



State of SB 1004 Palliative Care: Looking  
Back – Looking Forward  
*Part B: How Care Is Delivered and  
Reflections on Sustainability*

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# Outline

## Structures and Processes

- Eligibility criteria, referral sources, features of health plan programs, payment mechanisms, use of remote care

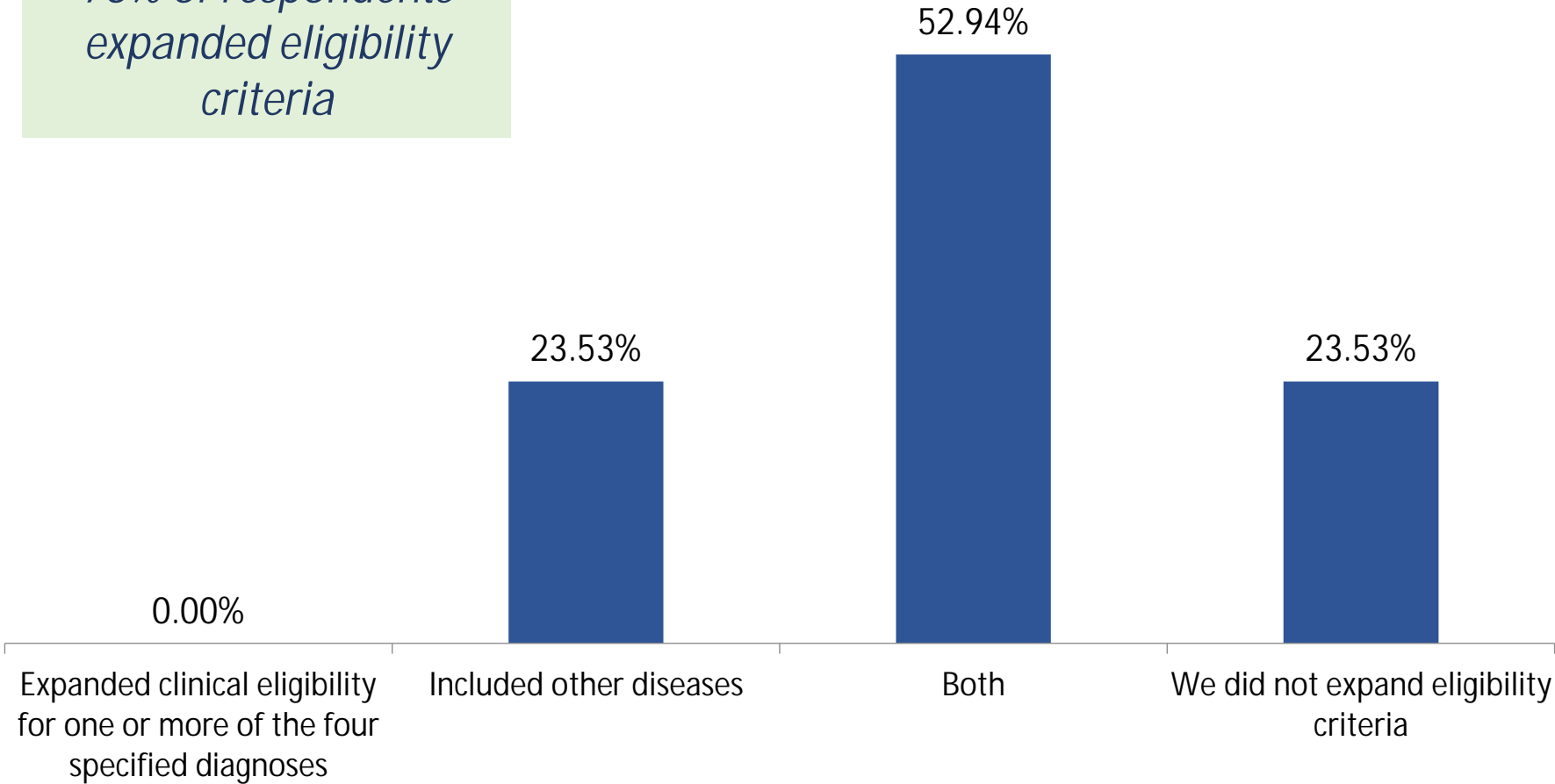
## Sustainability

- Assessment, concerns, obstacles to good care, global comments, plans for CaAIM, wish lists

