



California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Topic 3: Services, Costs, Payment

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Review: What Is SB 1004?

- [Senate Bill 1004](#) (2014) requires Medi-Cal managed care plans (MCPs) to ensure access to palliative care services for eligible patients
- Implemented January 1, 2018 for adult patients, expanded to include pediatric patients in 2019
- All Plan Letter (APL) describing plan requirements available at:

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

*For more information about palliative care and SB 1004
see Topic 1 in this series, **SB 1004 Basics***

Objectives

1. Appreciate different clinical and staffing models used to deliver SB 1004 palliative care (PC)
2. Appreciate service model and contract features that influence the cost of delivering SB 1004 PC
 - a) Variables related to patient care
 - b) Operational/administrative variables
3. Consider strategies to promote alignment between costs and payments

Review: SB 1004 Population

General and disease-specific criteria

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

See California Department of Health Care Services (DHCS) website for All-Plan Letter (APL) and most recent policy documents:

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

*For more information about eligibility requirements
see Topic 1 in this series, **SB 1004 Basics***

Seven Required Services

1. Advance Care Planning
2. PC Assessment and Consultation
3. PC Plan of Care
4. Interdisciplinary PC Team
5. Care Coordination
6. Pain and Symptom Management
7. Mental Health and Medical Social Services

Optional: *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 is a telephonic palliative care support line, separate from a routine advice line, which is available 24 hours a day, seven days a week.*

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

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 health care 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 (POLST) forms.

See APL and DHCS web site for most recent policy documents:

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

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 decisionmaker

See APL and DHCS web site for most recent policy documents:

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

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 pain and symptom management and curative care.

See APL and DHCS web site for most recent policy documents:

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

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. They 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 include, but not be limited to, physicians, nurses, social workers, and chaplains.

See APL and DHCS web site for most recent policy documents:

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

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.

See APL and DHCS web site for most recent policy documents:

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

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. The beneficiary's plan of care must include all services authorized for pain and symptom management.

See APL and DHCS web site for most recent policy documents:

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

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.

See APL and DHCS web site for most recent policy documents:

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

Chaplain Services

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

See APL and DHCS web site for most recent policy documents:

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

Settings and Providers

MCPs may authorize palliative care to be provided in a variety of settings, including inpatient, outpatient, or community-based spaces.

MCPs must use 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.

See APL and DHCS web site for most recent policy documents:

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

Variables that Impact the Cost of Care

The “What” Is Specified, The “How” Is Not

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 as well as many administrative processes will be negotiated by the payer-provider partners.

Examples of clinical and administrative topics not covered in the APL, where variation can be expected:

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

Specific Services, Several Possible Providers

While the APL specifies required services, it allows for variation in which team members deliver those services

Required Service	Individuals on PC team who may provide all or part of the service
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

Sample Delivery Model for Home PC

SERVICES	STAFFING	SETTING
Initial assessment	Nurse or Social Worker	Home Preferred
24/7 telephonic support	After-Hours Triage	Phone
Pain/symptom management	Primary Care, Medical Director, NP and Nurse	Home and Phone
Advance care planning	Social Worker	Home Preferred
POLST (when appropriate)	Social Worker	Home Preferred
Acute management plan	Nurse or Social Worker	Home and Phone
Assess caregiver support needs and refer and/or provide support	Nurse, Social Worker, Home Health Aide	Home and Phone
Warm hand-offs from hospital and hospice	Nurse or Social Worker	Community Based
Case management	Social Worker	Home and Phone

Possible Care Delivery Structure

Resource

- Registered Nurse (RN)
- Social Worker /
Community Health Worker
- Spiritual Care
- Volunteer RN
- Intake Team
- After-Hours Call
- Medical Director
- Business Coordinator

Frequency

- Two visits / month / patient
- Two visits / month / patient
- Shared with hospice
- Weekly check-in call / patient
- Shared with hospice
- Outsourced – Per call rate
- Four hours / month / 50 patients
- 10 hours / week / 25 patients

RN Case load = 25

Social Worker / CHW = 40

Providers Can Expect Differences in Payment Structures and Amounts Across Contracts

