payer alignment goals; mirror that playbook with a short spec (measures, withholds, SITS certification, attribution rules) that commercial payers can adopt voluntarily to reduce provider burden.
- **Anchor with national adoption signals.** Reference HCPLAN's APM adoption gains (all lines: **45.2%** VBC; MA: **64.3%**) to show momentum and offer a shared measurement pack (PROMs + hospice timeliness). This helps plans slot SICMB into their existing VBC portfolios.
- **Limit early complexity: hybrid payments, parsimonious measures.** NASEM and Health Affairs scholars recommend hybrid models, parsimonious outcomes, and utilization-based accountability. Framing SICMB as a **hybrid add-on** for specialty serious-illness care will reduce commercial friction.
- **ERISA navigation: voluntary employer uptake via stop-loss and network strategies.** Offer self-insured employers a standard rider through their ASO carriers; avoid state mandates that trigger preemption fights. Emphasize avoided acute utilization and caregiver benefits as ROI drivers. [mercer.com], [ebri.org]

Bottom line

Start where the **policy levers** and **population impact** are strongest—**MA, ACO REACH, and state Medicaid**—and grow via **multi-payer alignment** (AHEAD, HCPLAN) into commercial markets as readiness improves. This approach balances speed, equity, and legal pragmatism, while positioning your serious-illness PMPM to become the **de facto all-payer standard** over time.

4) **Core Measure Set — Dollars Follow Outcomes and Equity**

- **Parsimonious measures with teeth:**
  - **Feeling Heard & Understood** (patient-reported).
  - **Getting Help Wanted for Pain** (patient-reported).
  - **Hospice ≥3 days before death** (timeliness/utilization).
- Report by **race/ethnicity**, **preferred language**, **rural/urban**, and **SDI quintile**.
- **Equity Action Threshold:** If subgroup gaps exceed **15%** on PROMs or timeliness, **withhold a portion** of PMPM until corrective action demonstrates improvement; publicly report performance via a **Serious Illness Scorecard** extension.
- **What I'm glossing over**: The collapse of PCQC is an embarrassing debacle, quality improvement in Palliative Care and ambitious proposals like this one are caught in the wake.

5) **Equity-Forward Payment Adjustments**

- **Bonus PMPMs** for panels with higher shares of high-SDI ZIP codes; **redistributive pools** to support rural/low-resource teams, addressing workforce maldistribution and hospital access gaps.
- **Transparency:** Publish equity performance and improvement trajectories at plan and provider levels to spur accountable competition.
- **What I'm glossing over**: implementation here will need significant caretaking and piloting in key populations. Getting the details wrong, could incentivize cherry picking of patients or unfairly penalize programs trying to work with the most marginalized populations. Upstream societal failures leading to housing instability, food insecurity, weathering, etc could be unfairly attributed to palliative care programs as programmatic failures. We likely need to use improvement trajectories rather than absolute gap closure. And we need to ensure risk adjustment accounts for baseline disparities.

6) **Environmental Metrics — Accountability for Planetary Health Co-Benefits**

- **Avoided high-emission encounters:** Risk-adjusted ED visits/hospital days avoided per 100 patients/month as a carbon footprint proxy.
- **System reporting:** Health systems increasingly use decarbonization dashboards; palliative care reductions in acute utilization should be tracked and recognized in **total cost and environmental impact**.

- **What I'm glossing over**: no one has thought about environmental justice in this way before or attempted such risk adjustment, but I'm simply not willing to leave this unmentioned.

7) **Governance — Centering Impacted Communities**

- Establish an **Equity Advisory Panel** (community leaders, social workers, antiracism scholars) to set thresholds, review corrective plans, and recommend model adjustments. The institutional home for this panel needs significant input from the field (who is the convenor, where is it housed, what authority does it have, and who funds it).
- Require **public minutes and annual reports** on equity performance for SITS-certified programs and contracting payers.

Budget and Impact Considerations

- **Palliative ROI:** Evidence suggests palliative care reduces avoidable ICU admissions, ED visits, and hospital days; aligning PMPM payments to proactive home-based care and caregiver support should yield **offsets** in total cost of care.
- **Infrastructure Funding:** The PMPM must finance nonbilling roles (nursing, pharmacist, spiritual care, social work), after-hours coverage, and language access—elements currently missing from fee-for-service revenue.
- **Environmental Co-Benefit:** Reduced acute utilization confers measurable emission reductions, fulfilling health-sector decarbonization commitments.