## Questions and Comments

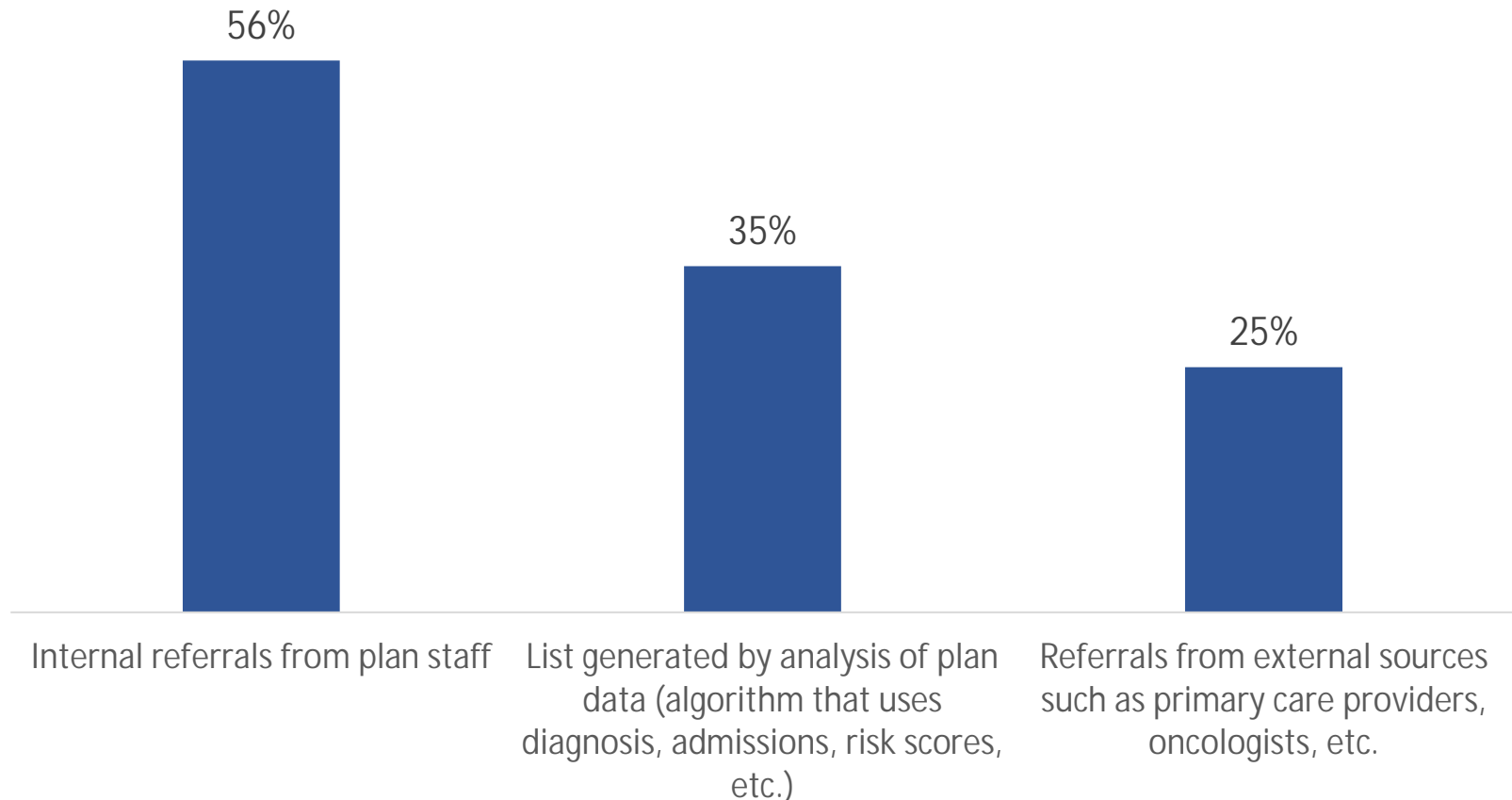
# Expanding on Eligibility Criteria

*76% of respondents expanded eligibility criteria*



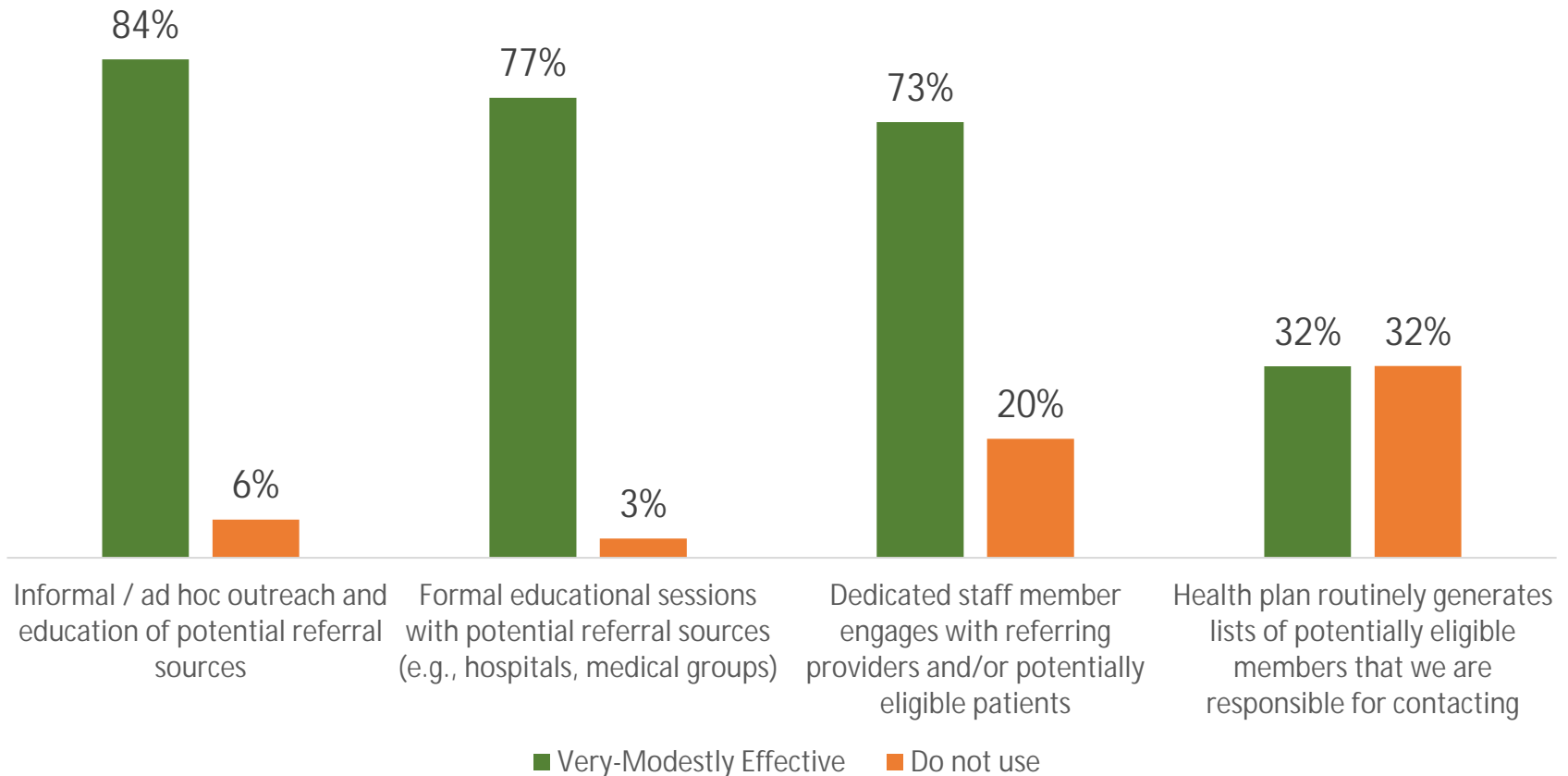
# Plans: Sources of Referrals

*% Health Plans that indicated "All" or "Many" referrals were generated by each source*



# Provider Perceptions: Efficacy of Referral Promotion Strategies

*Please rate the efficacy of the below listed strategies that your organization may use to generate referrals of Medi-Cal enrollees to your palliative care services.*

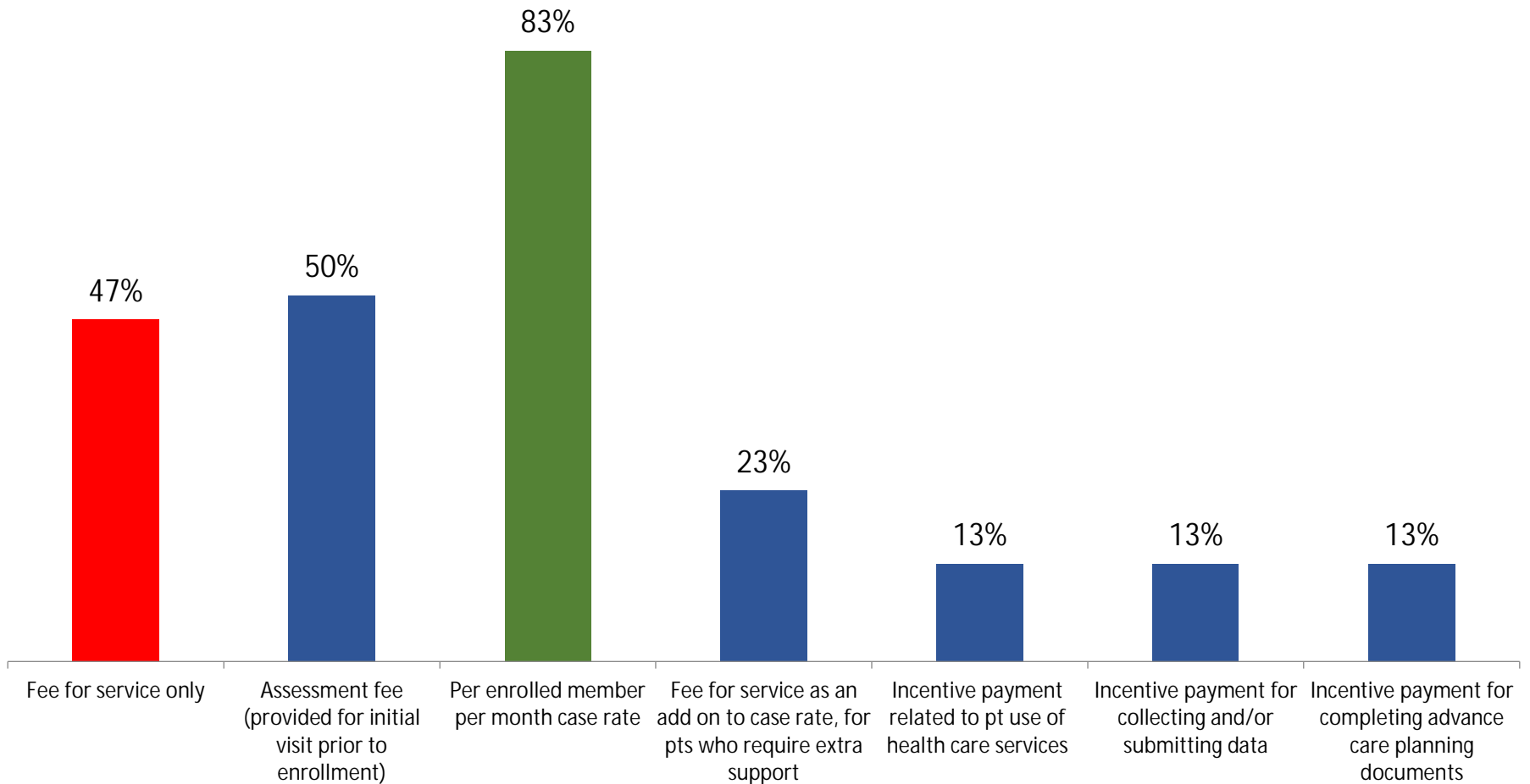


# Mechanisms Plans Use to Pay for PC

Fee for service only	29%
Assessment fee (provided for initial visit prior to enrollment)	41%
Per enrolled member per month case rate	65%
Fee for service as an add on to case rate, for patients who require extra support	18%
Fiscal penalty when performance measures are not met	12%
Incentive payment related to patient use of health care services	6%
Incentive payment for collecting and/or submitting data	6%
Incentive payment for completing advance care planning documents	6%
Incentive payment based on member satisfaction survey responses	0%

