



Essential Elements of Medi-Cal Palliative Care Services:

A Toolkit for Medi-Cal Managed Care Plans
and Palliative Care Providers



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About the Authors

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Acknowledgments

CHCF offers appreciation and gratitude to the MCPs, PC provider organizations, and palliative care expert organizations for their contributions to this guide, and for their efforts in the field of palliative care. See the appendix for a list.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Background

This is a guide to help California Medi-Cal managed care plans (MCPs) assess and optimize a palliative care program that meets or exceeds the state’s requirements to ensure access to palliative care (PC) for eligible members. The other main audience is palliative care provider organizations that are, or might become, contracted provider partners for these MCPs.

The five sections of the guide are organized in a stepwise progression, from designing core structures and processes to monitoring quality and improving operations. However, the sections and their related resources can be used in any order.

All sections except for Section B address the MCP role in managing its state-required PC program. Section B provides guidance and resources for the PC provider organization specifically. The whole guide is helpful for both sides of the MCP-PC provider partnership. Section E, in particular, focuses on program growth and quality improvement, so it is meant to serve both partners in their work together.

For a complex clinical service like palliative care, the work of collaboration and improvement should be continuous. To allow for this ongoing progress, the guide defines “minimum” capabilities that all users should consider adopting, as well as “enhancements” for users that wish to optimize and elevate their programs.

Curated resources are available for each of these sections on CHCF’s website; links to those resources are available in the sidebar of the corresponding section.

Steps to Assess and Optimize a Palliative Care Program

- A** Define (or refine) the MCP program
- B** Ensure readiness (and ongoing development) of the PC provider organization
- C** Develop (or optimize) MCP program operations
- D** Define (or refine) strategies to identify and engage MCP members
- E** Strengthen the partnership, improve quality, and monitor operations



TOOLS AND LINKS FOR THIS STEP
ARE AVAILABLE ONLINE.

*“Specific standards matter, like
availability around the clock of
palliative care provider staff.”*

— Established program representative

A Define (or Refine) the MCP Program

The Medi-Cal managed care plan (MCP) defines the core elements of its palliative care (PC) program, including patient eligibility, required services, and provider performance standards. Ideally, the program elements are developed in collaboration with contracted or potential PC provider partners, to bring their expertise to bear on program design. Once the basics are established, partners then negotiate (or renegotiate) mutual performance expectations and payment.

A1. Eligibility Criteria

Specify the criteria for program entry and graduation.

Minimum. Use the minimum eligibility criteria in the California Department of Health Care Services (DHCS) All-Plan Letter, including general criteria, eligible diagnoses, and disease-specific criteria.

Enhancements. Adjust criteria to expand access to palliative care and increase enrollments by adding eligible conditions or relaxing disease-specific criteria.

A2. Qualifications, Certifications, and Training for PC Provider Organizations and Staff

The MCP uses established criteria for excellence to select provider partners to deliver high-quality care. Provider organizations use the standards that come with certification to define their model of care and to monitor their approach.

Minimum. Specify the minimum level of training required for PC provider staff or minimum amount of organizational experience with delivering palliative care.

Enhancements. Require that PC providers be certified or accredited in palliative care by The Joint Commission, Community Health Accreditation Partner, or Accreditation Commission for Health Care, or require that this certification/accreditation be obtained within a specified period. Similarly, plans could require that individual provider staff be certified for disciplines where certifications are available (physicians, nurses, social workers, chaplains).

A3. Required Services

Clarify expectations for care model and staffing, frequency of contact, and other aspects of care delivery, ensuring the program is appropriately differentiated from hospice.

Minimum. Specify expectations for service delivery, including allowable mode of contact (in-person, phone, video visits). Consider defining different service tiers based on patient acuity and needs. Tiers could come with different payment levels or not.

Enhancements. Add services that meet additional patient family needs (such as caregiver support, 24/7 availability, spiritual care).

A4. Program Operational Processes Between Providers and the MCP, Including Reporting Requirements

Plans provide templates and mechanisms for reporting information and communication between the MCP and PC provider partners. Data include information about enrollments and disenrollments, documentation of services, and methods for submitting claims and/or invoices, as appropriate. (Note that quality measures are addressed separately in Section E on quality improvement and program growth.)

