California
Health Care
Foundation

SB 1004 Technical Assistance Series
Overview of Topic 2: Variables That Impact Cost of Care Delivery

ABOUT THE TECHNICAL ASSISTANCE SERIES

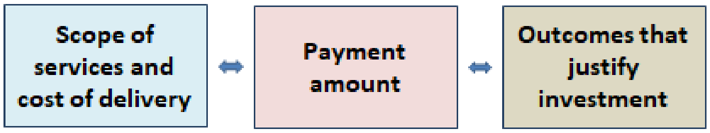
SB 1004, the California law that requires Medi-Cal Managed Care Plans (MCPs) to provide access to palliative care, is slated for implementation in January 2018. As part of CHCF's ongoing efforts to help health plans and providers prepare for and navigate its implementation, the foundation is offering a yearlong series of technical assistance activities related to the law. Series content focuses on topics that are central to creating and sustaining palliative care programs and is offered through webinars, in-person workshops, and documents that can be downloaded from CHCF’s website.

The material covered in “Topic 2: Variables that Impact Cost of Care Delivery” was presented in a webinar and in several workshops offered during September and October 2017. A recording of the webinar and accompanying slides is available on this topic page.

TOPIC 2: VARIABLES THAT IMPACT COST OF CARE DELIVERY

To build sustainable palliative care programs, payers and providers need to achieve alignment across three variables: the scope of services being offered and the cost of delivering that care; the amount of payment available to providers to cover those costs; and the quality and usage outcomes that payers need to achieve in order to justify investment in palliative care.

Achieving Alignment



For SB 1004, computing care delivery costs requires an understanding of the specific types of palliative care services that plans need to make available to eligible patients, as well as the various clinical models that could be used to deliver those services. Both plans and providers need to appreciate the service model and contract features that influence care delivery costs.

While some cost drivers are fixed, some reflect choices made by the payer and/or provider and thus may be modifiable. Recognizing these “decision points” and being open to choices that might reduce the cost of delivering care is an important strategy for aligning the cost of care delivery with the amount of available payment. Because payer-provider partnerships for delivering palliative care are still relatively rare, some lessons learned by early adopters are included in this set of materials, with an eye to recognizing practices that support successful partnerships.

SB 1004 REQUIRED SERVICES, PROVIDERS, AND SETTINGS

SB 1004 requires making a specific type of palliative care available to a specific patient population. Eligibility criteria and detailed descriptions of required services are included in the All Plan Letter (APL) that has been distributed to all Medi-Cal MCPs by the Department of Health Care Services (DHCS). In brief, required services include:

Advance Care Planning (ACP): Discussions between a physician or other qualified health care professional and a patient, family member, or surrogate that focus on advance directives, including Physician's Orders for Life Sustaining Treatment (POLST) forms.

Palliative Care 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. Topics may include treatment plans (including palliative care and curative care), pain and medicine side effects, emotional and social challenges, spiritual concerns, patient goals, and advance directives.

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 ACP discussion.

Palliative Care 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. The team is able to assist in identifying sources of the beneficiary's pain and discomfort. DHCS recommends that the palliative care team include, but not be limited to, a doctor of medicine or osteopathy, a registered nurse and/or nurse practitioner, a social worker, and a chaplain.

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.

Pain and Symptom Management: Prescription drugs, physical therapy, and other medically necessary services may be needed to address beneficiary pain and other symptoms. The beneficiary's plan of care must include all services authorized for pain and symptom management.

Mental Health and Medical Social Services: Counseling 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 must include, among other things, psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate.

In addition, DHCS recommends—but does not require—that plans provide access to chaplain services as part of the palliative care team. Further, DHCS notes that plans may authorize additional palliative care that is not described above, at the plan's discretion. An example of an additional service that is offered by many community-based palliative care programs is a telephonic palliative care support line, separate from a routine advice line, which is available 24 hours a day, seven days a week.

The APL notes that palliative care can be provided in a variety of settings, including inpatient, outpatient, or community-based spaces. Plans are directed to use qualified providers for palliative care based on the setting and needs of the beneficiary, with a recommendation for using providers with current palliative care training and/or certification to conduct palliative care consultations or assessments. Plans 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.

SERVICE MODEL AND CONTRACT FEATURES THAT INFLUENCE CARE DELIVERY COSTS

While the APL specifies eligibility criteria and required services, it does not offer direction on how those services are to be delivered. Most aspects of care delivery (such as the staffing model and the frequency and types of contacts with patients) as well as many administrative details (such as processes for identifying patients, verifying eligibility, and authorizing services) will be negotiated by the payer-provider partnership. Both payers and providers need to understand how these processes might impact the cost of care delivery.

A reference developed for this Topic, **23 Factors That Impact Cost of Care Delivery**, describes variables that payers and providers should be aware of as they design palliative care services and consider the expected cost of care delivery. A selection of these factors is presented here.

> **Population:** The SB 1004 target population is complex and providers can expect to see relatively high prevalence of mental health issues, poverty, substance use disorder, linguistic diversity, patients presenting with late stage disease, food and/or housing insecurity, etc. Care costs will be influenced by the extent to which these issues are prevalent in the eligible patient population, and the choices payers and providers make for meeting these complex needs.
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> **Scope of services:** Some plans may elect to provide services beyond the minimum required by the APL, and this will impact care costs. Further, it is quite common for multiple organizations to collaborate to meet the complex needs of palliative care patients, and such collaborations may impact care delivery costs. For example, if nurses employed by the health plan provide case management support to palliative care patients, the palliative care provider organization should spend less time on care coordination tasks, which would lower the provider organization’s costs.
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> **Care model:** Cost of care will be dramatically impacted by care model – that is, the frequency with which different types of services are provided, which team members provide those services (physician, nurse, social worker etc.) and where and how services are offered (clinic or office versus patient home, versus telephone/video).

