California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Variables that impact the cost of delivering SB 1004 palliative care services

Kathleen Kerr, BA
Kerr Healthcare Analytics
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SB 1004 Palliative Care

SB 1004 (Hernandez, Chapter 574, Statutes of 2014) requires the Department of Health Care Services (DHCS) to "establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services"

Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Palliative care may be provided concurrently with curative care and does not require the beneficiary to have a life expectancy of six months or less.

Policy documents, contact information for DHCS available at SB1004 web site:

http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Revised implementation date: January 1, 2018

Information in this webinar reflects content of May 2017 draft APL

Building blocks for implementing community-based palliative care

Estimating member/patient need

Estimating costs for delivering services

Evaluating current capacity for palliative care

Developing a strategy to expand services

Gauging and promoting sustainability and success

Webinar slides and a recording will be distributed early next week

Achieving balance

Scope of services / cost of delivery ⟺ **Payment amount** ⟺ **Outcomes that justify investment**

Topic #2 webinar objectives

- Review SB 1004 required services
- Appreciate service model and contract features that influence the cost of delivering care (for providers)
  - Variables related to patient care
  - Operational/administrative variables
- Consider strategies to promote alignment between payment and costs
- Consider issues that contribute to the quality of (new) payer-provider relationships
- Describe workshops that follow webinar

SB 1004 population

General and disease specific criteria

- Qualifying diagnoses: COPD, advanced cancer, heart failure and advanced liver disease
- Evidence of advanced disease
- Patient and caregiver / family preferences

See draft APL and DHCS web site for most recent policy documents
http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Eight required services

1. Advance Care Planning
2. PC Assessment & Consultation
3. Plan of Care
4. PC Team
5. Care Coordination
6. Pain and symptom management
7. Mental Health and Medical Social Services
8. Chaplain Services

- (24/7 telephonic support)

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Advance care planning

Advance care planning for beneficiaries enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment forms.

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PC Assessment and consultation

The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:

- Treatment plans, including palliative care and curative care
- Pain and medicine side effects
- Emotional and social challenges
- Spiritual concerns
- Patient goals
- Advance directives, including POLST forms
- Legally recognized decision maker

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Plan of care

A plan of care should be developed with the engagement of the beneficiary and/or his or her representative(s) in its design. If a beneficiary already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A beneficiary's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.

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PC team

The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of beneficiaries and their families and are able to assist in identifying sources of pain and discomfort of the beneficiary. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team includes, but is not limited to, a doctor of medicine or osteopathy (Primary Care Provider if MD or DO), a registered nurse, licensed vocational nurse or nurse practitioner (Primary Care Provider if NP), a social worker, and a chaplain.

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Care coordination

A member of the palliative care team should provide coordination of care, ensure continuous assessment of the beneficiary's needs, and implement the plan of care.

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Pain and symptom management

Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address beneficiary pain and other symptoms. <u>The beneficiary's plan of care must include all services authorized for pain and symptom management</u>.

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Mental health and medical social services

Counseling and social services must be available to the beneficiary to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate.

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Chaplain services

DHCS recommends that MCPs provide access to chaplain services as part of the palliative care team.

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Settings and providers

MCPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings.

MCPs must utilize qualified providers for palliative care based on the setting and needs of a beneficiary so long as the MCP ensures that its providers comply with existing Medi- Cal contracts and/or APLs. DHCS recommends that MCPs use providers with current palliative care training and/or certification to conduct palliative care consultations or assessments.

MCPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care.

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The “what” is specified, the “how” is not

- Staffing model
- Frequency / types of encounters
- Process for verifying eligibility
- Documentation and communication requirements
- Billing processes
- Authorization processes

Specific services, several possible providers

Required Service	Possible providers
Advance Care Planning	Could be done by MD/DO, NP/PA, nurse, social worker, chaplain or trained lay person
Palliative Care Assessment and Consultation	Could be done by nurse/social worker team, or might require input from physician, nurse, social worker and chaplain
Care Coordination	Could be MD/DO, NP/PA, nurse, or social worker; could be facilitated by case manager employed by health plan