Payment Methodology for Contract #1

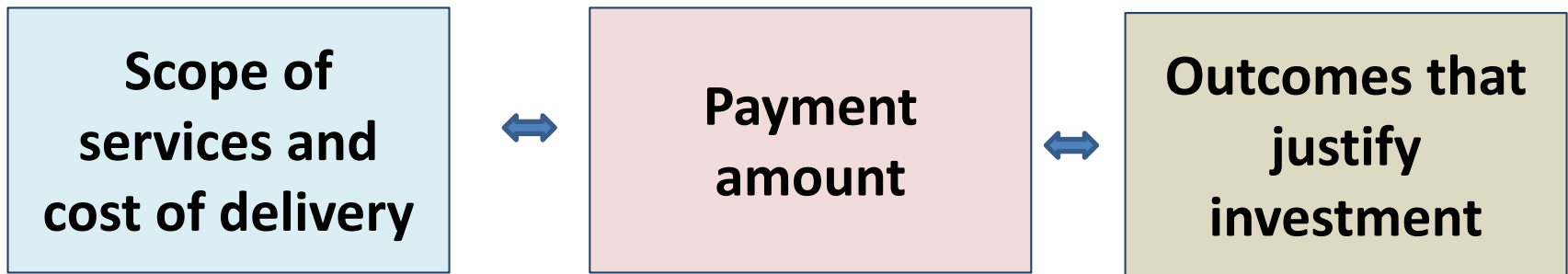
Service	Criteria	Rate
Palliative Care Services Evaluation	One time	100% of CMS
Palliative Care Service	Monthly	\$ xxx

Payment Methodology for Contract #2

Service	Criteria	Rate
Engagement Fee	Up to 7 days of care	\$ xxx
Enrolled Member (home; 2 RN visits/month)	Per Member every 14 days	\$ xxx
Enrolled Member (SNF or LTAC)	Per Member every 14 days	\$ xx
Quality Bonus ACP/POLST	One time	\$ xxx
Quality Bonus (No Hospitalization)	Monthly	\$ xxx

Achieving Balance

To build sustainable palliative care programs, health plans 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 health plans need to achieve in order to justify investment in palliative care.



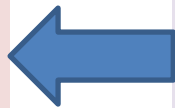
Achieving balance requires an understanding of the cost of delivering the expected set of services, and the fixed and modifiable factors that contribute to care costs.

Variables That Drive Costs

While some cost drivers are fixed, some reflect choices made by the health plan 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.

Cost components

- Direct care effort
- Operational costs
- Indirect costs



Cost drivers

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

The 23 Factors Resource

23 Factors That Impact Cost of Care Delivery, which is available in this section of the SB 1004 Resource Center, describes variables that plans and providers should be aware of as they design palliative care services and consider the expected cost of care delivery. Factors cover seven categories:

- Environment / region
- Population characteristics / eligibility criteria
- Scope of service
- Care model
- Communication / coordination
- Engaging patients / families and referring providers
- Operational effort

A Few Key Variables That Impact Costs

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 with food and/or housing insecurity, etc. Care costs will be influenced by the extent to which these issues and the choices plans and providers make for meeting these complex needs.

A Few Key Variables That Impact Costs

Scope: Some plans may elect to provide services beyond the minimum required by the APL, and this will impact care costs. Further, it is common for multiple organizations to collaborate to meet the complex needs of palliative care patients, and such collaborations may impact care delivery costs, too. 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 such tasks, which would lower the provider organization's costs.

A Few Key Variables That Impact Costs

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).

A Few Key Variables That Impact Costs

Care team communication effort: Cross-disciplinary communication is key to providing quality palliative care, 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).

A Few Key Variables That Impact Costs

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.

Reporting requirements: Provider organizations may be required to invest a great deal of time in collecting and collating data required by a plan, which could drive up care delivery costs.

Drivers and Decision Points

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 – plans and providers will 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 health plan and/or provider.

Recognizing these options or “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.

Eligibility Criteria: Variables – Implications – Options

Variable or circumstance	What this may mean for services and costs	Options
<ul style="list-style-type: none"> Health plan may specify very stringent disenrollment criteria (e.g., as soon as a patient stabilizes) 	<ul style="list-style-type: none"> Frequent assessments to confirm continued eligibility Brief duration of enrollment Confusion among referring providers and patients/families 	<ul style="list-style-type: none"> Consider broader criteria Agree to a minimum number of months for initial enrollment, for patients who do not die or transition to hospice Consider tiered services and payment for stable patients vs. active/unstable patients

Identifying Eligible Patients: Variables – Implications – Options

Variable or circumstance	What this may mean for services and costs	Options
<ul style="list-style-type: none">Health plan is unable to help to identify potential patients	<ul style="list-style-type: none">PC provider will spend considerable time educating referring providers and marketing servicesActual number of referrals may be dramatically lower than number of eligible patients	<ul style="list-style-type: none">Negotiate assistance from health plan in identifying appropriate patientsQuantify effort required to generate and screen referrals; incorporate it into negotiated pricePartner with medical group leadership to promote and incentivize appropriate referrals

