Scaling Palliative Care for Medicaid Enrollees

Lessons Learned from California

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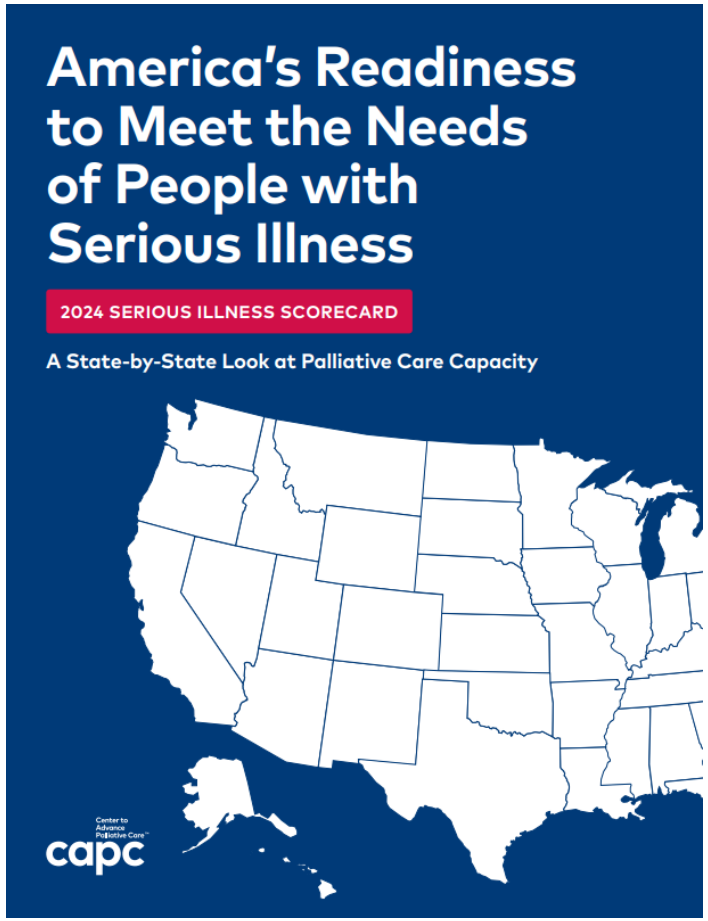
Palliative Care Payment Progress



- 13 states with legislation or regulation specifying payment for specialty palliative care
- Adults and pediatrics
- Reflects innovation and collaboration across multiple parties

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Implementation – If You Build It, Will They Come?

NEEDS:

- Clear understanding of admission/ discharge criteria and the services provided
    - Clarity to avoid duplication
- Referral relationships across care settings
- Training and education for new providers
- Effective public messaging

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Recommendations for Palliative Care Program Standards

High-quality palliative care delivery in any setting should adhere to the field's quality standards, the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care (NCP Guidelines), currently in the fourth edition.

The NCP Guidelines cover eight domains of care, including the structure and processes of the palliative care program as well as the physical, psychological/psychiatric, social, spiritual, cultural, end-of-life, ethical, and legal aspects of patient care. The guidance in each domain forms the basis of certification programs for palliative care programs, such as those offered by The Joint Commission or Community Health Accreditation Partner.

CAPC has coordinated conversations on serious illness strategies and standards and synthesized the NCP Guidelines into a summary that payers and policymakers might use to credential palliative care providers. Our recommendations includes the following:

An interdisciplinary team should have at least three of the following disciplines, including at least one prescriber. Multiple disciplines coordinating on one patient ensures that that physical-psycho-social-spiritual needs are recognized and addressed.

- → *Physician (MD or DO)*
- → *Advanced Practice Provider*
- → *Nurse (Registered Nurse or Licensed Practical Nurse)*
- → *Social Worker (Note: Medicaid-serving programs should **require** a social worker on the team)*
- → *Chaplain or Spiritual Care Professional*

At least one prescriber on the team must have specialty certification in palliative care. We recognize that hiring a certified prescriber may be difficult in certain geographic areas or types of organizations; in this case, the prescriber should demonstrate specific competencies.

Other team members must have either specialty certification in palliative care or documentation of specific competencies, preferably with a goal of working toward certification. Specific competencies gained through credible education programs such as CAPC Designation may be used while working toward specialty certification.

Palliative care services must include, at a minimum:

- → *Comprehensive assessment, to include: pain and symptom distress; functional status; cognitive status; polypharmacy; caregiver burden; emotional and spiritual distress; and social risk factors.*
- → *Pharmacological and non-pharmacological management of pain and other symptoms, including dyspnea, depression, anxiety, nausea, vomiting, fatigue, and constipation*
- → *Specific conversations with the patient and caregiver(s), covering:*
  - *What to expect with their particular diagnosis(es), including prognosis and anticipated symptoms*
  - *What treatment options exist, and the foreseeable impacts of each option (including financial impacts)*
  - *Clarifying values, goals, and treatment preferences. After clarifying goals and preferences, the palliative care team will coordinate with the treating team to help align treatment with patient goals, while considering the least restrictive alternatives.*
  - → *Psychological, social, and spiritual support for patient and caregiver(s), including counseling, education, and connection to needed community resources.*
- → *Development of a crisis intervention plan.*

The program must ensure reliable access to other health professionals and services such as to pharmacists, community health workers, physical therapists, or personal care services; this may be done through linkage and referral.