Methods used to screen patients for eligibility: Provider organizations may be required to invest significant time in gaining access to and reviewing medical records if responsibility for determining patient eligibility for palliative care is not shared by the payer partner.

Care team communication effort: Cross-disciplinary communication is key to providing quality palliative care, promoting team unity, and preventing staff burnout, but may require considerable time investments. Similarly, requiring field staff to participate in frequent organizational meetings can reduce time available for patient contacts, especially if providers are required to travel to a specific meeting site (versus joining via phone or video).

Reporting requirements: Provider organizations may be required to invest a great deal of time in collecting and collating data required by a payer partner. Such requirements can be especially burdensome if the requested metrics cannot be generated with data that are already housed in an electronic health record.

STRATEGIES TO PROMOTE ALIGNMENT BETWEEN PAYMENT AND COSTS

The cost of delivering palliative care is determined by many factors. Some factors, such as characteristics of the patient population or region, cannot be modified – you just need to account for these when designing the palliative care service and estimating costs. Other factors are modifiable and reflect policies, preferences, or practices of the payer and/or provider.

For example, neither the payer nor the provider can alter the fact that care is being delivered in a rural area; there is no way to shorten the physical distance, which could result in significant costs related to travel time for a home-based palliative care service, between patients' homes. To reduce costs, the provider may propose a service delivery model that features video visits, which reduce travel time and lower the cost of care delivery in a rural area. The rurality of the region is a fixed factor, but the choices about which types of contacts are allowable in the contract are adjustable.

Together, payers and providers can consider the extent to which their policies, preferences, and practices could be modified to bridge gaps between the estimated cost of providing care and the amount of payment being offered.

Payers and providers can use the **Decision Points Worksheet** to explore circumstances that impact care delivery costs and options for addressing those circumstances in ways that might improve efficiency and reduce costs.

PRACTICES THAT PROMOTE SUCCESSFUL PAYER-PROVIDER PARTNERSHIPS

Many studies have shown that patients who receive palliative care experience better quality of life and live longer with fewer symptoms of illness. Payers and providers are recognizing this value and collaborating on new ways to deliver and pay for community-based palliative care.

To promote and support these collaborations, CHCF provided planning grants to pairs of payers and providers engaged in developing operational and financial plans for delivering palliative care services in their community. These grants resulted in service proposals, including details of eligibility criteria, reimbursement, delivery mechanisms, and other considerations. In September 2015, two-year implementation grants were made to six partnerships.

Payers and providers who participated in the initiative identified lessons learned from developing and enacting an agreement to deliver community-based palliative care, a few of which are presented here.

1. Initial engagement: Invest in the beginning

   Take the time to get to know the potential partner organization. To the extent possible, meet in person rather than relying on phone and email. Use this time to make sure partners have a mutual understanding of:
   - What palliative care is
   - Goals or what they hope to achieve
   - What success looks like
   - Each organization’s priorities and pressures

   As part of the orientation process, expect to both gather and offer information.

Information providers might gather from a payer	Information payers might gather from a provider
• Size and geographic footprint of payer partner • Number of patients likely eligible for SB 1004 palliative care (PC) • Expectations of service levels, number of visits, etc. • Infrastructure and resources the health plan (case managers, data systems, staff to support ancillary service authorizations, etc.) might dedicate to support the PC service	• Geographic catchment area • Referral relationships with other network providers • Experience delivering PC • Care model the organization has used (e.g., nurse-led, physician-led, team members, case management, telehealth) • Capacity to take on new patients

2. Identifying patients and promoting appropriate referrals

   There is no one right way to manage these critical processes. Common strategies include identifying patients by mining claims data, relying on referring (primary care or specialty) providers to identify and refer potentially eligible patients, and a hybrid approach that uses both lists generated by claims data and referring provider input. Most organizations endorse the hybrid approach as being the most effective.

3. Service / operational issues

Some contracts have relatively fixed service delivery requirements; two home visits by a registered nurse each month, for example. Other contracts do not include mandatory minimums, and instead allow the provider organization to adjust the number of visits and engaged disciplines according to their perceptions of patient need. There are pros and cons (and the potential for unintended consequences) to both approaches. To achieve a mutually satisfactory compromise, the partners often need to discuss this topic on an ongoing basis.

4. Relationship issues

- Relationships between organizations were deemed to be **really important**. Participants endorsed the importance of nurturing relationships over time and creating open lines of communication.
- Aim for building trust and being flexible, and avoid any hint of “us vs. them” attitudes.
- Listening and transparency are highly valued.
- Collaborative problem solving is highly valued.

5. General advice

- Setting up a new service may cost more and take a lot longer than expected.
- The number of eligible patients and the number of actual referrals might not match up. It is not uncommon for actual referrals to lag behind known need, especially in the Medi-Cal population.
- Even small volumes need full infrastructure; providers report that it takes some time to achieve break-even (the point where revenues offset costs completely). Start-up support from payer partners is often needed.
- From the provider perspective, more than one payer partner is (probably) better, as the additional volume helps provider organizations achieve break-even more rapidly. That being said, if each payer has distinct expectations about service model, frequency of visits, reporting requirements authorization practices, etc., then the added complexity can be quite burdensome for the provider organization.

ADDITIONAL RESOURCES AVAILABLE ON THIS TOPIC PAGE

- Slides used in the Topic 2 Workshops
- 23 Factors That Impact Cost of Care Delivery
- Decision Points Worksheet