Risks and Mitigations

- **Model churn/instability:** Anchor SICMB in statute or multi-year CMS guidance; align with existing APM frameworks to reduce risk of early termination.
- **Equity backlash or under-resourcing:** Protect equity requirements through public reporting, withholds, and redistributive payments; involve **community governance** to sustain legitimacy.
- **Workforce capacity:** Use PMPM to fund full teams; pair with training grants and rural add-ons; track maldistribution and incentivize practice in high-need areas.
- **Gaming risk:** Keep the Core Set **parsimonious and patient-reported**; stratify by subgroup; enforce corrective action via withholds; audit attribution and eligibility triggers.

How to Get It Done

AAHPM brought the **Patient and Caregiver Support for Serious Illness (PACSSI)** model to PTAC in 2018, which **recommended limited-scale testing** and urged CMS to move with "the highest possible priority." The model proposed **tiered, monthly payments** to fund interdisciplinary palliative teams, including non-billing roles (social work, chaplaincy) that fee-for-service does not support. PACSSI was acknowledged as promising, but CMS did not stand up a national test; subsequent HHS responses emphasized value-based transformation while signaling that proposed PFPMs would need stronger evidence on savings, operational simplicity, and alignment with CMS priorities.

Several dynamics help explain why PACSSI did not launch at scale: (1) **portfolio discipline at CMMI**—models now must demonstrate early, credible savings and feasibility; (2) unclear multi-payer alignment, since PACSSI had to fit a brief for a **physician-focused** test; and (3) concern that payments could be **over- or under-generous** over time, prompting researchers to float "PACSSI-Flexible" variants to address actuary concerns, but without a formal CMS RFA.

The implementation environment has changed. **AHEAD** (the updated state **total cost of care** framework) now explicitly equips states to align **Medicare, Medicaid, and commercial payers**, extends through **2035**, and introduces **geographic attribution** for original Medicare—precisely the scaffolding a serious-illness PMPM needs to scale with accountability. At the same time, **ACO REACH** centers **equity**, tightens quality withholds, and provides a claims-based, parsimonious quality set—an on-ramp for Original Medicare segments where serious-illness teams can be financed and measured. And CMS's **Universal Foundation** is streamlining measures across programs and digitizing reporting, which favors our **Core Set** (patient-reported communication and pain relief; timely hospice) because it is **parsimonious, outcomes-oriented, and equity-ready**. Finally, with **Medicare Advantage** covering **~54%** of beneficiaries in 2025—and with enrollment concentrated among a few national carriers—contracting leverage exists to adopt SITS-gated PMPMs quickly in large markets.

How To Run Where PACSSI Walked

- **Start with certifiable teams beyond a payment concept.** PACSSI's strength was recognizing the interdisciplinary team; this approach makes team capability a **precondition** for enhanced payment via **SITS certification** (TJC for hospitals; ACHC/CHAP for community), tied to NCP guidelines and NQF stewardship. That

turns "who gets paid" into "who meets standards," reducing variation and increasing payer confidence.

- **Anchor where CMS already wants to move dollars.** Instead of seeking a stand-alone PFPM, submit a **CMMI model application** for a Serious Illness Care Management Benefit (**SICMB**) that runs as: (a) an **option inside ACO REACH** for Original Medicare; (b) a **module inside AHEAD** states to ensure multi-payer alignment; and (c) an **MA contracting pathway** where plans elect to pay SITS-certified teams a risk-adjusted PMPM. This uses established lanes (REACH; AHEAD; MA contracting) rather than waiting for a new PFPM to be blessed.
- **Solve the VBID lessons up front.** The MA **hospice carve-in** ended on **December 31, 2024** due to **operational challenges** and **low use** of palliative/concurrent services—driven by **poor eligibility understanding** and **non-standard identification processes**. SICMB hard-codes **standardized triggers**, **concurrent hospice by default**, and **transition protocols** to prevent the access confusion that sank VBID's hospice component.
- **Pay for outcomes with equity consequences.** CMS wants models that show savings and equity; PACSSI sketched measures, but our Core Set is **small, patient-reported, and linked to withholds** with mandatory **subgroup stratification** (race/ethnicity, language, SDI, rural/urban). States under **AHEAD** already face **transparency** and **choice/competition** requirements; pairing those with equity withholds makes SICMB consistent with CMS's strategy and protects against widening disparities.
- **Use multi-payer alignment instead of a single-payer test.** PACSSI was designed as a physician-focused PFPM; SICMB is designed for **AHEAD's multi-payer TCOC** structure and **REACH's equity focus**, with MA adoption for scale. That means states can push common rules across payer types rather than stitching together pilots with different measurement and attribution.
- **Meet CMMI's portfolio discipline.** CMS has been **terminating and updating models** to prioritize cost control and feasibility; SICMB commits to early **savings checkpoints** (avoidable ED/hospital days; timely hospice use) and to **operational simplicity** (SITS gate, standard triggers), improving odds of acceptance compared with a broad PFPM proposal.

