Palliative Care for D-SNP Members

Webinar #2: Payment Model, Program Administration, and Quality Monitoring

August 18, 2023

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Webinar Series Objectives

- Ensure plans understand the palliative care policy
- Support networking and peer-peer learning
- Introduce tools, resources and lessons learned from implementing Medi-Cal palliative care

Please use the Zoom Q & A feature for questions and comments

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Series Content

Date	Time*	Topics
6/29	9-10	Policy, Population, Services, and Providers
8/18	10-11	Payment Model, Program Administration, and Quality Monitoring
9/14	10-11	Promoting Referrals, Enrollments, and Awareness

**All times PDT*

Please invite plan colleagues who have an interest in these topics!

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D-SNP Webinar Series

This series and its supporting materials were created to educate California's Dual Eligible Special Needs Plans (D-SNPs) about new requirements to provide access to palliative care services starting in 2024. Funding for the project was generously provided by the California Health Care Foundation.

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Webinars

June 29, 2023

Palliative Care for D-SNP Members: Policy, Population, Services, and Providers

Recording | Slides | DHCS D-SNP Palliative Care Fact Sheet | D-SNP PC Webinar #1 Highlights

https://coalitionccc.org/CCCC/Our-Work/D-SNP-Webinar-Series.aspx?WebsiteKey=0a2ca98e-d803-448c-9cad-06171c65bed9

Today's Webinar

- **Payment**: Economic outcomes, payment methods and platforms, care model considerations
  - Dr. Tom von Sternberg, Medical Director SNP, Medicare, and Care Management, HealthPartners
- **Administration**: Key structures and processes, monitoring quality
  - Kathleen Kerr, Transforming Care Partners
- **Case Study**: Partnership HealthPlan of California
  - Dr. James Cotter, Associate Medical Director, Health Services Department
- **Wrap-Up**: Takeaways, resource review, Q & A

Webinar slides, brief summary of key points, and link to webinar recording will be distributed to all registrants and made available on the CCCC web site

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Overview of Payment Model Elements for Successful Implementation

Dr. Tom von Sternberg

Medical Director SNP, Medicare, and Care Management

HealthPartners, Mpls, Mn

Multiple Examples of Cost-Effective Programs

- Kaiser RCT came first (Brumley 2007)
- 7 well-designed observational studies have compared HBPC to Usual Care
- Findings: HBPC costs 20-65% lower
- Decedent cohort used in 5 studies; avoids potential regression to the mean

Program	Insurance type	Reduced costs compared to usual care
Kaiser Permanente	HMO	33%
Buffalo	88% Medicare Adv.	36%
Prohealth	MSSP ACO	37%
Sharp Transitions	Medicare Adv.	49% - 59%
Sutter AIM	Medicare FFS	29%
Mayo	Medicare	65%
Turnkey	Medicare Adv.	20%
CMS MCCM	Medicare – MCCM	40%

See *Studies of HBPC Economic Outcomes* handout for sources and additional details

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REPORT / 12-17-22

Palliative Care in Medicaid Costing Out the Benefit: Actuarial Analysis of Medicaid Experience

National Academy for State Health Policy, 2022, https://nashp.org/palliative-care-in-medicaid-costing-out-the-benefit-actuarial-analysis-of-medicaid-experience

Actuarial Analysis Suggests Positive ROI

Cost avoidance savings between $231 and $1,165 per Medicaid member per month

Potential return on investment between $0.80 and $2.60 for every $1 spent on palliative care

Source: National Academy for State Health Policy, 2022, https://nashp.org/palliative-care-in-medicaid-costing-out-the-benefit-actuarial-analysis-of-medicaid-experience

Methods and Platforms for Payment

Methods of Payment

Bundled / Value-based

- Recognizes team-based care and includes costs for each team member
- Significant work is not transactional (telephonic, IDG, coordination)
- Payment can be upfront or backend

FFS / Visit-based

- Very challenging
- Doesn’t include between-visit care
- Doesn’t compensate entire team
- Incents only face-to-face care
- Does not support ongoing relationship that drives impact