Scope: Variables – Implications – Options

Variable or circumstance	What this may mean for services and costs	Options
<ul style="list-style-type: none"> The breadth of required services exceeds the capacity or training of the PC provider organization, but they have formed no collaborative relationships with other organizations 	<ul style="list-style-type: none"> PC team works in isolation from other service providers in community PC team feels responsible for meeting all the needs of their patients PC team tries to do everything, but they are not compensated to do everything 	<ul style="list-style-type: none"> Form collaborative relationships and partnerships with other service providers in the community Set limits for PC team Set reasonable expectations that some other providers will have to address some needs (be specific)

Authorization Processes: Variables – Implications – Options

Variable or circumstance	What this may mean for services and costs	Options
<ul style="list-style-type: none">• Considerable effort required to secure authorizations for DME, prescription approvals, refills, etc.	<ul style="list-style-type: none">• Ties up clinical staff on the phone	<ul style="list-style-type: none">• 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

Mandatory Minimums: Variables – Implications – Options

Variable or circumstance	What this may mean for services and costs	Options
<ul style="list-style-type: none">Health plan mandates frequent visits per patient per month	<ul style="list-style-type: none">High cost per patient per monthSome patients may not make themselves available for visits at predictable intervals, which reduces revenues for provider	<ul style="list-style-type: none">Negotiate other approaches – contacts via phone, other mediaSuggest high-frequency initial phase followed by maintenance phaseCreate process to waive requirement for certain patients

24/7 Access: Variables – Implications – Options

Variable or circumstance	What this may mean for services and costs	Options
<ul style="list-style-type: none">• One or both partners want to ensure patients and families have 24/7 access to palliative care team members	<ul style="list-style-type: none">• Payment may be insufficient to support this service	<ul style="list-style-type: none">• Teach patients/families to recognize when symptoms and distress are starting to escalate, for earlier intervention• Provide 24/7 call only for subset of high-need or high-risk patients, or for limited periods• Leverage existing hospice staff to triage calls

Decision Points Worksheet

- Together, health plans 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.
- Health plans and providers can use the **Decision Points Worksheet**, which is available in this section of the SB 1004 Resource Center, to explore circumstances that impact care delivery costs and options for addressing those circumstances in ways that might improve efficiency and reduce costs.

Key Points

- The APL specifies (minimum) eligibility, services, and providers
- The “what” is fixed; the “how” is up to you
- Costs will be driven by the population and care environment, as well as health plan and provider policies, preferences, and resources
- Some cost drivers are fixed, but many are flexible; contract terms will reflect negotiated choices
- Know the cost of delivering services and the modifiable variables that are contributing to costs, and experiment with different choices if there is a gap between expected effort/costs and available payment

Six Steps to Aligning Costs and Payments

1. Understand the population and environment
2. Identify the palliative (and other) services needed
3. Decide on a clinical model
 - a) Who on the PC provider team will do what, how frequently, and in which settings
 - b) Examine what (if any) services will be delivered by external organizations (not the PC provider organization)
4. Think about effort beyond direct patient contact that will be required to deliver quality care and attend to operational issues
 - a) Processes and activities mandated by the PC provider
 - b) Processes and activities mandated by the health plan
5. Do the math to identify any difference between expected cost of care delivery and expected payment
6. If there is a gap, the plan and PC provider should revisit choices and decisions made in steps three and four

COST DRIVERS

Patient population attributes that impact your service model and effort (poverty, isolation, mental health needs, complexity, etc.)

Patient selection/acuity

- Eligibility criteria (late-stage or less advanced?)
- Disenrollment criteria (probability of stable patients remaining on service)

Volume and duration

- Number of eligible patients in your service area
- Number of patients referred, screened, and enrolled
- Length of time (months) that patients are enrolled

Scope

- Services from your team (goals of care, ACP, symptom management, etc.)
- Services from others (plan, community organizations, medical group)

Service Model

- Care modalities and settings (home, office, phone, video)
- Interdisciplinary staffing

Variable (per patient) care team effort

- Frequency of contacts by modality and discipline
- Length of those contacts
- Travel time
- Charting and communication/coordination work
- IDT meeting time

