Palliative Care for D-SNP Members

Webinar #1: Introduction to palliative care, the DHCS D-SNP palliative care policy, and Medi-Cal plans' experiences with eligibility criteria, palliative care provider organizations, and required services starting in 2024

June 29, 2023

Background

The webinar series, "Palliative Care for D-SNP Members," is aimed at helping D-SNPs implement palliative care programs. The series is sponsored by the Department of Health Care Services (DHCS) and Coalition for Compassionate Care of California (CCCC), with funding from the California Health Care Foundation (CHCF) and technical support from Transforming Care Partners.

The purpose of this document is to summarize key points from the first webinar, which introduced palliative care, the DHCS D-SNP palliative care policy, and Medi-Cal managed care plans' experiences operationalizing a very similar policy. A recording of the webinar and the presentation slides are available on the CCCC website.

The next webinar will be on **August 18, 2023 from 10-11 PST** and will focus on Program Administration, Payment, and Quality Monitoring.

For any questions, please contact Loren Pogir at loren@tranformingcarepartners.com.

Palliative Care Definition

Palliative care (PC) is specialized medical care for people living with a serious illness. PC is focused on providing relief from the symptoms and stress of serious illness, with the goal of improving the quality of life for both the patient and the family.

PC is provided by a specially trained team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and any stage in a serious illness, and it can be provided along with curative treatment. PC is not the same as Hospice Care which is intended for people who are no longer seeking curative treatment.

Palliative care has been shown to improve quality of care, improve patient and family experience, and reduce emergency room visits and hospital stays. Furthermore, according to the 2019 survey sponsored by CHCF, *Help Wanted: Californians' Views and Experiences of Serious Illness and End-of-Life Care*, when palliative care is described, 9 in 10 Californians say they would want this type of care if they had a serious illness.

Please see Louisa's story here to give you glimpse of the members' experience of PC.

D-SNP Policy Requirements

The D-SNP PC requirement is modeled after the Medi-Cal PC Requirement.

- **Minimum** eligible conditions include Cancer, CHF, COPD, and Liver disease, though plans may authorize PC for members with other conditions.

- Members experiencing all the following circumstances may meet the referral criteria for PC:
  1. The member is likely to or has started to use the hospital or emergency department (ED) to manage their late-stage disease.
  2. The member is in a late stage of illness and is not eligible for or declines hospice enrollment.
  3. The member's death within a year would not be unexpected based on clinical status.
  4. The member has received appropriate member-desired medical therapy, or for whom treatment is no longer effective.
  5. The member and, if applicable, the family/member's designated support person agree to both of the following: 1) willing to attempt in-home, residential-based or outpatient disease management as recommended by the MCP Palliative Care team instead of first going to the ED and 2) willing to participate in Advance Care Planning discussions.
  6. A member must also meet disease-specific criteria. For example, Advanced Care disease specific criteria includes any Stage III or IV cancer, locally advanced or metastatic cancer, leukemia, or lymphoma **and one** of the following: 1) Karnofsky Performance Scale (KPS) score < or equal to 70 (KPS=70 Cares for self; unable to carry on normal activity or do active work, or 2) being failed by two lines of standard chemotherapy. See additional disease specific criteria in the policy.

- PC services include the following seven **minimum** services: 1) Advance Care Planning, 2) Palliative Care Assessment and Consultation, 3) Plan of Care, 4) Palliative Care Team, 5) Care Coordination, 6) Pain and Symptom Management, and 7) Mental Health and Medical Social Services.

Lessons Learned from Medi-Cal Plans: 2023 MCP PC Survey

Since the D-SNP PC policy is nearly identical to the Medi-Cal PC policy, which was implemented in 2018, it is useful to consider the experiences of the Medi-Cal managed care plans. Earlier in 2023, 58% of MCPs shared information about their experiences offering Medi-Cal palliative care in a survey administered by CCCC. Some highlights from the survey are presented here.

- **Plans expanded eligible diseases:** Most plans expanded eligibility to include other diseases including renal disease (57%), cerebral vascular accident/stroke (50%), neurodegenerative disease (50%), dementia (36%), and AIDS (36%).

