Essential Elements of Medi-Cal Palliative Care Services: Payment Models in Medi-Cal Palliative Care Programs

This resource is part of "Section A: Define (or refine) the health care program" of the California Health Care Foundation publication *Essential Elements of Medi-Cal Palliative Care Services: Tips and Tools for Medi-Cal Managed Care Plans and Palliative Care Providers*.

Medi-Cal managed care plans and their palliative care provider partners shared information from their programs for this guide, including internal policies and procedures. CHCF is grateful for this leadership and willingness to contribute for the benefit of more people whose health and lives can be improved with high-quality palliative care.

In March 2021, the Coalition for Compassionate Care of California and the California Health Care Foundation surveyed Medi-Cal managed care plans (MCPs) and palliative care providers about their Medi-Cal community-based palliative care programs. Nineteen MCPs and 31 palliative care providers responded, providing a picture of the range and types of payment models in use.

Payment Models Employed in MCP Contracts with Palliative Care Providers

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-Related Instructions from One MCP Program Guide's "Frequently Asked Questions"

How will I be reimbursed for services provided?
You will receive a case rate for services, which is considered an all-inclusive payment for the services referenced above and rendered in accordance with your contract. The case rate applies per member per month for the duration of the member's enrollment in the program. This includes four contacts with the member each month, with a minimum of one in-person visit. During exceptional times, the mandate for in-person visits may be conducted via telephone or videoconferencing, in alignment with state guidance.

What codes do I bill to receive the case rate for enrolled members?
Claims must be billed with either CPT codes 99497 or 99498 (use whichever code was submitted on the authorization request), with diagnosis code Z51.5 (encounter for palliative care) to trigger the case rate payment, in accordance with your contract. This CPT code and diagnosis code combination must be

indicated on all claim submissions for successful case rate payment. Other codes billed on the case rate claim will not be paid separately.

What type of bill is used for palliative care services?
We do not prescribe a specific type of bill for palliative care reimbursement. Please use the type of bill that is most reflective and appropriate for your organization, as you would when billing for other, nonpalliative care services. For example, vendors who are hospice providers would use the hospice bill type (81X), while our other vendors who are home health providers would use the home health type of bill (32X). Please refer to the appropriate CMS billing guidelines for type of bill.

What if additional physician or nurse practitioner visits are needed outside of the case rate?
Separate reimbursement is provided for additional visits that may be needed to manage the member's condition, in accordance with your contract. However, you must bill valid Medi-Cal reimbursable codes with diagnosis code Z51.5 to receive payment.