Variables that drive costs

Cost components

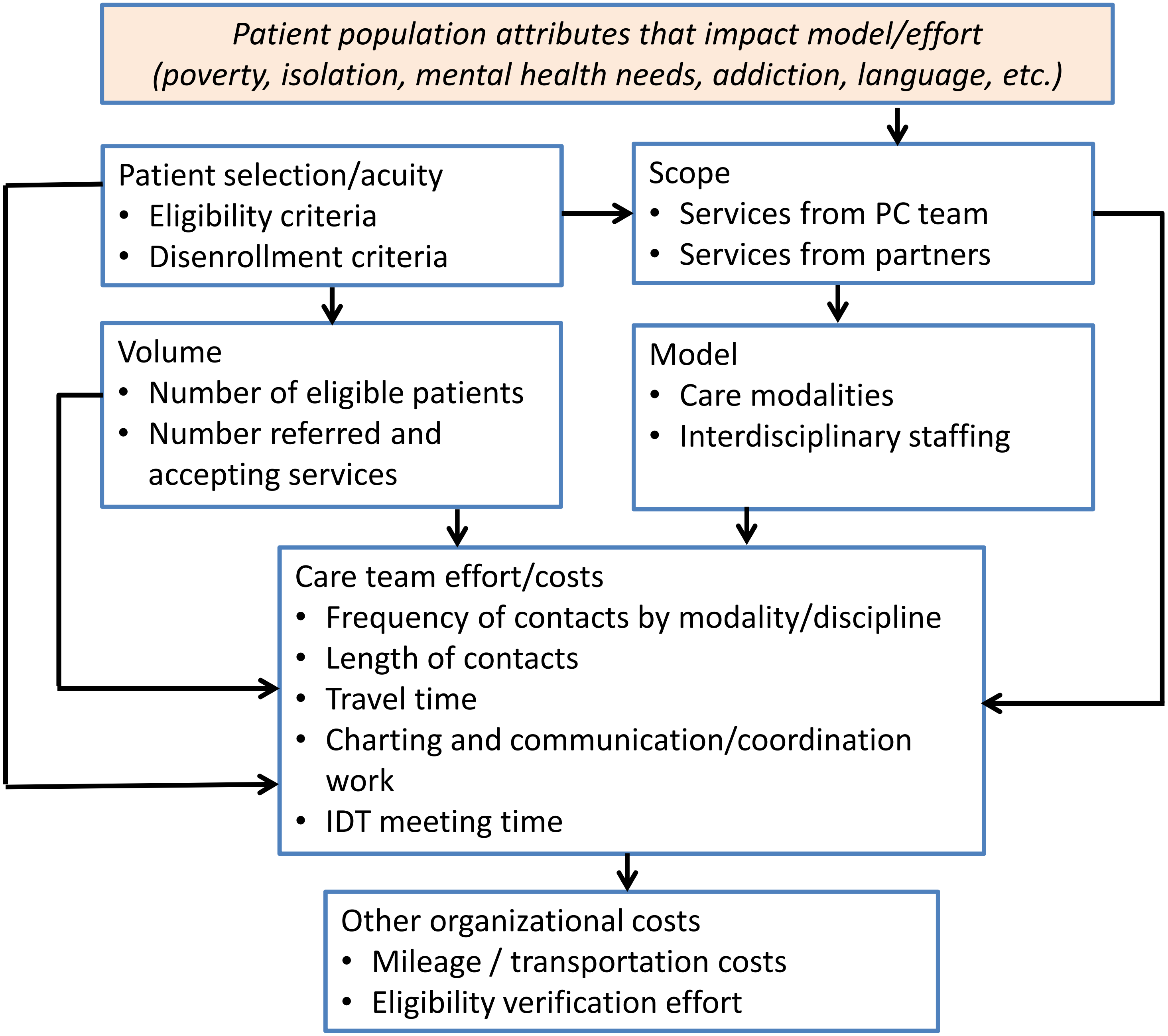
- Direct care effort
- Operational costs
- Indirect costs

Cost drivers

- PC population and care environment
- Provider organization characteristics and resources
- Payer policies, preferences and resources

Some cost drivers are fixed and some reflect choices
(issues that can be negotiated between the payer and provider)

Interdependency of variables that contribute to direct care costs



Patient population attributes that impact model/effort
(poverty, isolation, mental health needs, addiction, language, etc.)

Patient selection/acuity
- Eligibility criteria
- Disenrollment criteria

Scope
- Services from PC team
- Services from partners

Volume
- Number of eligible patients
- Number referred and accepting services

Model
- Care modalities
- Interdisciplinary staffing

Care team effort/costs
- Frequency of contacts by modality/discipline
- Length of contacts
- Travel time
- Charting and communication/coordination work
- IDT meeting time

Other organizational costs
- Mileage / transportation costs
- Eligibility verification effort

Know your costs, and which are modifiable

Working within the parameters of SB1004 policy and APL …

- Account for time / resources required to deliver direct patient care, as well as operational factors that will generate effort/costs
- Which costs are fixed?
- What choices are available to your payer-provider partnership to increase efficiency / reduce resource burden while maintaining quality?