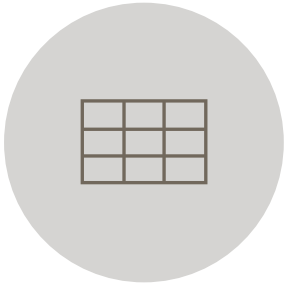
Bundled Payment Features to Consider

Episode of care	6-12 months with bills submitted at intervals (2,4,8 week)
Authorization	Re-authorization at 3-12 months in Medi-Cal
Tiering option	31% uptake in Medi-Cal (higher $$$ for higher complexity members)
PMPM amount	Wide range of PM/PM payments in Medi-Cal contracts (+/- >$800)
Incentives or Bonus	With or without withhold for agreed upon metrics

Incentives/ Bonus Elements to Consider

ER or Hospitalization Utilization Parameters

Evidence of Intervention before ER or Hospital



Submitting data to the National Palliative Care Database (PCQC)

Presence of ACP or POLST in the EMR

Payment Mechanisms Used in Medi-Cal PC*

Per-Enrolled-Member-Per-Month Bundled Payment (67%)

vs.

Fee-For-Service (33%)

Tiers of Service (31%)

Supplemental FFS Payments (17%)

Incentive Payments (8%)

Assessment Fee (25%)

- For initial visit, to determine eligibility/service tier
- Used in both bundled payment and FFS models

*Percentages represent proportion of Medi-Cal managed care plans that endorsed using each item in the 2023 MCP PC survey. Full results available at https://coalitionccc.org/common/Uploaded%20files/PDFs/MCP%20LC%20Resources/Survey%20Findings.pdf

Payment and Contracting Under Medicaid

- The existing platform for payment for Medi-Cal PC
- Medicaid Fee Schedule NOT sustainable as FFS
- PM/PM is preferred
- With the Dual population should expect much greater uptake/ utilization of PC benefit

Payment and Contracting Under Medicare

- Higher degree of complexity for payment
- BID Calculation requires accurate assessment of costs, so ALL costs of services must be included
- New program - challenging to estimate usage, LOS in program
- Can’t include cost mitigation
- Actuaries will struggle with simply trusting the existing evidence
- Supplemental Benefit
  - Limited in its financial support
  - Yearly changes in funds available based on BID results and quality incentives

Care Model Elements are Critical to Success

IDT: MD, NP, RN, SW, Chaplain

Training and certification of IDT

Care planning customized to patient and family needs

Visit frequency and communication cadence adequate to meet patient needs

24/7 capabilities; 1st call for change in status / patient needs

Derived from: Insights and Recommendations from the Center to Advance Palliative Care and the Palliative Care Quality Collaborative https://www.capc.org/documents/download/1100/

Key Takeaways

- Multiple examples of cost-effective PC programs
- Higher proportion of seriously ill members in the D-SNP population will drive even more success than Medicaid
- Payment methodology can reward and incent the outcomes you need
  - Bundled/PMPM is the preferred payment model
  - Incentives and bonuses should also be considered
- There are options for how to construct the contract under Medicaid and Medicare
- Palliative care will have a positive impact on your members and help to mitigate costs

Questions and Discussion

Please use the Zoom Q & A feature for questions and comments

Key Structures and Processes, and Monitoring Quality

Kathleen Kerr

Transforming Care Partners

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https://www.chcf.org/resource-center/essential-elements-medi-cal-palliative-care-services/c-develop-optimize-mcp-program-operations/

C: Develop (or optimize) MCP program operations

The Medi-Cal managed care provider (MCP) specifies an administrative home, assembles a staff team, and develops workflows for internal processes. The team creates cross-organization workflows in collaboration with palliative care providers and referring providers.