# Payment Mechanisms in Provider Contracts

*Payment mechanisms featured in SB 1004 palliative care contract(s)*



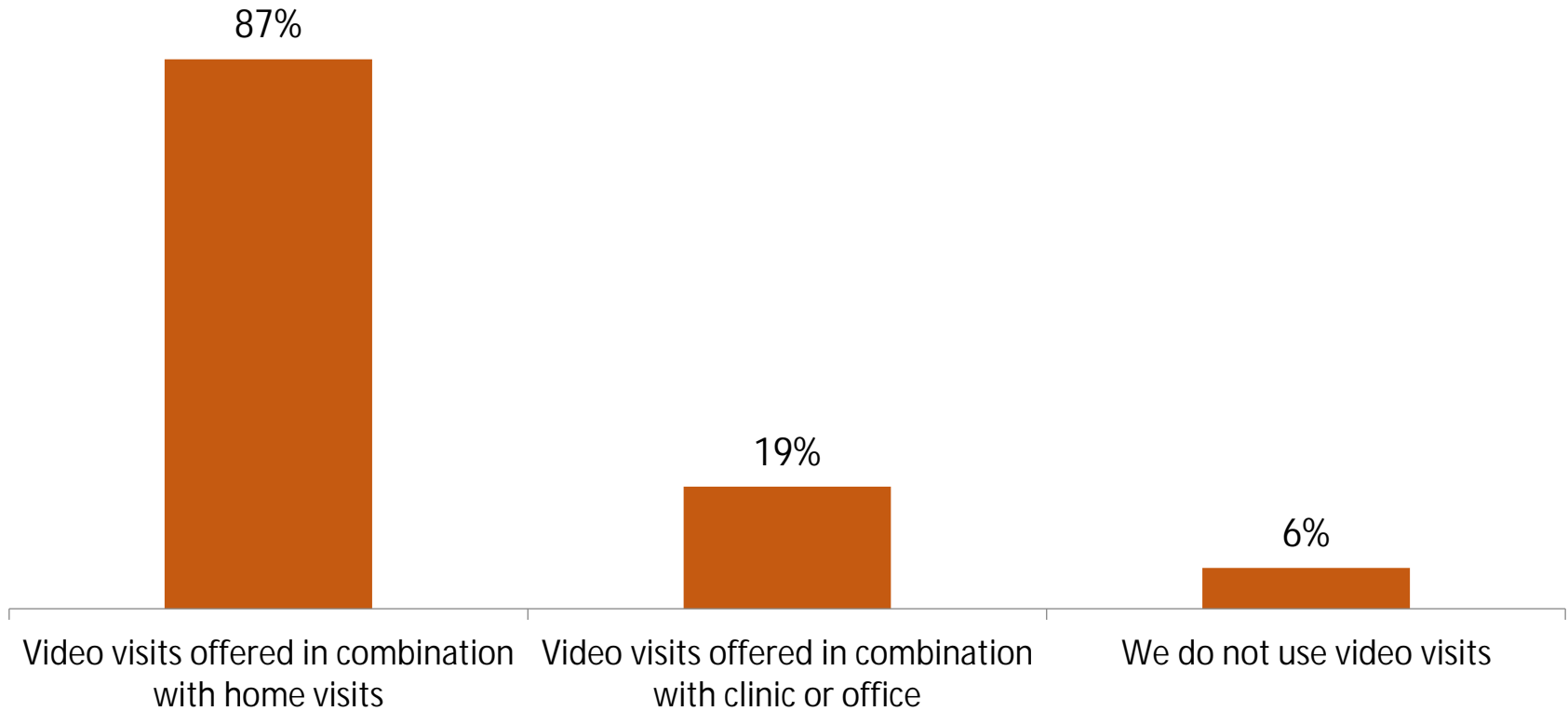
# Features of Plan PC Programs

Regular monitoring of the number of referrals and enrollments	94%
PC program has a specific administrative home within organization	89%
Dedicated contact person for PC providers (administrative issues, needs of specific members)	89%
PC program clinical champion	83%
At least once a year plan staff are trained on PC and the features of the PC program	83%
Regular reporting to plan leadership on palliative care program	83%
Provider-facing materials that describe palliative care and the SB 1004 benefit	78%
Standing operational or interdisciplinary care team meetings with PC providers	77%
Member-facing materials that describe palliative care and the SB 1004 benefit	72%
PC program is described on the plan website separate from description of hospice benefit	65%
Standardized process for assessing quality of care delivered by PC providers	65%