Drivers and decision points

Population
- Need for interpreter services, and which type of services used

Scope
- Which services the PC team will provide
- Expected collaboration with other organizations, including the health plan

Model
- Disciplines on the team
- Frequency of providing different types of services, by discipline, by modality / setting (clinic/office, vs patient home, vs telephone/video)
- Strategy for ensuring 24/7 access (triage service, leverage hospice staff, pay staff call), if you will provide this

Care team communication effort
- Frequency of IDT and other internal provider organization meetings
- Presence/frequency of meetings with external organizations (participate in clinic rounds, health plan case management meetings, etc.)

Drivers and decision points

Operational factors

- Effort required to screen, enroll and dis-enroll patients
  - DC criteria impact need for on-going authorizations and probability of some enrolled patients experiencing periods of stability
  - Lots of screened patients who are ineligible = lots of uncompensated effort for provider organization
- Strategies for promoting referrals (impacts expected number patients referred, case finding effort by PC org)
- Strategies used to orient/engage patients and families to the PC service
- Effort required to gather and submit data needed for payer case review/on-going authorization for services/severity rating
- Effort required to secure authorizations for DME, medication re-fills etc. (single point of contact in plan, or chasing PCP to get permission?)
- Metrics required to report to plan and proportion that are not simple extractions from EHR
- Process for submitting claims; provider and payer billing infrastructure

Variables – implications - options

Patient or program characteristic	What this may mean for your services and costs	Options
Target population is complex: mental health issues, poverty, substance abuse, linguistic diversity, etc.	• Frequent visits • Intense case management • Broad set of services required • Team needs behavioral health training	• Collaborate with other organizations that have separate funding streams • Negotiate with payer to provide case management support • Hire bilingual staff to reduce need for interpreter services

Variables – implications - options

Patient or program characteristic	What this may mean for your services and costs	Options
Considerable effort required to secure authorizations for DME, prescription approvals, refills, etc.	• Ties up clinical staff on the phone	• Negotiate exception to some rules while patients are enrolled in PC • Identify single point of contact at plan or within medical group to handle such requests

Start-up / ramp-up costs

- Gap between revenues and salary costs while building referral base
- Developing (new) workflows, developing data collection strategies
- Training new staff in palliative care

Learning from others

- California Health Care Foundation Payer-Provider Partnership initiative
- 6 teams of payer and provider organizations
- Providers: large academic medical centers, hospices, and a specialty palliative care practice
- Payers: national insurers, regional insurers, a Medicaid managed care plan
- 6 month planning process, yielding operational and financial plans for delivering CBPC
- 24 month implementation phase, where contracts were executed and clinical services were delivered

Payers and providers who participated in the initiative identified lessons learned from developing and enacting an agreement to deliver CBPC.

Three lesson areas

1. Initial engagement
2. Promoting appropriate referrals
3. Relationship issues

Initial engagement

- Take the time (meet in person)
- Make sure there is a common understanding of ….
  - What palliative care is
  - Goals / what hoping to achieve
  - What success looks like
  - Each organization’s priorities and pressures

Promoting appropriate referrals

- Data mining vs provider referrals vs hybrid
- Creating and maintaining referring provider relationships

Relationship issues

- REALLY important (don’t be the last to know)
- Aim for building trust and being flexible, not us vs. them
- Listening and transparency are valued highly
- Collaborative problem solving is valued highly

Key points

- APL specifies population, services, providers
- The (minimum) “what” is fixed; the “how” is up to you
- Costs will be driven by the population and care environment, provider resources/characteristics, and payer policies / preferences / resources
- Some cost drivers are fixed, but many are flexible; contract terms will reflect negotiated choices
- Know your costs and cost drivers and experiment with different choices if there is a gap between your expected effort / costs and payment offered
- Develop and nurture your payer-provider relationships

Topic #2 Workshops

Content and approach

- More in-depth exploration of issues presented in webinar, case studies, worksheets
- Participatory with opportunities to share strategies and experiences; planning with colleagues

Who should attend

- Individuals from provider organizations (teams of 1-4 people) with knowledge of administrative/fiscal operations, the needs of the target palliative care population, and the current or proposed care model, as well as individuals from payer organizations with an interest in the topic

Offerings (registration **open through noon Sep 29)**

- Southern California on October 4 and 5
- Northern California on October 25 and 27

If you want to register for a workshop please contact Glenda Pacha by noon Friday, September 29 at gpacha@chcf.org

Acknowledgements, and your questions

Thanks to colleagues who shared their knowledge, wisdom and experiences

- Anne Kinderman, MD, Zuckerberg San Francisco General
- J Brian Cassel, PhD and the team working on the CAPC Accelerator initiative
- The payers and providers and project staff that participated in the CHCF Payer-Provider initiative

Questions about the SB1004 Technical assistance series?

- Glenda Pacha gpacha@chcf.org
- www.chcf.org/sb1004

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