Political pathway in practice

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- **Champions:** AHEAD states (MD, CT, HI, VT, RI, downstate NY), **REACH ACO sponsors**, and national **MA carriers** with large footprints; each has direct levers to implement SICMB within existing CMS frameworks.
- **Primary filing:** a **CMMI model application** that nests SICMB in **REACH** and offers an **AHEAD state addendum** for multi-payer alignment—explicitly mapped to the **Universal Foundation**'s measure philosophy.
- **Parallel actions: Medicaid managed care** clauses (e.g., modeled after **California SB1004**) to pay SICMB PMPMs to SITS-certified teams while states participate in AHEAD; **MA plan elections** to pilot SICMB in concentrated markets.
- **Supportive comments:** file **regulatory comments** when CMS updates **AHEAD** operations or **Universal Foundation** digitization to keep SICMB's Core Set aligned with agency measurement strategy.

Bottom line: PACSSI proved the concept—interdisciplinary teams need **monthly payments** tied to **patient need**—but it lacked the **multi-payer, measure-aligned, equity-enforced scaffolding** CMS now expects. SICMB provides that scaffolding: **SITS-gated teams**, **AHEAD + REACH lanes**, **Universal Foundation-compatible Core Set**, and **explicit fixes** to VBID's failure modes. That is how this model succeeds where PACSSI failed—**by wiring the payment to standards, outcomes, and equity inside the programs CMS is already expanding**.

Conclusion

The path forward is not another slogan—it's **payment infrastructure** aligned to the **standards we already endorse** and the **justice we value**. A national **SICMB**—funded via risk-adjusted PMPMs and gated by **SITS**—ties money to outcomes, mandates equity action, and recognizes environmental co-benefits. This architecture finances the **teams** serious illness care requires and delivers in the **places** that need it most. That is the right path.

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Appendix A — Serious Illness Team Standard (SITS): Certification Criteria & Audit Protocol

A.1 Purpose and Scope

SITS defines the minimum clinical and equity requirements a program must meet to qualify for enhanced payment under the Serious Illness Care Management Benefit (SICMB). It operationalizes NQF/NCP interdisciplinary standards and embeds cultural/structural competence as a precondition for team-based financing.

A.2 Certification Domains and Criteria

1) Team Composition & Staffing (clinical minimums)

- Interdisciplinary team (required): physician and/or APRN/PA; RN; social worker; chaplain/spiritual care professional.
- Minimum staffing thresholds (to be calibrated locally using CAPC Registry benchmarks):
    - Inpatient programs: per 10,000 annual hospital admissions, maintain ≥0.5 FTE physician, ≥1.5 FTE RN, ≥1.0 FTE social worker, ≥0.5FTE pharmacist, ≥0.5 FTE chaplain; scale up for ICU-dense case mix.
    - Community-based programs: per 1,000 attributed lives, maintain ≥0.2 FTE physician, ≥0.4 FTE RN, ≥0.3 FTE social worker, ≥ pharmacist, ≥0.2 FTE chaplain, with documented after-hours coverage.

2) Cultural & Structural Competence (equity minimums)

- Language access: on-demand interpretation (human or qualified VRI) with ≤60-minute response; translation of core patient documents into top two non-English languages in the service area.
- Spiritually respectful care: routine spiritual assessment and documented accommodation of practices; referral pathways to faith/community resources.
- Community partnership: at least two active MOUs with community-based organizations serving high-deprivation or historically marginalized populations; annual joint quality projects.
- Antiracism and equity training: ≥8 hours/year per team member with curriculum covering structural racism, implicit bias, and culturally responsive communication; training completion tracked.