Minimum. Specify required information, format, reporting frequency, and mechanism.

Enhancements. Regularly review reporting requirements with contracted providers to ensure minimum reporting burden while meeting requirements.

A5. Payment Model and Amount

In addition to paying for core services, consider PC provider time and resources needed for program management activities like data collection and reporting, and participation in meetings.

Minimum. Use case rate payment that accounts for time invested by all PC provider interdisciplinary team members.

Enhancements. Ensure that payment covers the range of PC provider efforts (e.g., a comprehensive assessment before enrollment, support for extraordinary needs of individual patients). Add incentive payments for meeting or exceeding performance benchmarks in activities of care (e.g., advance care planning, avoiding hospitalizations, meeting patient experience survey goals).

Progress in California

In a March 2021 survey by CHCF and the Coalition for Compassionate Care of California, 13 of 17 MCPs (76%) reported expanding their program's criteria beyond the minimum requirements established by the state. These MCPs either added more eligible medical conditions to the four required (congestive heart failure, COPD, advanced cancer, liver disease) and/or relaxed the disease-specific criteria for the four required conditions.

This survey also found that over half of responding MCPs require their palliative care provider partners to be certified by The Joint Commission or Community Health Accreditation Partner.

"To find the best palliative care partners, ask local hospitals and specialists which providers in the community they trust with their patients."

— Established program representative



TOOLS AND LINKS FOR THIS STEP
ARE AVAILABLE ONLINE.

B Ensure Readiness (and Ongoing Development) of the PC Provider Organization

The palliative care (PC) provider organization has the staffing, services, and administrative capabilities needed to provide high-quality palliative care under a contract with a Medi-Cal managed care plan (MCP).

B1. Well-Prepared Interdisciplinary Team

Establish an interdisciplinary team (IDT) with appropriate clinical skills and training for provision of high-quality PC.

Minimum. Clinical team should include physician / advanced practice nurse / nurse practitioner (as clinical director or provider of direct care, or both), nurse, social worker, and spiritual care professional. Ideally, all clinical team members have current professional certification for PC; at minimum, they have completed training in core PC clinical skills, including:

- ▶ Recognizing, assessing, and managing physical and emotional distress
- ▶ Discussing goals of care
- ▶ Conducting advance care planning and completing documentation (health care proxy, advance directive, POLST) where appropriate
- ▶ Connecting patients and families to other health care and social needs resources like substance use treatment, mental health care, housing, financial supports

Enhancements. Include the role of community health worker or outreach specialist on the care team. Seek and secure organizational certification in palliative care from an accrediting body. Ensure current professional certification for PC for all IDT members where such certification exists for their discipline. Support additional training in:

- ▶ Communications skills and difficult conversations
- ▶ Anticipating and managing crises
- ▶ Identifying and managing support needs of caregivers and family members

B2. Standardized Model, Processes, and Tools for Patient Care

The provider defines a consistent but flexible patient-centered approach to assessing and addressing patient and family needs.

Minimum. Identify standard approaches and tools for intake, initial and ongoing screening and assessments, development of the care plan, and documentation of care, with clear roles and responsibilities for different team members.

Enhancements. Cross-train staff in different aspects of care to allow for more flexibility, capability, and capacity to identify and respond to patient needs. Define triggers for engaging other team members.

B3. Operational and Administrative Processes

The provider establishes clear processes that support team readiness, internal and external communication, and administrative functions supporting the MCP-provider partnership. The team refines these processes over time as the program grows and evolves.

Minimum. Define team member roles and responsibilities, and clinical documentation expectations. Develop processes for team communication, internally for real-time clinical management and externally for communication with MCPs, referring providers, and other treating providers. Establish clear processes for managing MCP authorizations, submitting claims, and monitoring payments.

Enhancements. Define standards for in-person care versus care by video or phone. Establish clinical quality targets. Define a routine process for performance monitoring and ongoing improvement efforts.

B4. External Awareness and Understanding of Palliative Care

The provider organization promotes its palliative care services, with separate materials and approaches for health care professionals (referring providers, other treating providers) and patients and families.