> "Palliative care fits best within care management programs or similar programs, and not with a department like utilization management that is more focused on all MCP members or a specific care event.
>
> —Established program representative

In this section:

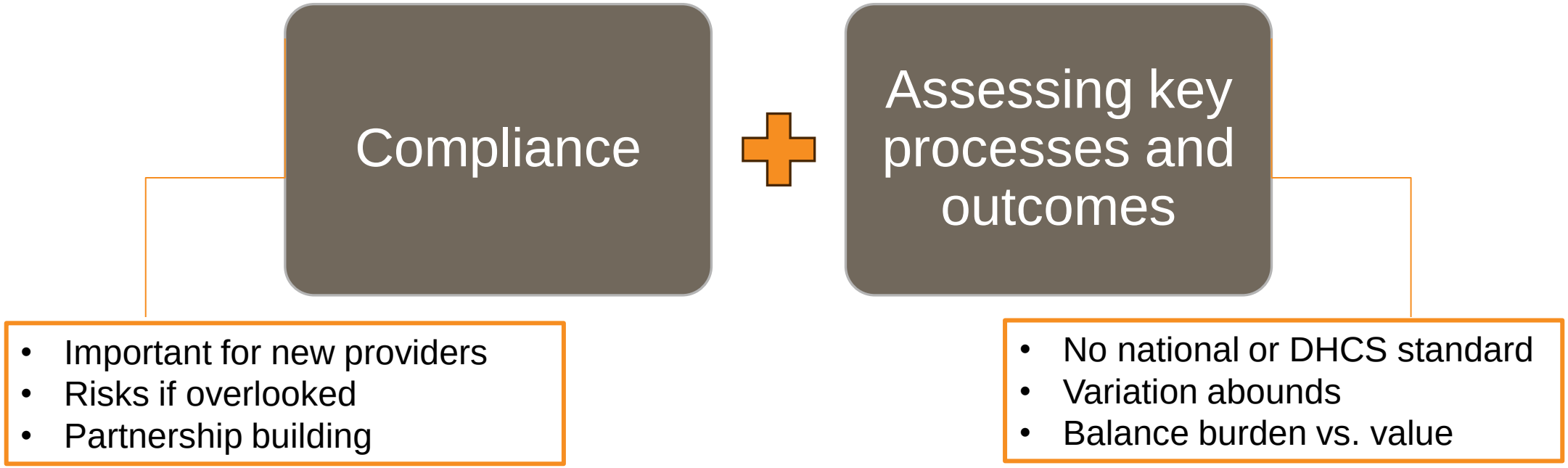
Best Practice Structures and Processes

MCP Responses to 2023 Medi-Cal PC Survey

Dedicated contact person for PC provider organizations, to assist them with administrative issues and the needs of specific members	**100%**
At least once a year train plan staff such as care managers on palliative care and the features of the plan's palliative care program	**93%**
Have **provider-facing** materials that describe palliative care and the plan's palliative care benefit	**85%**
Palliative care program is described on the plan website separate and distinct from any descriptions of our hospice benefit	**85%**
Regularly report to plan leadership on the palliative care program	**79%**
Regularly monitor the number of referrals and enrollments	**79%**
Have **member-facing** materials that describe palliative care and the plan's palliative care benefit	**77%**
Have a health plan clinical champion for the palliative care program	**77%**
Have a standardized process for assessing the quality of care delivered by PC provider organizations	**77%**

Full survey results at: https://coalitionccc.org/common/Uploaded%20files/PDFs/MCP%20LC%20Resources/Survey%20Findings.pdf

Monitoring Quality



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Monitoring Compliance

Provider Quality Review

Point Allocation: "5" Excellent "4" Very Good "3" Average "2" Less Than Average "1" Poor "0" Requirement Not Included

Business Requirement	Comments	Score	Average Score
Provider 1			
Documented goals of care (advanced directives/POLST)		**0**	0
Symptom assessment (pain, SOB, etc)		**0**	
POA/AOR designation		**0**	
Provider 2			
Documented goals of care (advanced directives/POLST)		**0**	0
Symptom assessment (pain, SOB, etc)		**0**	
POA/AOR designation		**0**	