Variable (per patient) organizational costs

- Travel costs
- Screening, enrollment, and dis-enrollment efforts

Administrative efforts and indirect costs

- Reporting effort
- Care team training costs
- Meetings with others (e.g., sit in on plan's high-utilizer meeting)
- Marketing services to referring providers

COST CALCULATIONS

Calculate direct care costs

Cost per patient per month

Multiplied by average enrollment duration

Cost per patient over the course of their enrollment

Multiplied by number of patients



Direct costs of care per year



Operational costs to implement and administer contract per year



Indirect costs



Annual, per month, and per patient costs of delivering specified services

Example Palliative Care Proforma

Description	Per Patient Per Month	One Time Per Patient	All Patients Annual	All Patients Per Day	Per Patient Per Day
Revenue					
One-Time Engagement Fee		\$ xxx	\$ xxx	\$ xxx	\$ xxx
Patient Bundled Fee	\$ xxx		\$ xxx	\$ xxx	\$ xxx
Quality Bonus (ACP/POLST)		\$ xxx	\$ xxx	\$ xxx	\$ xxx
Qty. Bonus Hospitalization	\$ xxx		\$ xxx	\$ xxx	\$ xxx
Total Revenue	\$ xxx	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Expenses					
RN @ \$xxx/hr. /FTE	\$ xxx		\$ xxx	\$ xxx	\$ xxx
CHW @ \$xxx/hr. / FTE	\$ xxx		\$ xxx	\$ xxx	\$ xxx
SW @ \$xxx/hr. / FTE	\$ xxx		\$ xxx	\$ xxx	\$ xxx
Prgm. Coord. @ \$xxx/hr. /FTE	\$ xxx		\$ xxx	\$ xxx	\$ xxx
Benefit Expense xx%	\$ xxx		\$ xxx	\$ xxx	\$ xxx
Total Staffing	\$ xxx		\$ xxx	\$ xxx	\$ xxx

Example Palliative Care Proforma (continued)

Description	Per Patient Per Month	All Patients Annual	All Patients Per Day	Per Patient Per Day
Other Expenses				
Medical Director	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Mileage (staffing)	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Administrative Costs	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Other Expenses	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Total Other Expenses				
Indirect Costs (Overhead)	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Total Expenses	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Profit / (Loss)	\$ xxx	\$ xxx	\$ xxx	\$ xxx
Profit Margin	\$ xxx	\$ xxx	\$ xxx	\$ xxx

Recommendation #1

Become familiar with SB 1004 required and optional services, providers, and settings.

Useful resource: **All Plan Letter** (available on [DHCS website](#))

1. Advance Care Planning
2. PC Assessment and Consultation
3. Plan of Care
4. PC Team
5. Care Coordination
6. Pain and Symptom Management
7. Mental Health and Medical Social Services
 - Chaplain Services (optional)
 - 24/7 telephonic support (optional)

Recommendation #2

Appreciate service model and contract features that influence the cost of delivering SB 1004 palliative care, including variables related to patient care as well as operational and administrative variables.

Useful Resource: **23 Factors That Impact Care Costs**, which is available in this section of the SB 1004 Resource Center

- Environment / region
- Population characteristics / eligibility criteria
- Scope of service
- Care model
- Communication / coordination
- Engaging patients and families and referring providers
- Operational effort

Recommendation #3

Consider strategies to promote alignment between payment and costs.

Useful Resource: **Decision Points Worksheet**, which is available in this section of the SB 1004 Resource Center

- Consider adjusting administrative and clinical aspects of program that are modifiable (policies, preferences, practices of health plan and provider)

Check Out All of the SB 1004 Resource Center Topics

1. SB 1004 Basics

Includes basic information about SB 1004 requirements, as well as survey data collected from health plans and provider organizations describing early experiences implementing SB 1004

2. Patient Population

Includes a review of eligibility criteria, characteristics of the eligible patient population, and strategies for identifying eligible patients

3. Services, Costs, Payment

Includes a review of required services, staffing models used by PC providers, payment models, variables that impact cost of care delivery, and strategies for increasing efficiency

4. Engaging Patients & Providers

Reviews strategies for engaging patients, strategies for engaging providers who might refer eligible patients, and options for optimizing referral processes

5. Optimizing for Success

Includes a review of the factors that promote success in launching and sustaining PC programs

6. Quality and Impact

Reviews data that health plans report to DHCS, approaches to quality assessment in PC, and tools and resources for plans and providers to support improvement efforts

7. Webinars

Provides an archive of the recorded webinars from CHCF's 2017-18 SB 1004 Technical Assistance Series