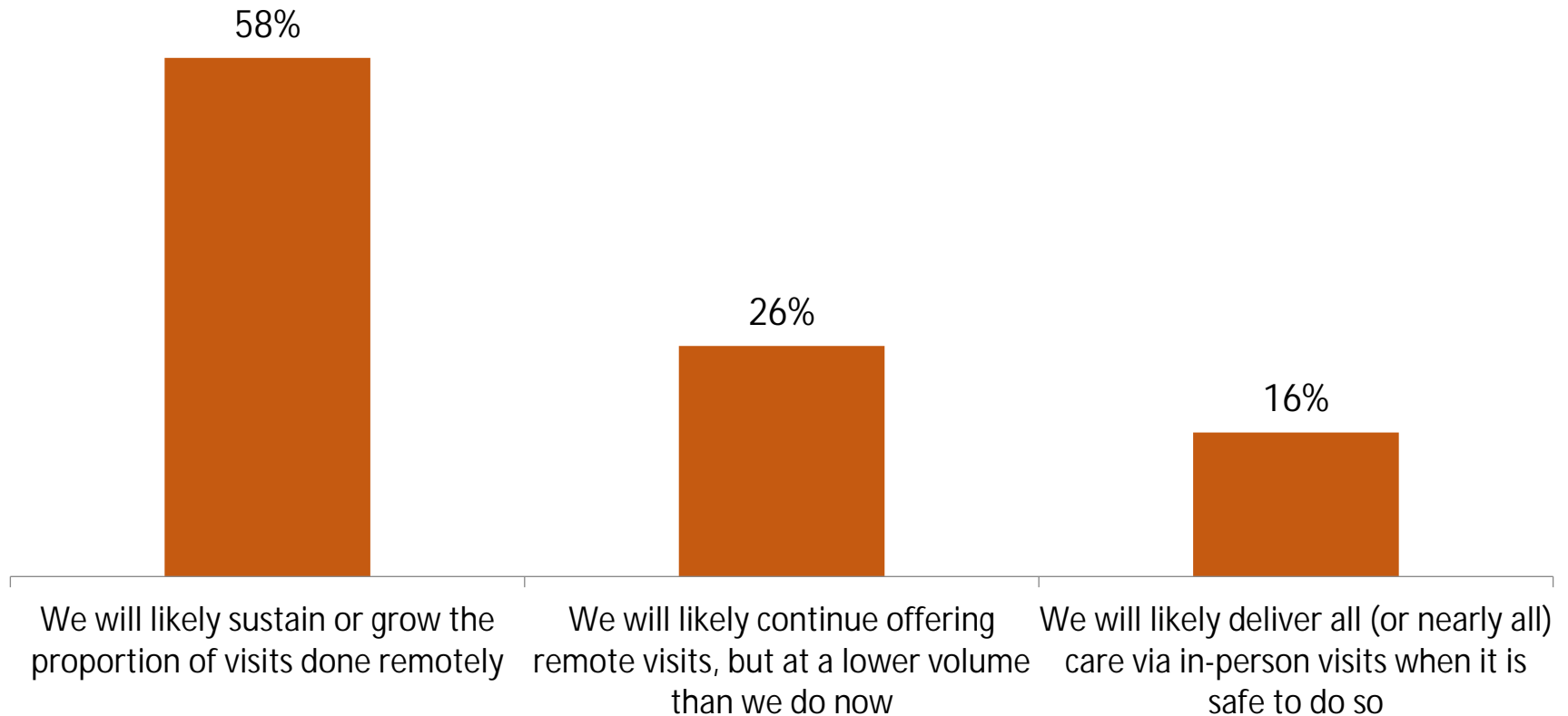
# Provider Use of Remote Care

*Please specify if and how you use video visits in combination with in-person visits when delivering palliative care*



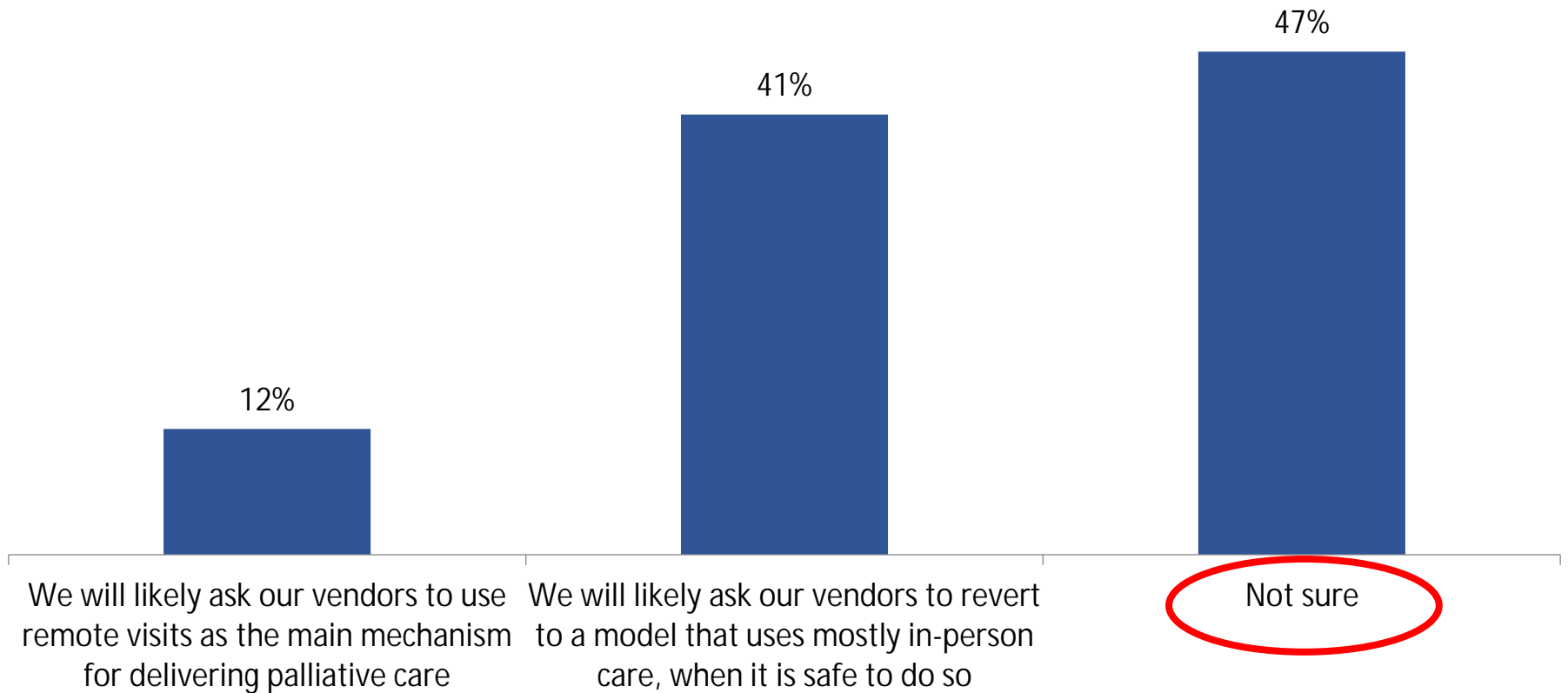
# Provider Use of Remote Care Going Forward