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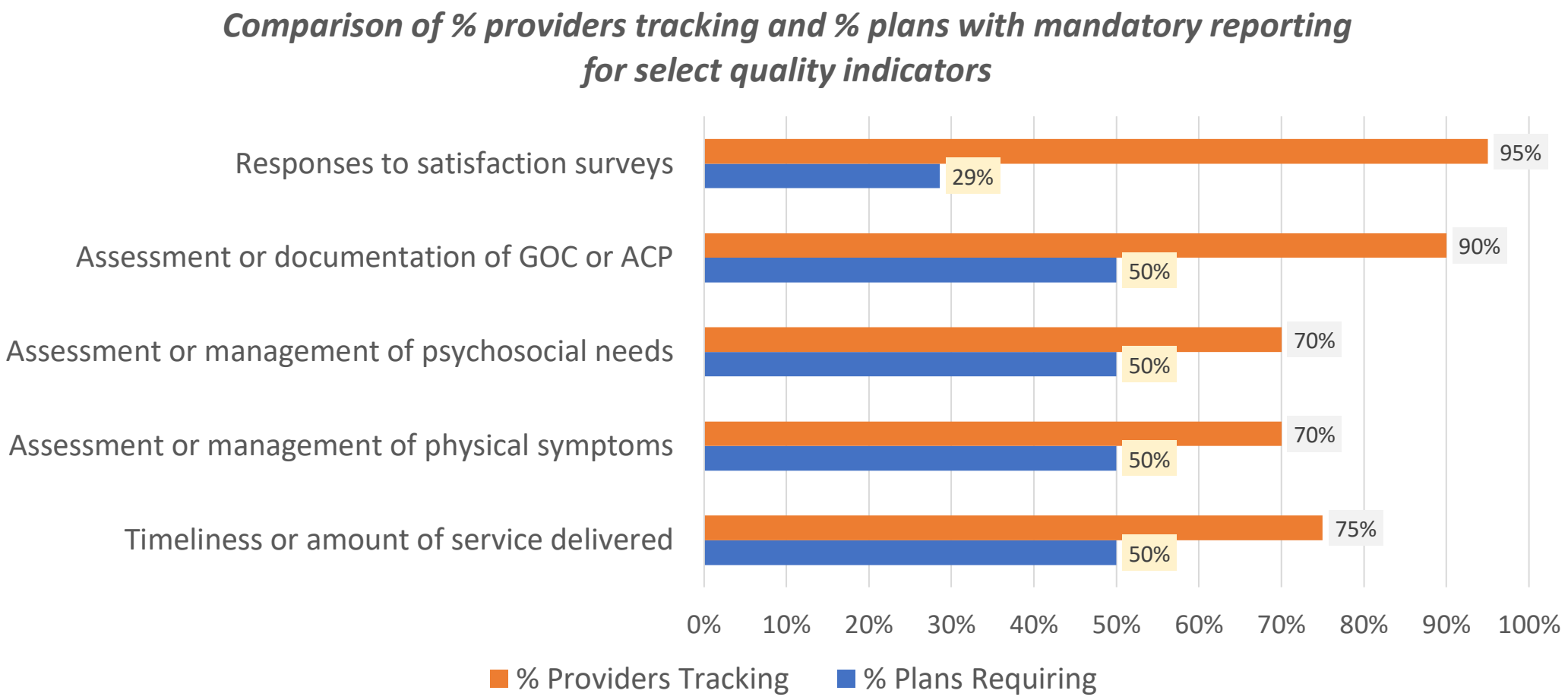
Provider Tracking vs. Mandatory Reporting



Consensus Standards for CBPC in California

A. **Process Measures**

1. Number of patients enrolled in palliative care
2. Duration of patient enrollment
3. Proportion of palliative care patients who transition to hospice
4. Documentation of advance care planning conversation, including Advance Healthcare Directive or POLST, where appropriate. Should documentation not be completed due to patient choice or readiness, the following must be completed:
    a. Documentation of a surrogate decision maker or absence of surrogate decision maker AND notification to the individual that they have been selected as the surrogate decision maker
    b. Documentation of conversations or attempts to discuss advance care planning