Minimum. Create materials (both print and web-based) for both audiences that clearly describe (1) what palliative care is (using language that clearly differentiates PC from hospice), (2) how it can help, (3) information about the PC provider organization, and (4) how to seek services.

Enhancements. Collaborate with MCP to conduct educational sessions with high-volume, high-value referral sources including hospital-based PC providers, hospital discharge planners and case managers, specialty care medical groups, and community-based organizations that serve people with serious illness. Distinguish palliative care and hospice in all aspects of the PC provider organization, including marketing, staff roles, and services. This could mean separate phone lines for palliative care and hospice, or even rebranding and renaming the organization.

Progress in California

A March 2021 survey by CHCF and the Coalition for Compassionate Care of California found 71% of provider organization respondents (22 of 31) with active MCP contracts are certified by The Joint Commission (TJC) or Community Health Accreditation Program (CHAP). An additional 13% (4) plan to seek accreditation soon. Of the MCP survey respondents, 53% (10 of 19) require TJC or CHAP certification.

“Offering palliative care has helped our agency grow as a whole. It helps that we can also directly bring on our own home health team or hospice.”

— Established program representative



TOOLS AND LINKS FOR THIS STEP
ARE AVAILABLE ONLINE.

*“Palliative care fits best within
care management programs or
similar programs, and not with
a department like utilization
management that is more focused
on all MCP members or a specific
care event.”*

— Established program representative

C Develop (or Optimize) MCP Program Operations

The Medi-Cal managed care provider (MCP) specifies an administrative home, assembles a staff team, and develops workflows for internal processes. The team creates cross-organization workflows in collaboration with palliative care providers and referring providers.

C1. Administrative Home for the PC Program

Accountability for the program should be integrated with other MCP programs that serve seriously ill members, to eliminate silos and improve care coordination within the MCP.

Minimum. Designate an administrative home that connects palliative care with related programs (e.g., population health, case management, Enhanced Care Management, managed long-term services and supports).

Enhancements. Include program staff in related programs’ meetings to support coordination and case finding, and to ensure members receive all beneficial services. Share team members and roles/responsibilities across these programs where practical.

C2. MCP PC Program Team

Include a medical director / clinical champion and an operations lead. Specific roles include referrals management and communication with referring providers, working with internal MCP peers, data management, and coordination with other network providers for services such as durable medical equipment (DME) and behavioral health services.

Minimum. Designate clinical and operations leads, with alternates for coverage when the primary leads are unavailable.

Enhancements. Monitor MCP program team capacity so staffing and roles evolve as the care model evolves and enrollment grows.

C3. MCP Processes That Support Timely Delivery of Services

The MCP manages referrals (both internal and external), service authorizations, and care coordination. The MCP provides for members' related needs (e.g., DME, medications).

Minimum. Create policies and processes for program entry, monitoring care delivery and member needs while enrolled, and program graduation. Specify expected turnaround times for processing initial referrals and authorizations for specific services and supports such as home health, medications, and DME.

Enhancements. Establish expectations for rapid processing of referrals and authorizations, through process efficiencies or increased staff resources, to meet patients' needs sooner. Establish an expectation for PC providers to work directly with other contracted providers including DME providers and mental health case managers, without all referrals and coordination passing through the MCP.

C4. MCP Processes That Support Easy Flow of Information and Reporting

The MCP establishes clear expectations and processes for information sharing to ensure effective program operations, both within the MCP itself and between the MCP and PC providers.

Minimum. Internal to the MCP, create procedures and workflows for communication and data sharing among the MCP's own programs, for internal referrals between MCP programs and services, and to minimize confusing and redundant efforts. For PC providers, the MCP has policies and processes for data reporting by PC providers.

Enhancements. The MCP regularly reviews lists of members served by multiple programs and ensures effective coordination. The MCP and PC providers collaborate to automate reporting from PC providers' electronic records. The MCP reduces the number of steps and data platforms that PC providers must use to submit the information required, with the goals of eliminating duplicative data entry and maximizing the use of live data.