*Based on your experience with providing remote care (by phone or video) in 2020, how do you imagine your organization will use remote visits in the future?*



# Plan Use of Remote Care Going Forward

*Based on your experience with remote care (phone or video) provided to your members in 2020, how do you imagine your plan will view remote visits for palliative care in the future?*



# Reflections on Structures and Processes

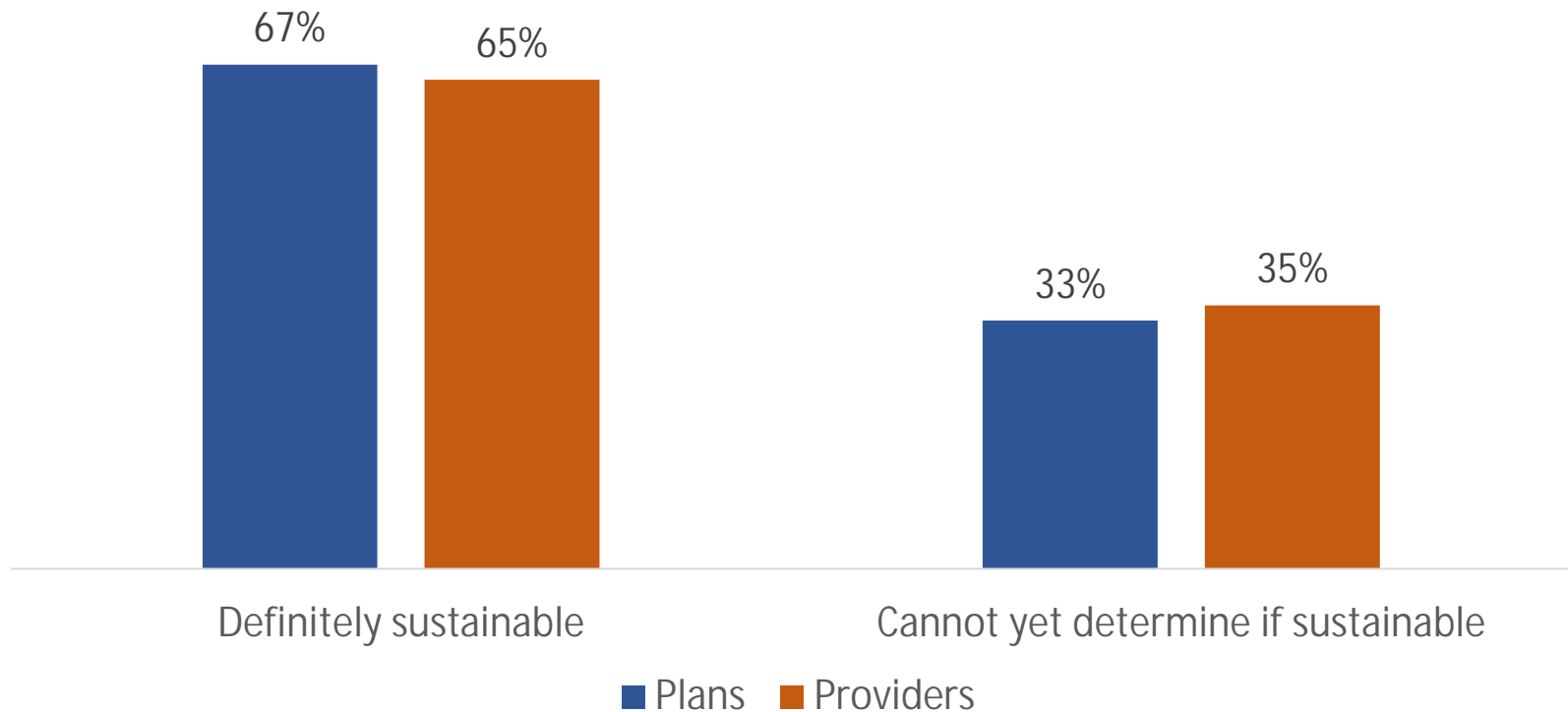
- Most plans have expanded eligibility criteria
- Most referrals come from internal plan staff
- Providers focus on in-person outreach and education to promote referrals
- Providers still have mixed feelings about chase lists
- 29% of plans only offer FFS payment
- Most providers manage both FFS and case-rate revenues
- 94% of providers use remote care and 84% expect to keep doing so
- 47% of plans are unsure of their future approach to remote care