B. **Outcome Measures** (if available)

1. Patient satisfaction and family satisfaction
2. Inpatient utilization and ED utilization rates
3. Hospice length of service
4. Total days at home in the last 6 months of life (excludes inpatient days in an acute care facility, an inpatient rehabilitation facility, a skilled nursing facility, or an inpatient hospice unit)

Useful Quality Resources

- CCCC Consensus Standards for CBPC in California
- CAPC Recommended Quality Measures
- National Coalition for Hospice and Palliative Care Recommendations for Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness
- Palliative Care Quality Collaborative

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Key Takeaways

- Consider adopting best-practice structures and processes used by Medi-Cal plans
- Auditing a small number of records can catch compliance issues early
- There are several collections of quality measures to choose from
- Work with providers to minimize data collection and reporting burden, or account for data collection/reporting effort in payment

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Questions?

Please use the Zoom Q & A feature for questions and comments

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James Cotter, MD, MPH
Associate Medical Director
Health Services Department

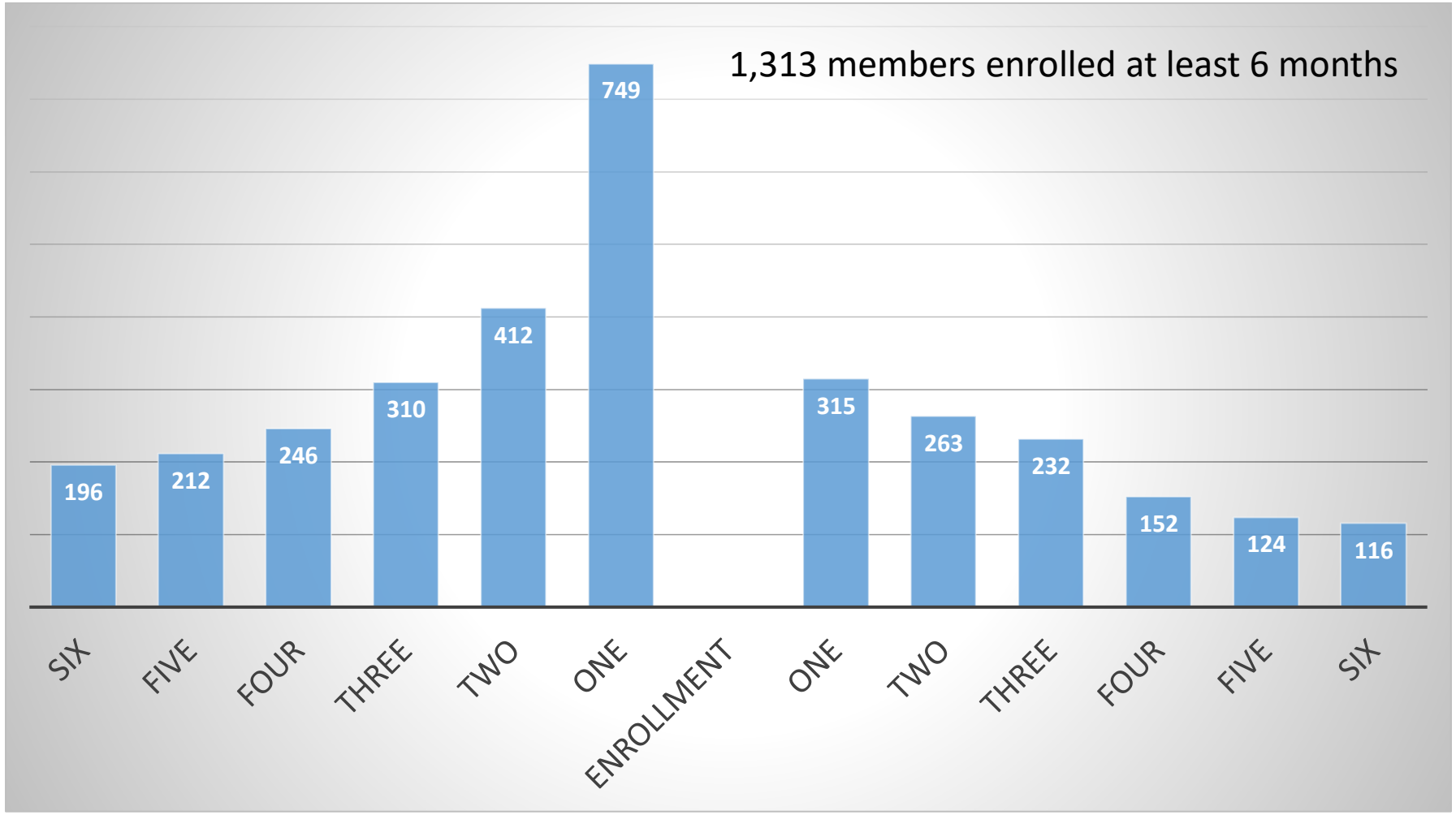
Partnership HealthPlan of California

- County Organized Health System (COHS)
- Non-profit Medi-Cal Managed Care Plan

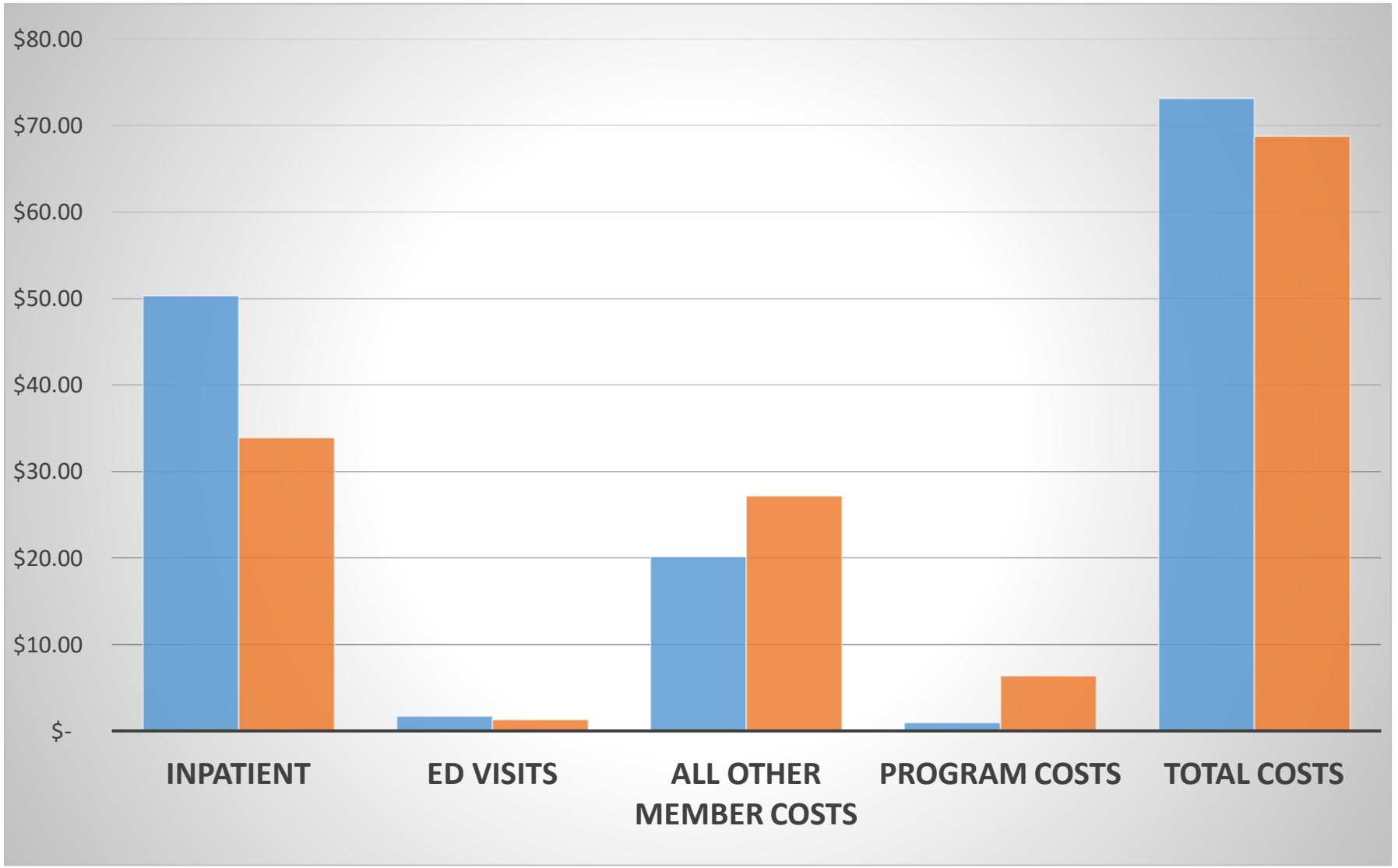
- Fourteen counties in Northern California
- Ten additional counties will be joining in 2024