3) Care Processes

- Longitudinal care: documented transitions across settings; shared care plans; routine caregiver assessment and support.
- Access & continuity: 24/7 clinician triage; urgent visits within 24 hours for uncontrolled symptoms; proactive visit cadence for high-risk patients.
- Social needs navigation: screening for food insecurity, housing, transport; warm handoffs and closed-loop referrals.

A.3 Documentation Requirements

- Staffing rosters with role/FTE; coverage schedules.
- Policy and procedures for language access; evidence of translation.
- MOUs with community partners; annual joint project summaries.
- Training logs and curricula.
- Quality dashboards: symptom control, caregiver support, transitions.

A.4 Audit Protocol

- **Cycle:** Initial certification, annual renewal, and for-cause audits.
- **Methods:** Document review; random chart abstraction (≥60 charts across settings); patient/caregiver interviews (stratified by language and SDI); direct observation for access/logistics.
- **Scoring:** Pass/fail on mandatory criteria; graded compliance (0–100) on process elements.
- **Remediation:** Deficiencies trigger corrective action plans with deadlines; failure to remediate leads to suspension from SICMB eligibility.

Rationale: NQF/NCP define the clinical blueprint; VBID's hospice carve-in experience shows that absent clear benefit definitions and equity safeguards, serious-illness services are underutilized and unevenly distributed.

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Appendix B — SICMB PMPM Risk Banding & Example Rate Structure

Note: The following structures are **illustrative** to guide model design from the small brain of this physician. Rate ranges must be finalized by actuaries using local claims, encounter data, and population characteristics. This appendix describes the **variables and formulas** needed to compute risk-adjusted PMPM.

B.1 Eligibility & Attribution

- **Eligible population:** Adults and children with serious illness (advanced cancer, advanced heart/lung/renal disease, neurodegenerative conditions, multimorbidity with functional decline), meeting standardized triggers (diagnosis + utilization + functional status).
- **Attribution:** Patient is attributed to a SITS-certified team upon eligibility confirmation; attribution follows patient across settings.

B.2 Risk Variables

- **Clinical severity:** e.g., HCC score or Charlson Comorbidity Index percentile.
- **Functional status:** e.g., Palliative Performance Scale (PPS) band or ADL impairment count.
- **Symptom burden:** recent uncontrolled pain/dyspnea (validated instruments).
- **Social risk:** neighborhood Social Deprivation Index (SDI) quintile; language; rural/urban.
- **Caregiver complexity:** presence of single/overburdened caregiver; caregiver health risks.

B.3 PMPM Formula

Conceptual form

- PMPM = Base_Rate × ClinicalMultiplier × FunctionalMultiplier × SymptomMultiplier × SocialRiskMultiplier × CaregiverMultiplier
- **Base_Rate:** actuarially determined to cover core team costs (prescriber, RN, social work, chaplain), after-hours coverage, navigation, interpreter services.
- **Multipliers:**
    - ClinicalMultiplier (e.g., 1.0–1.4),
    - FunctionalMultiplier (1.0–1.3),
    - SymptomMultiplier (1.0–1.2),
    - SocialRiskMultiplier (1.0–1.2; higher in SDI Q4–Q5),

- CaregiverMultiplier (1.0–1.15).

B.4 Example Risk Bands (illustrative)

- **Band A (moderate severity; PPS ≥60; SDI Q1–Q2):** PMPM = Base × 1.0–1.1
- **Band B (high severity; PPS 40–60; SDI Q3):** PMPM = Base × 1.15–1.25
- **Band C (very high severity or SDI Q4–Q5; rural):** PMPM = Base × 1.3–1.4

B.5 Benefit Design Elements

- **Covered services:** interdisciplinary assessment and care planning; in-person/telehealth visits; after-hours triage; caregiver training; social needs navigation; spiritual care; care coordination across settings.
- **Concurrent hospice:** permitted by default; standardized transitions and shared plans to prevent gaps.
- **Care cadence:** minimum monthly touch for Band A; biweekly for B; weekly for Band C.

B.6 Guardrails

- **No double billing:** PCM/CCM codes may not be billed for the same condition/month when SICMB PMPM is active.
- **Quality linkage:** PMPM subject to withholds tied to Core Set results and equity action threshold (see Appendix C/D).
- **Transparency:** publish uptake and outcomes by plan/ACO to prevent selective enrollment.