# Sustainability

*Maintaining, enhancing or expanding programs*

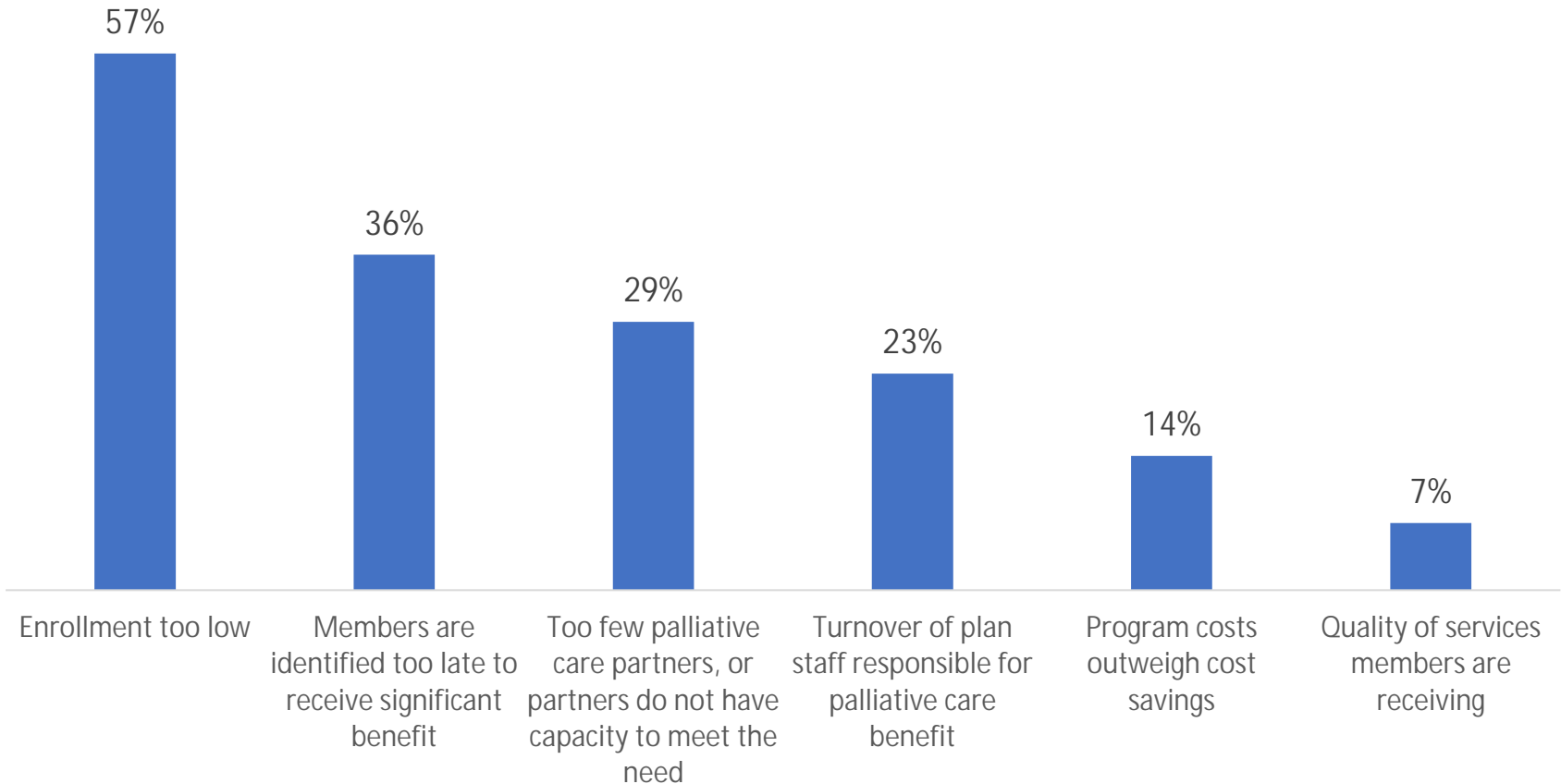
# Most Plans and Providers Feel PC Programs are Sustainable

*Do you feel that your current model for providing SB 1004 palliative care services is sustainable for your organization?*



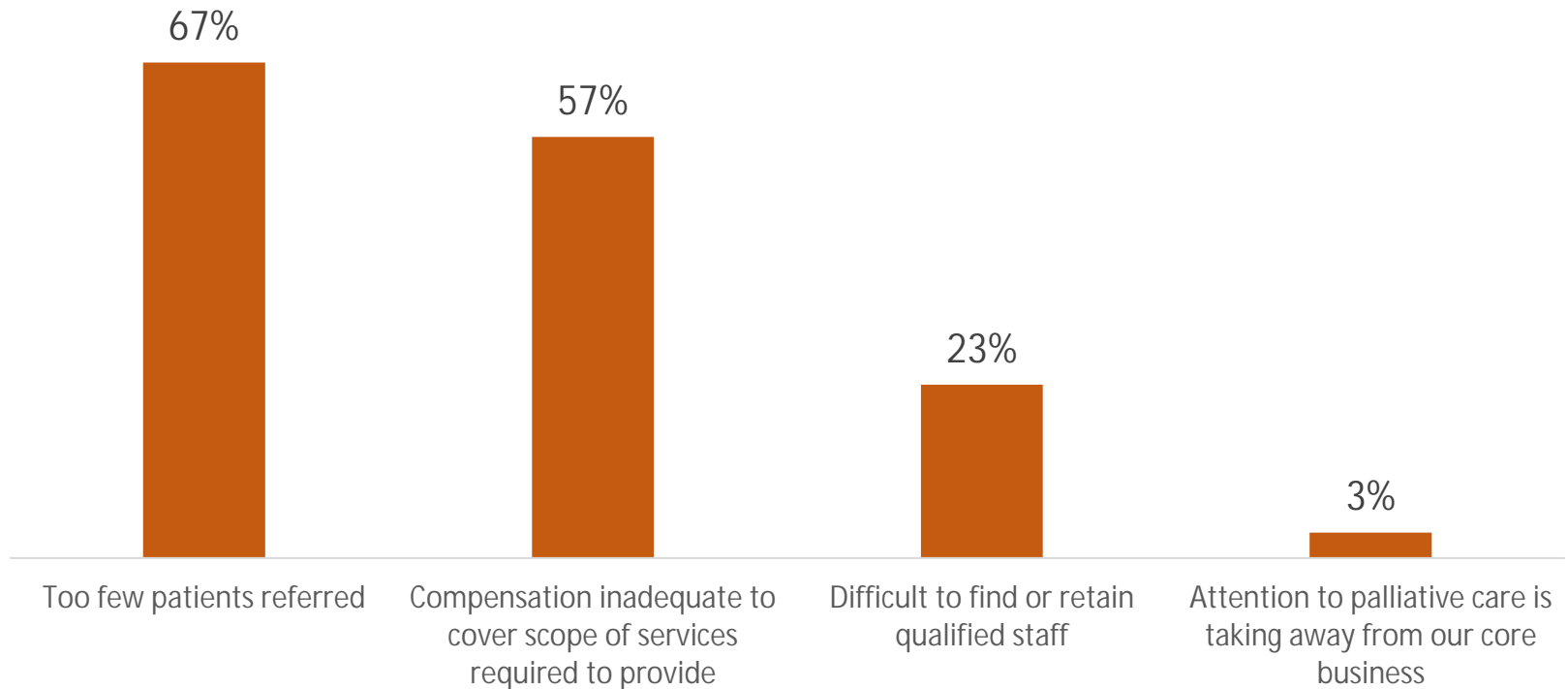
# Plan Concerns About Sustainability or Efficacy

