

Palliative Care for D-SNP Members

*Webinar #2: Issues related to payment model, program administration and quality monitoring
August 18, 2023*

Background

The webinar series, “Palliative Care for D-SNP Members,” is aimed at helping D-SNPs implement palliative care (PC) 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 second webinar in the series, which reviewed issues related to payment model, program administration and quality monitoring for a palliative care program, highlighting Medi-Cal managed care plans’ (MCP) experiences gleaned from operationalizing a very similar palliative care policy. A recording of the webinar and the presentation slides are available on the [CCCC website](#).

The next webinar will be on **September 14th** from **10-11am PDT** and will focus on Promoting Referrals, Enrollments and Awareness, with an emphasis on addressing the needs of a diverse member population.

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

Payment Model Elements

Dr. Tom von Sternberg, Medical Director for SNP, Medicare, and Care Management at HealthPartners, began by reviewing studies of economic outcomes for home-based palliative care. The presented studies, which included one randomized controlled trial and seven well-designed observational studies, found cost reductions ranging from 20-65%, compared to usual care. A summary of the key elements and findings of these studies is available on the [CCCC website](#).

Dr. von Sternberg also pointed to an actuarial analysis of a palliative care benefit for Medicaid beneficiaries available on the [National Academy for State Health Policy website](#). This analysis found cost avoidance savings between \$231 and \$1,165 per Medicaid member per month, with potential return on investment between \$0.80 and \$2.60 for every \$1 spent on palliative care.

In comparing bundled payments to fee-for-service (FFS), Dr. von Sternberg noted that bundled payments are the preferred method, as they recognize the contributions and costs of each team member and cover the cost of delivering essential services outside of face-to-face interactions with members. In designing a bundled payment model for palliative care, plans will need to consider the duration of the episode of care, length of authorization, whether to use tiering that provides higher

compensation for higher complexity members, and the amount of the per-enrolled-member-per-month (PMPM) payment. Plans will also want to consider using incentives, which could be based on emergency department (ED) visits or hospitalizations, completion of advance care planning documents, submission of data to [Palliative Care Quality Collaborative](#) (PCQC) - a national palliative care registry, or similar activities or outcomes. There is wide variation among the MCPs in most approaches to payment model, though it is notable that 67% use bundled payments. Plans will also need to determine if they will use the Medicare or Medicaid platform when paying for palliative care.

Several features of the care model used for palliative care will ensure that the benefit will have a positive impact on clinical, member experience and economic outcomes. These essential elements include use of an appropriately trained interdisciplinary team, care planning that is customized to member and family needs, visit frequency and communication cadence adequate to meet member needs, and 24/7 capabilities to address changes in member status or needs.

Plan Structures and Processes

Kathleen Kerr of Transforming Care Partners reviewed some key administrative issues, noting that in the five years since the Medi-Cal palliative care policy was implemented MCPs have learned much about the structures and processes needed to effectively administer a PC program. Many of these lessons have been captured in a free resource, [Essential Elements of Medi-Cal Palliative Care Services](#), available on the CHCF website. Section “C” of this resource describes administrative and operational issues that D-SNPs will want to attend to when designing their palliative care programs. Responses to the [2023 survey of MCPs](#) showed that most MCPs have implemented many of the “best practice” structures and processes described in the Essential Elements toolkit.

MCP Adoption of Best Practice Structures and Processes

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

Quality Monitoring

Ms. Kerr reviewed issues related to monitoring the quality of the PC program. Monitoring would need to address compliance with the requirements of the plan's PC program (such as adherence to documentation requirements), as well as assessing key processes and outcomes for palliative care (such as regular assessments of physical symptoms.) The DHCS policy guidance does not recommend approaches to quality monitoring specific to palliative care.

For assessing compliance, some MCPs elect to use an audit process, where a random sample of records from each contracted provider are assessed for adequacy of documentation and care plans, evidence that the minimum required number of visits occurred, and similar items. There is no dominant approach for compliance monitoring among the MCPs, though there are lessons related to the risks of not doing this work.

There is no universally adopted or endorsed set of quality indicators for palliative care, though the Center to Advance Palliative Care has assembled a set of [recommended measures for use by health plans](#). CCCC, through the California Advanced Illness Collaborative project, led the development of [consensus standards for community-based palliative care](#), which include recommended measures.