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Appendix C — Core Set Technical Specifications

C.1 Measure Definitions

- **Feeling Heard & Understood** (patient-reported experience of serious illness care), standardized instrument; recommended specification aligns to CMS/PCORI "Feeling Heard and Understood," Measure ID 3665.
- **Getting Help Wanted for Pain** (patient-reported experience of symptom relief), recommended specification aligned to Measure ID 3666.
- **Hospice ≥3 days before death** (timeliness of hospice use among decedents), utilization outcome calculated from claims/encounters, Measure ID 0216.

C.2 Population, Sampling, and Modes

- **Population:** All patients attributed under SICMB during the measurement month.
- **Sampling:** Monthly rolling samples targeting ≥30 completed surveys per program per month; oversample non-English speakers and rural/high-SDI subgroups to ensure representativeness.
- **Modes:** Telephone, SMS, secure web, paper, and in-person (when needed); offer surveys in patients' preferred language; employ qualified interpreters.

C.3 Risk Adjustment & Stratification

- **Risk adjustment:** Adjust PROM results for age, diagnosis group, functional status, language, and caregiver complexity using hierarchical models.
- **Stratification (required):** Report disaggregated results by race/ethnicity, preferred language, rural/urban residence, and SDI quintile.

C.4 Calculation, Validity, and Reliability

- **PROM scoring:** 0–100 scale based on item aggregation; define thresholds for acceptable performance (e.g., ≥80).
- **Timeliness measure:** Numerator = decedents admitted to hospice ≥3 days before death; Denominator = all decedents attributed.
- **Reliability:** Achieve ≥0.70 reliability at program level via sufficient sample size; use rolling quarterly aggregation where monthly n is small.

C.5 Data Integrity and Privacy

- HIPAA-compliant collection; secure transmission; audit trails.
- Patient consent and opt-out procedures explained in preferred language.

- Blinded analyses when reporting subgroups to protect confidentiality.

C.6 Payment Linkage (Withholds)

- Tie ≥30% of PMPM to Core Set performance; release withholds quarterly upon meeting thresholds or demonstrating meaningful improvement through an approved corrective plan (see Appendix D).

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Appendix D — Equity Action Threshold: Methodology & Remediation Playbook

D.1 Threshold Definition

An **Equity Action Threshold (EAT)** is triggered when any subgroup's performance on PROMs (Feeling Heard & Understood; Getting Help Wanted for Pain) or hospice timeliness differs from the program's overall mean by **>15 percentage points**, after risk adjustment and confidence interval assessment.

D.2 Statistical Method

- Use hierarchical generalized linear models to estimate subgroup performance.
- Calculate 95% confidence intervals (Wilson method for proportions).
- Trigger EAT if adjusted difference >15 points and CI excludes ≤10-point difference (to avoid false positives).
- Confirm persistence over two consecutive months or one quarter.

D.3 Remediation Workflow

1. **Root-cause analysis** (30 days): review access barriers, communication/language services, care pathways, staffing, and community partnerships.
2. **Action plan** (30 days): specify interventions (e.g., add bilingual staff, extend hours, revise symptom protocols, deepen CBO engagement).
3. **Implementation** (90 days): execute plan; monitor weekly; document leading indicators (reach, timeliness, interpreter use).
4. **Evaluation** (end of quarter): reassess subgroup performance; submit results.

D.4 Payment Consequences

- **Withhold continuation:** PMPM withhold remains in place until subgroup performance improves to within 10 points of overall mean for two consecutive months.
- **Bonus eligibility:** Equity-forward bonus PMPMs released upon documented closure of ≥50% of baseline gap.

D.5 Community Governance

- Equity Advisory Panel reviews action plans and progress; provides technical assistance; may recommend additional investments or redistributive support for high-SDI/rural zones.

D.6 Reporting

- Publish subgroup performance and remediation summaries on a public dashboard; include narrative on community engagement and outcomes.

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Appendix E — 20-Year Futures: How SICMB/SITS Could Evolve (Analysis Assisted by CopilotGPT 5)

E.1 Framing

A foresight analysis in three horizons (0–5, 5–10, 10–20 years) considering **policy**, **market**, **technology**, **workforce**, **equity**, and **planetary health**. Each horizon includes **signals**, **risks**, and **policy levers**. Projections reflect current trajectories in CMS APM strategies, state Medicaid innovation, MA dominance, decarbonization commitments, and documented workforce trends.