*% Plans Flagging as Moderate or Major Concern*



# Provider Concerns About Sustainability or Efficacy

% Providers Flagging as Moderate-Significant issue





# Provider issues that are impacting the feasibility of continuing to deliver palliative care to Medi-Cal enrollees

“Communication/logs, data, education, and meeting requirements from managed care plans is time and labor-intensive. This is difficult to manage with multiple payors which detracts from patient care and impacts outcomes and financial sustainability.”

“Fee for service reimbursement does not provide adequate payment for SB1004 patients”

“The physicians not understanding goal of program and the time that is invested by palliative team to have to continue the education surrounding this. A lot of time to be invested on education without compensation or resulting in increased referrals or the group/physician still not willing to support palliative care.”

# Provider Perceptions: Barriers to Delivering Best Care Possible

## *% Providers Flagging as Moderate-Significant Issue*

Primary and specialty providers unwilling to introduce/recommend PC to their patients	77%
Too few referrals	74%
Competition with other plan programs creates confusion and limits enrollment	50%
Referrals come too late	41%
Patients have psychosocial needs that are beyond the scope of our service	35%
Difficult to recruit trained/qualified staff for our SB 1004 palliative care service	32%
Loss of enrollees due to annual open enrollment and change in plans	30%
Lack of effective coordination with other care providers	29%
High staff turnover/difficulty with staff retention	19%
Patients have clinical needs that are beyond the scope of our service	16%
Lack of effective collaboration with plan partners	16%
Unable to effectively meet patients' needs remotely, during the COVID-19 pandemic	16%

# Other Barriers to Best Care Possible Experienced by Providers

## Patient Issues

- Patient's refusing palliative care when home health is also involved
- Refusal by pt. of visits in home and pt. unable to utilize/understand telehealth
- Homelessness

## Referring Provider Issues

- Local providers are unaware of our Palliative Care program or lack full understanding of what Palliative Care is, what qualifies patients for our program
- The resistance of primary care physicians
- Referring providers have so many programs that they get confused and forget palliative care
- Unable to reach the medical groups as well as their delay in approval or review of pending auths for services such as DME, specialty providers, supplies

## Plan Issues

- Health plan referrals often do not have recent history and physical or updated contact information
- Diagnosis and prognosis limitations to palliative benefit

# Palliative Care and CalAIM

“Our providers and Case Management team members will continue to be educated on the Palliative Care services as we anticipate the members enrolled in ECM or receiving ILOS may benefit from Palliative Care. No change to our process to how we are managing HHP and WPC.”

“Require our ECM providers to promote and refer PC services to target populations that would qualify under the current eligibility criteria.”

“Palliative care will become part of ECM for high utilizing population”

“Palliative care is an integral part of the case management and enhanced case management program. We will fully integrate palliative as a part of our care model for CalAIM.”

# Plan Observations (Good News, Bad News)

- The Palliative program has been beneficial in providing supportive interventions to members and their families. The collaborative approach with the members of the interdisciplinary care team helps promote a holistic approach to taking care of the member.
  - Outcomes such as, symptom management have helped decreased utilization to ED and inpatient admission. Early advanced care planning/identify DPOA ensures the members can make their own decision and engage in the process. Having dedicated staff to support the program enables us to be successful. Additionally, the reports we have created have enabled us to analyze our data and create interventions. (plan)
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- I think the state stopped their quarterly reporting too soon given the low utilization.
  - Stigma of Hospice versus Palliative Care and Specialty providers resistant to referring patients to PC care in a timely manner have been significant barriers. We are trying to drive towards a case rate or shared risk payment model, but need more data to move from fee for service to more quality driven payment structures.

# Provider Wish List

- More compelling data to convince health plans of the value of value-based payment models for palliative care
- More access to patient information in all counties we service
- Limiting the different IPA's and Medical Groups involved
- Chaplain services would be helpful for the patients

# Plan Wish List

- Additional data from our providers
- Additional funding to incentivize providers to promote Palliative care (similar to Prop 56 payment model)
- Improving quality of member contact information
- Health information exchange platform to increase the early identification of seriously ill members
- Increasing provider capacity to accept more member referrals
- More public awareness
- Providers (PCPs, Specialists etc.) identifying members and helping them engage with the Palliative Care program
- Having a dedicated responsible person or team within the plan that manages this benefit

# Reflections on Sustainability

- Plans and providers report PC programs are sustainable
- Low enrollment is the biggest threat to sustainability for both plans and providers
- Providers worry about effort invested in non-clinical activities
- Plans expect to link PC and CaAIM programs
- Access to multiple types of accurate data is a wish list item for plans and providers



# Questions and Comments

- What surprised you? Why?
- What would you like to discuss further with your team?
- Are there any questions you want to ask or issues you would like to discuss



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# *BREAK*

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*The convening will  
resume at 10:40*