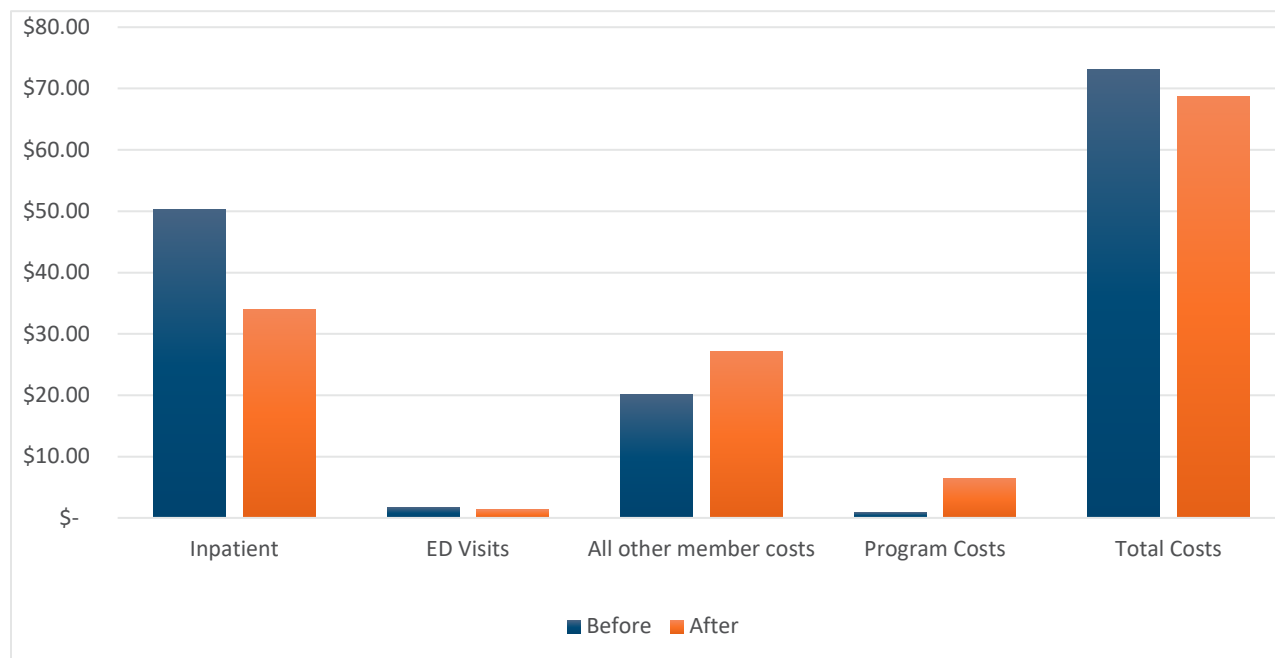
In addition to considering measures endorsed by state and national organizations, D-SNPs should discuss quality measurement with contracted palliative care providers. Survey results have shown that most palliative care providers are collecting quite a bit of information about their processes and some outcomes. Plans should consider incorporating measures that PC providers are already monitoring into the plan's quality assessment program, as doing so will help to manage the data collection and reporting burden for providers.

Case Study: Partnership HealthPlan of California

Dr. James Cotter, Associate Medical Director, Health Services Department, Partnership HealthPlan of California (PHC), shared information about the PHC palliative care program. Currently PHC has about 650,000 members and enrolls more than 1,000 individuals in palliative care each year. The PHC program is supported by a physician lead, a quality analyst, and provider relations representatives. They hold semi-annual meetings for all contracted PC providers to support sharing of best practices and to support quality improvement.

PHC has determined that the PC program is cost-effective and sustainable. On-going monitoring has shown that among members who are enrolled in PC for 6 or more months there is a notable and persistent reduction in inpatient days and costs, and an increase in costs and use of home-based and ambulatory services. Overall, total costs are lower for the 6 months following PC enrollment, compared to the six months before enrollment. Cost analysis includes the cost of delivering palliative care and the cost of administering the PC program.

Member Costs (in Millions) Before and After PC Enrollment*



*PHC analysis of costs before and after enrollment in PC; 1,313 members enrolled in PC for at least 6 months

PHC uses a PMPM model and incentives associated with ED visits and inpatient care, POLST completion, and submission of data to PCQC. They use data submitted to PCQC as the core of their quality monitoring program, assessing demographic characteristics of enrollees (to assess equity), reasons for referral and referral source, distribution of services delivered face-to-face or virtually, goals of care and POLST completion, assessment and impact on physical symptoms, and screening for psychosocial and spiritual supports.

Resources

- [Studies of HBPC Economic Outcomes](#)
- [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](#)
- [Palliative Care Quality Collaborative](#)