- Current membership: 650,000

Inpatient Days Before and After Enrollment



Member Costs (in Millions) Before and After Enrollment



Base Payment Model

Per Member Per Month base payment

- TAR is approved for 12 weeks at a time
- Billing code (T2025) covers a two-week period of care
- TAR allows billing for up to six (2 week) periods
- The TAR is reapproved every 12 weeks if the member continues to meet criteria
- Required care for the PMPM payment:
  - RN must see the member once a month virtually or FTF
  - RN must see the member in-person at least once every 12 weeks
  - SW must see the member once a month virtually or FTF
  - Two visits must be documented in PCQC each month

Incentive Payments

Inpatient Care and Emergency Department visits

- Each member enrolled in the program for each month
- No inpatient admissions and no emergency department visits
- Paid every 6 months

POLST Completion and PCQC documentation

- Each member enrolled in the program for each month
- POLST completion documented in PCQC
- At least two patient encounters per month documented in PCQC
- Paid every 6 months

Quality

Palliative Care Quality Collaborative

- National database for palliative care quality
- Data Set Elements
  - Demographics: i.e. ethnicity, gender, language, race
  - Reason for referral and referral source
  - Primary diagnosis
  - Location: face to face or virtual
  - Goals of Care and POLST completion
  - Symptoms: pain, dyspnea, etc.
  - Psychosocial and spiritual need screening

Partnering with our Providers

The PHC Palliative Care Team:

- Physician lead
- Quality analyst
- Provider relations representatives

Semi-annual in-person meeting for all providers

Monthly or as needed individual meetings with our palliative care providers

Key Learnings

- PMPM payments minimize billing issues
- Incentive payments align the provider care to the health plan's needs
- Expanded diagnosis list has captured more members in need of palliative care
- Patient list for potentially eligible health plan members has helped sites with enrollments
- National database for quality (PCQC)
  - Allows quality data comparison across the nation
  - Minimizes reporting requirements for palliative care sites

Questions and Discussion

Please use the Zoom Q & A feature for questions and comments

Three Takeaways

- Payment methodology can reward and incent the outcomes you need
  - Bundled/PMPM is the preferred payment model
  - Incentives and bonuses should also be considered
- Leverage MCP lessons learned regarding best practice structures and processes
- Monitor compliance and quality strategically

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Resources

- *Studies of HBPC Economic Outcomes (handout will be posted on CCCC website)*
- Palliative Care in Medicaid Costing Out the Benefit: Actuarial Analysis of Medicaid Experience
- CHCF Essential Elements of Medi-Cal Palliative Care
- CCCC Consensus Standards for CBPC in California
- CAPC Recommended Quality Measures
- National Coalition for Hospice and Palliative Care Recommendations for Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness
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Questions?

- Email questions to loren@transformingcarepartners.com
- We will include responses in the webinar summary or in a future webinar

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Next in Series

- Topics: Promoting Referrals, Enrollments, and Awareness
- Date: Thursday, September 14, 2023, 10-11am PDT

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