E.2 Horizon 1: 0–5 Years (2026–2030)

Signals

- CMS refines Universal Foundation measures; patient-reported serious-illness experience gains traction (pilot inclusion).
- MA continues to expand; selected states adopt Medicaid palliative PMPMs with equity conditions.
- Hospital-at-home and virtual care stabilize post-pandemic; caregiver benefits grow modestly.

Model Evolution

- SICMB becomes an **Advanced APM option**; SITS certification recognized by major payers.
- Core Set expanded to include **caregiver experience** (short PROM module), still parsimonious.
- Equity Action Thresholds embedded in contracts; redistributive payments funded via plan quality pools.

Risks & Mitigations

- **Model churn** (early terminations) → anchor SICMB in multi-year guidance; cross-payer alignment.
- **Uneven uptake** in rural/for-profit markets → targeted add-ons; technical assistance; public transparency.

E.3 Horizon 2: 5–10 Years (2031–2035)

Signals

- Integration of **social care** platforms (housing/food/transport) with health data accelerates; common SDOH APIs mature.
- HRSA workforce projections confirm shortages; expanded scope for APRNs/PAs and **community health workers** (CHWs).
- Health sector **decarbonization** targets tighten (public reporting norms).

Model Evolution

- SICMB risk bands incorporate **digital biomarkers** (RPM flags) and **caregiver strain indices**; PMPMs recognize CHW/lay navigator contributions.
- Environmental co-benefits become part of public rating; some payers introduce small **sustainability incentives** tied to AHEE/CO_2e avoidance.

Risks & Mitigations

- **Data privacy** concerns → strong consent standards; community governance; penalties for misuse.
- **Algorithmic bias** in risk adjustment → fairness audits; require transparent models; equity overrides.

E.4 Horizon 3: 10–20 Years (2036–2045)

Signals

- Aging demographics intensify serious-illness prevalence; home-centric care mainstream; **hospital-at-home** widely available.
- AI-assisted triage/communication standard; multimodal PROMs (voice-to-text, translation) ubiquitous.
- Carbon pricing or strong regulatory incentives affect health-sector operations.

Model Evolution

- SICMB becomes the **national default** for serious-illness care in Medicare and Medicaid; commercial adoption follows.
- **Payment convergence**: hybrid base (PMPM) + small FFS for select procedures + quality/equity/sustainability bonuses.
- Core Set persists (PROMs + timeliness) but adds **goal-concordant care** outcome verified via structured goals-of-care documentation.
- Environmental metric matures from proxy to **facility-level Scope 1–3 contribution attribution**; high-performers leverage low-carbon supply chains.

Risks & Mitigations

- **Commercial capture**: consolidation reduces access in low-margin geographies → enforce network adequacy, equity floors, and redistributive pools.
- **Equity rollback** under changing political winds → codify equity standards in statute; maintain public dashboards and payment withholds.

E.5 Scenario Lens (Cross-Horizon)

Scenario A — Acceleration

- Rapid multi-payer alignment; SICMB scaled nationally by 2033; measurable reductions in ED/hospital days and closed subgroup gaps in high-SDI ZIPs.
- **Indicators:** growth in SITS certifications; Core Set improvements; CO_2e avoidance increasing.
- **Actions:** expand PMPM pools; strengthen community governance.

Scenario B — Stalled Patchwork

- Fragmented adoption; rural/for-profit lag; persistent equity gaps.
- **Indicators:** uneven Scorecard performance; limited PMPM bonuses paid.
- **Actions:** federal grants; statutory minimums; targeted oversight.

Scenario C — Commercial Capture

- Large platforms dominate; narrow networks; quality up but equity down.
- **Indicators:** concentration indices rise; SDI gaps widen.
- **Actions:** antitrust scrutiny; equity-tied contracting; redistributive pools.

E.6 Strategic Guardrails for the Next 20 Years

- **Keep measures parsimonious and patient-centered**; resist metric creep.
- **Equity in the payment DNA** (withholds, bonuses, transparency) regardless of administration.
- **Open data standards** (FHIR/HL7) and **privacy-preserving analytics** to maintain trust.
- **Planetary health accounting** to tie avoided utilization to sustainability commitments.