Progress in California

In a March 2021 survey by CHCF and the Coalition for Compassionate Care of California, half of responding PC provider organizations flagged "competition with other plan programs creates confusion and limits enrollment" as a barrier to delivering the best care possible, highlighting the need for coordination within the MCP and for clarity for external partners.

"Flexibility is important, once standards are established in the early stages of a partnership and trust develops. Now, either our MCP staff or PC provider staff can be the first person to contact a member, which is a big benefit."

— Established program representative



TOOLS AND LINKS FOR THIS STEP
ARE AVAILABLE ONLINE.

“We removed the requirement for a physician gatekeeper as the only person who could refer. Now anyone can refer a patient to us.”

— Established program representative

D Define (or Refine) Strategies to Identify and Engage MCP Members

The Medi-Cal managed care plan (MCP) and palliative care (PC) providers identify eligible members through inbound referrals, MCP claims data, and MCP staff referrals. MCPs seek referrals from primary care providers and specialists in their provider networks, with education about the value of palliative care and about the MCP PC program.

D1. Processes for MCP Internal Case Finding

Strategies include internal referrals from other MCP programs that support members with serious illness, case finding using risk stratification tools, and data reports from claims, encounters, authorizations, and pharmacy.

Minimum. Specify processes for identifying eligible members through referrals from other MCP programs and from analysis of diagnoses and utilization data such as hospitalizations and emergency department visits.

Enhancements. Create palliative care-specific reports that combine different data sources, or use predictive modeling to identify members who might benefit from palliative care. Create referral volume goals for MCP case managers or other key staff.

D2. Education and Engagement for High-Value External Referral Sources

Promote program with high-volume, high-value referral sources including hospital-based PC providers, hospital discharge planners and case managers, specialty care medical groups, and community organizations that serve Medi-Cal enrollees with serious illness.

Minimum. Create and disseminate materials written for health care and social services professionals that describe PC. Create patient-facing materials for these partners’ patients/clients, in multiple languages to support equitable access. In these materials, distinguish palliative care from hospice and describe how PC aligns with other MCP and community-based services.

Enhancements. Meet regularly with the individual professionals at these high-value referring partners who serve seriously ill MCP members. Use these meetings for ongoing relationship management and monitoring of the progress of these partnerships.

D3. Processes for Member Engagement and Education

Where prior relationships exist, the MCP member/patient is introduced to palliative care by that MCP staff person or the community provider. This person with an existing relationship explains the PC program and its benefits, and then facilitates a warm handoff to the PC organization.

Minimum. Orient MCP staff to palliative care as a specialty health care service, and to the MCP's own program specifically, so staff are prepared to discuss PC services with members.

Enhancements. Establish warm handoffs as a standard expectation for all MCP members starting PC, and create a performance metric to track success. Provide in-depth training to MCP staff to increase comfort discussing palliative care with members and their families.

D4. Educational Materials for MCP Members and Families

MCPs and PC providers collaborate to develop clear, accessible materials to promote the program and clarify the who, what, and why of PC. Information is distributed through websites and in printed form, at the required Medi-Cal reading level and in the MCP's threshold languages.

Minimum. Develop print materials and web content for MCP members, with clear and simple language to describe how PC supports patients and families while patients are treated for their disease. Clearly distinguish palliative care from hospice.

Enhancements. Increase awareness of PC and the MCP program among community-based organizations serving seriously ill people in the Medi-Cal population, including providers in the MCP's Health Homes and Enhanced Care Management programs.

Progress in California

In a March 2021 survey by CHCF and the Coalition for Compassionate Care of California, a shared priority for the next year for both MCP respondents (at 89%) and PC provider respondents (at 71%) was to increase program enrollment. The chief concern related to program sustainability for both MCPs and PC providers was too few patients/members.

The top two barriers to a successful program, according to the PC provider respondents, were "PCP unwillingness to introduce/recommend palliative care" (at 77%) and "too few referrals" (at 74%).

"To build referrals, patient stories are the most effective. To make it fun, we use a 'Who is eligible?' quiz in sessions with referring groups."

— Established program representative



TOOLS AND LINKS FOR THIS STEP
ARE AVAILABLE ONLINE.