- **Plans expanded services:** Most plans expanded services that PC providers deliver to include spiritual support (85%), home visits during evening/weekend hours (85%), 24/7 phone support (77%),

assistance with caregiver becoming an IHSS provider (50%), identification of the primary caregiver in the medical record (43%) and referral to additional resources for caregivers (36%).

- **Plans contracted with 1-11 providers:** Plans contracted with a median of five PC providers with a range of 1-11; 21% of plans had to increase their network capacity in 2022.
- **Majority of PC providers are independent organizations:** 87% of PC providers are independent organizations and 13% are affiliated with health systems, with a relatively even split between for-profit and non-profit entities.
- **Majority of PC providers offer several clinical services:** Most contracted PC providers offer other clinical services, including hospice (77%), home health (38%), Enhanced Care Management (23%), hospital-home transitions support (13%), and home-based primary care (9%).
- **There is an opportunity to increase certification and training requirements for delivering PC:**
  - 38% of plans require PC provider organizations to be accredited or certified in palliative care by The Joint Commission (TJC) or Community Health Accreditation Partner (CHAP)
  - 57% require that Medical Directors (MD) be board certified, have Hospice MD certifications, or have 200+ hours of PC experience
  - 31% require that PC nurses be certified in PC
  - 8% require that PC social workers or chaplains be certified in PC
  - 15% have standards for PC team training, apart from certification requirements

IEHP Example: My Path Palliative Care

Dr. Mercy Kagoda, Medical Director- Care Management, at Inland Empire Health Plan (IEHP) presented a case study on My Path, the IEHP PC program.

Population Served:

- San Bernardino and Riverside counties
- IEHP lives covered: ~1,6M Total ~33K D-SNP
- My Path Enrolled members: >1K annually

Provider Qualifications:

- Community based palliative care certification – Joint Commission
- IEHP credentialing requirements

Eligibility Criteria:

1. Advanced medical illness with prognosis of 2 years or less
2. Open to in-home resources for advance care planning and assistance with symptom management
3. At risk for using the ER to manage illness
4. Declined or not eligible for hospice
5. Prognosis 2 years or less, non-compliance issues
6. Expanded disease criteria to include neurodegenerative, dementia, End Stage Renal Disease, AIDS, and “other”.

Resources

- Feeling Prepared: Louisa's Story (brief video)
- DHCS palliative care policy guidance
- DHCS D-SNP Palliative Care Fact Sheet
- CHCF Essential Elements of Medi-Cal Palliative Care
- 2023 Medi-Cal palliative plan and provider survey full results
- IEHP My Path program documents
- Help Wanted: Californians' Views and Experiences of Serious Illness and End-of-Life Care

Follow Up Questions from the Webinar

1. Can providers use telehealth in lieu of home-visits?

Yes. From DHCS's perspective, 24/7 coverage includes both telephonic and video visits. There is variation in how MCPs have approached telehealth. Some require home visits by specific disciplines at specific frequencies (e.g., in-person visit at least once per quarter by a physician or Advanced Practice Provider). Per the 2023 MCP PC survey, 71% of MCPs have no specific policies regarding in-person vs. telephonic or video visits and instead rely on PC providers to determine the type of visit needed.

2. What is the intent of this phrase in the policy, "All D-SNPs must have a process to determine the type of palliative care services that are medically necessary or reasonable for eligible members"?

Members who meet eligibility requirements for palliative care will have varying needs and D-SNPs should develop processes to ensure that palliative care services are medically necessary and reasonable. Such processes will ensure that members receive the services they need and prevent delivery of unnecessary services. Medi-Cal managed care plans have addressed this requirement in several ways when operationalizing their palliative care programs. Examples include requiring re-authorization for home-based palliative care services in a specified time frame (every 12 months, for example), specifying that a palliative care provider with prescribing ability conduct a home visit every three months for members enrolled in home-based palliative care, or using service tiers based on medical or social criteria to determine the required frequency of visits by different disciplines (physician, registered nurse, social worker, etc.) that comprise a home-based palliative care team. DHCS leaves it to each D-SNP to develop policies that align with this requirement