Bottom line: Over two decades, the SICMB/SITS architecture can mature from a corrective reform to the **default financing model** for serious-illness care—provided payment remains

tightly linked to outcomes, equity, and accountability, with continuous governance by the communities most affected.

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Appendix F — SICMB and the Medicare Hospice Benefit: Complementary Design

F.1 Purpose and Scope

This appendix clarifies the relationship between the Serious Illness Care Management Benefit (SICMB) and the Medicare Hospice Benefit. SICMB is designed as **upstream infrastructure**—serving patients with serious illness who are not yet hospice-eligible or not yet ready to elect hospice—rather than as a parallel or competing benefit. The architecture anticipates that SICMB-attributed patients who become hospice-appropriate will transition to hospice with continuity of relationship, information, and support.

F.2 The Gap SICMB Fills

The Medicare Hospice Benefit requires a prognosis of six months or less if the disease follows its usual course and, for most services, forfeiture of curative treatment coverage for the terminal condition. These requirements create a structural gap: patients with serious illness who could benefit from interdisciplinary, team-based care but who are not yet hospice-eligible, not yet ready to forego disease-modifying treatment, or whose prognosis is uncertain.

SICMB addresses this gap. The target population includes:

- Patients with advanced cancer continuing active treatment
- Patients with advanced heart failure, COPD, or renal disease with functional decline but uncertain prognosis
- Patients with neurodegenerative conditions across a multi-year trajectory
- Patients with multimorbidity and frailty who do not meet hospice prognostic criteria

These patients currently receive fragmented care financed through E/M billing, ACP codes, and patchwork contracts, arrangements that do not fund the full interdisciplinary team. SICMB provides team-based financing for the period **before** hospice eligibility or election.

F.3 Evidence: Upstream Palliative Care Increases Appropriate Hospice Use

A concern sometimes raised is that robust community-based palliative care might reduce hospice referrals by providing a "good enough" substitute. The evidence does not support this.

- A home-based palliative care program in an ACO **increased** hospice enrollment and **lengthened** hospice length of stay while reducing acute utilization.

- Brumley et al. (2007) demonstrated that in-home palliative care increased patient satisfaction **and** appropriate hospice transitions.
- The Medicare Care Choices Model (MCCM), which tested concurrent curative and hospice care, showed that earlier engagement with palliative-oriented services facilitated—not displaced—hospice election.

SICMB's Core Set measure (**Hospice ≥3 days before death**) operationalizes this logic: model success is defined partly by whether patients who need hospice get there in time. Teams whose patients die without hospice, or with only hours of hospice care, will underperform on a measure tied to payment.

F.4 Transition Design Principles

SICMB must include explicit protocols for transitioning patients to hospice. The following principles should guide operational design:

Attribution Handoff

- SICMB attribution ends when a patient elects the Medicare Hospice Benefit and is admitted to a Medicare-certified hospice.
- A **30-day concurrent attribution period** is permitted, during which SICMB PMPM and hospice per diem may both apply. This period supports warm handoffs, joint care planning, and relationship continuity and offsets some of the most expensive days of hospice enrollment. After 30 days, hospice attribution is exclusive.
- During the concurrent period, SICMB covers interdisciplinary team services (social work, spiritual care, navigation) not duplicative of hospice per diem-covered services; hospice covers routine home care or the applicable level of hospice care.

Shared Care Planning

- SITS-certified programs must maintain **structured goals-of-care documentation** using a standardized format (recommend alignment with HL7 FHIR-based advance care planning resources).
- Upon hospice referral, the SICMB team transmits to the receiving hospice: (1) current goals-of-care documentation, (2) symptom management plan, (3) caregiver assessment summary, (4) spiritual care notes, and (5) active community resource referrals.
- Hospices receiving SICMB-transitioned patients must acknowledge receipt and confirm review of transmitted documentation within 48 hours.

Team Continuity Options

- With patient/family consent, SICMB team members (particularly social worker, chaplain, or navigator with established relationships) may continue involvement during the hospice period in a consultative or supportive role.
- Payment for continued SICMB team involvement during hospice requires explicit contract terms between the SITS-certified program and the hospice; this is **not** covered under either SICMB PMPM or hospice per diem by default but may be negotiated as a value-added service.