“We meet with our palliative care providers monthly to discuss the member list, status, needs, level of care, referrals, and progress toward graduation. Quarterly we discuss opportunities, like how to grow the program and our network.”

— Established program representative

E Strengthen the Partnership, Improve Quality, and Monitor Operations

As the program grows and evolves, the Medi-Cal managed care plan (MCP) and palliative care (PC) providers educate all relevant staff and leadership, and oversee the program together. Regular discussions between the partner organizations ensure smooth operations, enable expansion when the opportunity arises, and most importantly, support excellence in care and service to patients and communities.

E1. Education at the MCP on Palliative Care and the PC Program

The managed care plan’s PC program team and staff, and managers from related programs (like care management), learn about the benefits of palliative care and its relationship to existing services for members with serious illness. Managed care plan (MCP) leadership learns the benefits to members and to the MCP’s population health and patient experience goals, and how to support the ongoing relationship between partner organizations.

Minimum. Deliver education and consultation to all relevant MCP staff during new staff orientation, as part of regular program review, and when there are changes to program eligibility. Meet with senior leadership to describe the program’s benefits to members and to the MCP business.

Enhancements. Incorporate training on the PC program into regular MCP staff education, such as annual refresher trainings required for certifications or organization licensure. Hold formal training sessions led by a PC partner for new staff at the MCP. Provide training in communications skills for staff who discuss PC with MCP members. Cross-train staff from related programs (like case management) in PC.

E2. Regular Operations Meetings

Partners review program criteria and patient volume, solve problems, monitor progress, and make plans for improvement. They review process measures and clinical quality measures. They work on operations and coordination issues, like the shared work of connecting patients to related services like care management or durable medical equipment (DME). Some established partnerships recommend holding these meetings monthly.

Minimum. Meet regularly with each contracted PC provider to discuss program operations with an oversight and monitoring perspective.

Enhancements. Define specific expectations of improvement and increased efficiency by both partners in collaboration.

E3. Regular Interdisciplinary Team Clinical Meetings

In a case conference–style forum, partners focus on the needs of three groups of shared patients: new patients, high-needs patients, and patients in care transitions. Some established partnerships recommend holding these meetings monthly.

Minimum. Designate the MCP clinical lead to attend, to support PC providers in addressing specific patient needs that arise.

Enhancements. For plans with multiple contracted PC providers, conduct annual or semiannual meetings with all vendors to discuss challenges and promising practices.

E4. Regular Assessment of Quality, Growth, and Impact

Partners monitor performance, including data on quality measures and numbers of members served. They may consider changing or expanding eligibility criteria and other ways to better serve members/patients. Together, they revise the quality measures set annually.

Minimum. Meet quarterly with PC providers to review program enrollment and quality metrics.

Enhancements. Pay membership costs for contracted PC providers to join the Palliative Care Quality Collaborative (PCQC) with the expectation that the PC provider will submit quality data to PCQC as part of membership and report those data to the MCP. Conduct ongoing assessment of impact on quality and total costs of care to ensure long-term investment by the MCP. Implement specific growth targets for the palliative care program.

Progress in California

In a March 2021 survey by CHCF and the Coalition for Compassionate Care of California, 87% of MCP respondents reported having a formal quality improvement component for their palliative care program.

“We host an annual meeting attended by all of our palliative care provider partners where we discuss how to improve the program and grow the program. It creates a community of practice for our MCP team and for the staff and leaders of the PC provider partners.”

— Established program representative

Appendix. Contributors to This Guide

CHCF offers appreciation and gratitude to the MCPs, PC provider organizations, and palliative care expert organizations for their contributions to this guide, and for their efforts in the field of palliative care.

Anthem

Aspire Health

Blue Shield of California / Blue Shield Promise

California State University Shiley Haynes Institute for Palliative Care

Center to Advance Palliative Care

Coalition for Compassionate Care of California

Health Net

Hospice of Santa Cruz County

Housecall Providers (Oregon)

Inland Empire Health Plan

L.A. Care Health Plan

LightBridge Hospice & Palliative Care

Molina Healthcare

National Hospice and Palliative Care Organization

Partnership HealthPlan of California

Providence Health

ResolutionCare

Roze Room

Snowline