F.5 Position on Concurrent Care

The hospice field is actively debating whether the Medicare Hospice Benefit should permit disease-modifying treatment concurrent with hospice services. MCCM tested a version of this; VBID's concurrent care provisions were poorly operationalized and underutilized.

SICMB takes the following position:

- **Within SICMB (pre-hospice):** Disease-modifying treatment is **permitted and expected**. SICMB serves patients who are pursuing curative or life-prolonging therapies; interdisciplinary support is provided alongside, not instead of, such treatment.
- **During the 30-day concurrent attribution period:** Limited disease-modifying treatment may continue under SICMB coverage while hospice services begin. This mirrors MCCM's concurrent care approach and provides a transition runway.
- **After hospice election (post-concurrent period):** SICMB defers to hospice benefit rules as they exist or as they may be reformed. If CMS or Congress modifies the hospice benefit to permit broader concurrent care, SICMB's transition protocols should be updated accordingly.

SICMB is designed to be **compatible with multiple hospice payment structures**, including potential future reforms. The model does not presuppose a particular resolution of the concurrent care debate but provides a structured bridge for the pre-hospice and early-hospice periods.

F.6 Lessons from VBID: Shared Accountability

The VBID hospice carve-in terminated December 31, 2024, after declining participation and operational challenges. This brief has cited VBID's **palliative care failures**—low utilization of palliative and transitional services, unclear eligibility, poor identification

processes. It is equally important to acknowledge VBID's **hospice-specific operational failures**:

- Hospices struggled to join MA plan networks and negotiate contracts
- Claims processing and payment timeliness were problematic
- Notice of Election (NOE) acceptance procedures were inconsistent
- Data sharing between MAOs and hospices was inadequate

SICMB must learn from both sets of failures. The palliative care design elements (SITS certification, standardized eligibility triggers, explicit PMPM financing) address the first set. But SICMB implementation must also address hospice contracting, claims routing, and data exchange infrastructure—or risk replicating VBID's hospice-side dysfunctions.

Operational requirement: CMS guidance for SICMB should include **network adequacy standards** for hospice access. MAOs and ACOs participating in SICMB must demonstrate contracted relationships with hospice providers sufficient to serve their attributed population, with geographic and capacity adequacy metrics.

F.7 Hospice Modernization as a Parallel Track

The Medicare Hospice Benefit faces its own modernization agenda, distinct from SICMB:

- Per diem payment restructuring (intensity-adjusted payments, outlier policies)
- Quality measurement and public reporting enhancements
- Fraud and abuse enforcement following OIG findings
- Rural access gaps and workforce constraints
- Concurrent care policy resolution

SICMB does not solve these problems and does not attempt to. Hospice payment reform is a separate policy conversation with its own stakeholders, evidence base, and legislative/regulatory pathways.

SICMB is designed to be **compatible with hospice modernization** rather than dependent on any particular reform outcome. Whether hospice payments shift to intensity-adjusted models, whether concurrent care expands, whether quality withholds are implemented—SICMB's upstream financing and transition protocols remain functional across these scenarios.

The National Coalition for Hospice and Palliative Care and member organizations (including AAHPM, NHPCO, HPNA, and others) are engaged in both SICMB-relevant and

hospice-specific policy conversations. Coordination across these tracks is appropriate; conflation is not.

F.8 Invitation for Hospice Stakeholder Input

This appendix represents a framework, not a final specification. The transition protocols, concurrent attribution period, and operational requirements outlined here require refinement through stakeholder input—particularly from hospice providers, MAOs with hospice contracting experience, and state Medicaid agencies operating palliative-to-hospice pathways.

Specific questions for hospice stakeholder input:

- Is a 30-day concurrent attribution period operationally feasible? Too short? Too long (probably)?
- What data elements are essential for SICMB-to-hospice handoff documentation?
- What network adequacy metrics would ensure hospice access for SICMB-attributed patients?
- How should SICMB and hospice teams coordinate when both are involved during concurrent periods?
- What contractual or regulatory barriers currently impede smooth palliative-to-hospice transitions, and how might SICMB design address them?

SICMB's success depends on hospice as the appropriate destination for patients whose illness progresses. Hospice stakeholders are essential partners in designing a model that works—not competitors to be outmaneuvered. This brief invites that partnership.