For community-based programs, 24/7 access to a clinician with proven competencies in pain and symptom management and access to the patient's medical record must be provided, using telehealth as warranted.

Learning Outcomes

- Review the key elements of California's Medicaid palliative care benefit and compare them with the National Coalition for Hospice and Palliative Care's recommendations for community-based palliative care services.
- Outline five actions palliative care advocates can take in states planning to develop or expand Medicaid palliative care, to help shape policy and prepare for implementation of services.
- Describe five promising practices to promote successful implementation of Medicaid palliative care services after a state has defined its benefit parameters.

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Key Elements of California's Medicaid Mandate

Acknowledgments & Background

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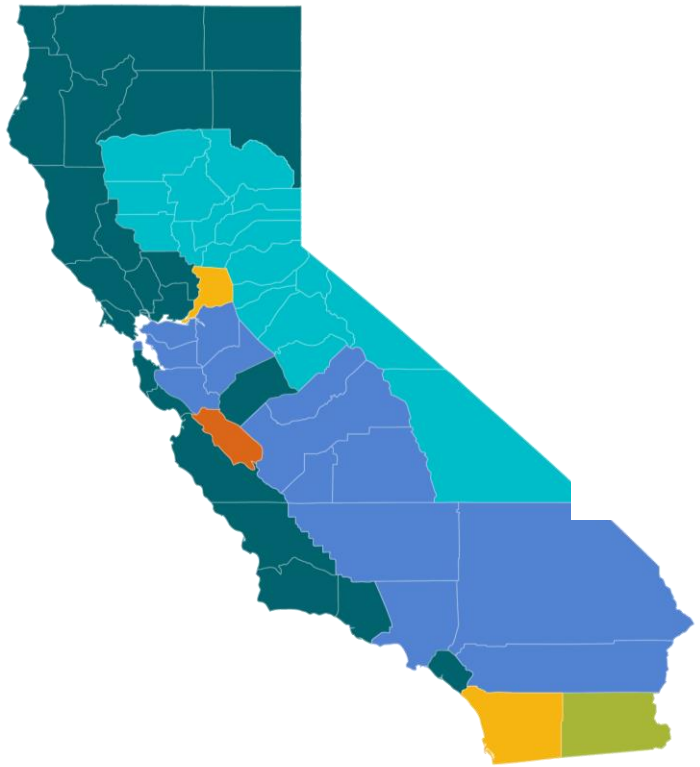
Medicaid (Medi-Cal) managed care in California



California

- 40M people
- 58 counties, range <5K to >10M residents

23 Managed Care Plans (MCPs)

- 13.1M enrollees (86%)
- 20K-2.2M members each
- Mix of commercial and county-organized

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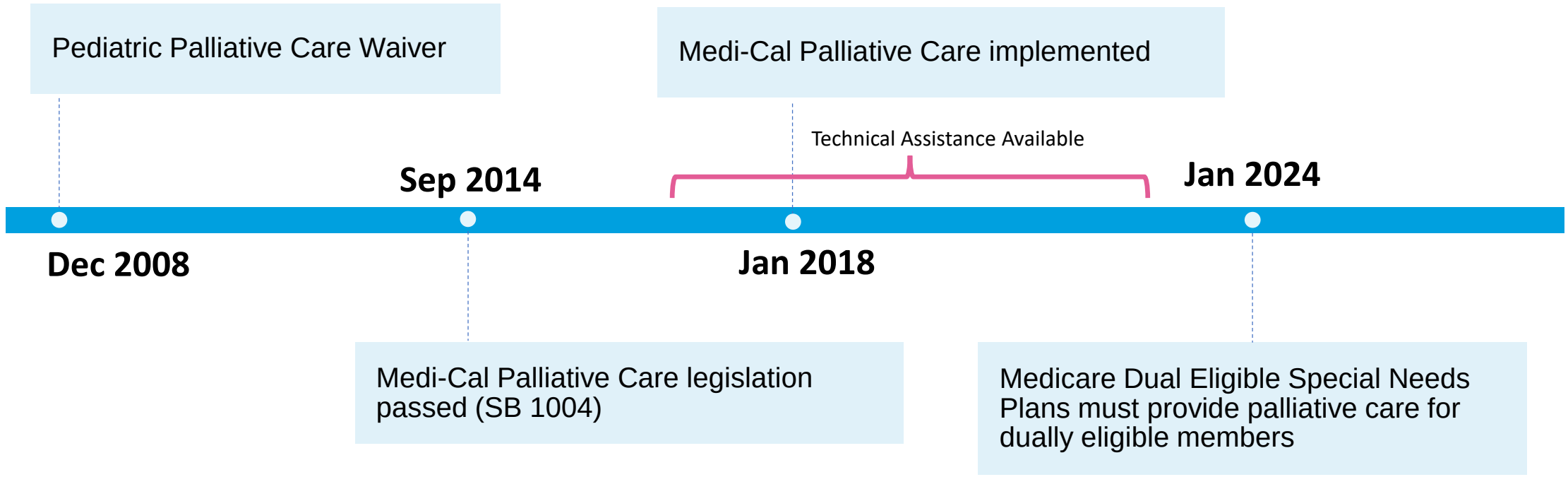
Medi-Cal Facts and Figures – 2024 Edition - California Health Care Foundation

Expansion of palliative care for seriously ill children and adults in California



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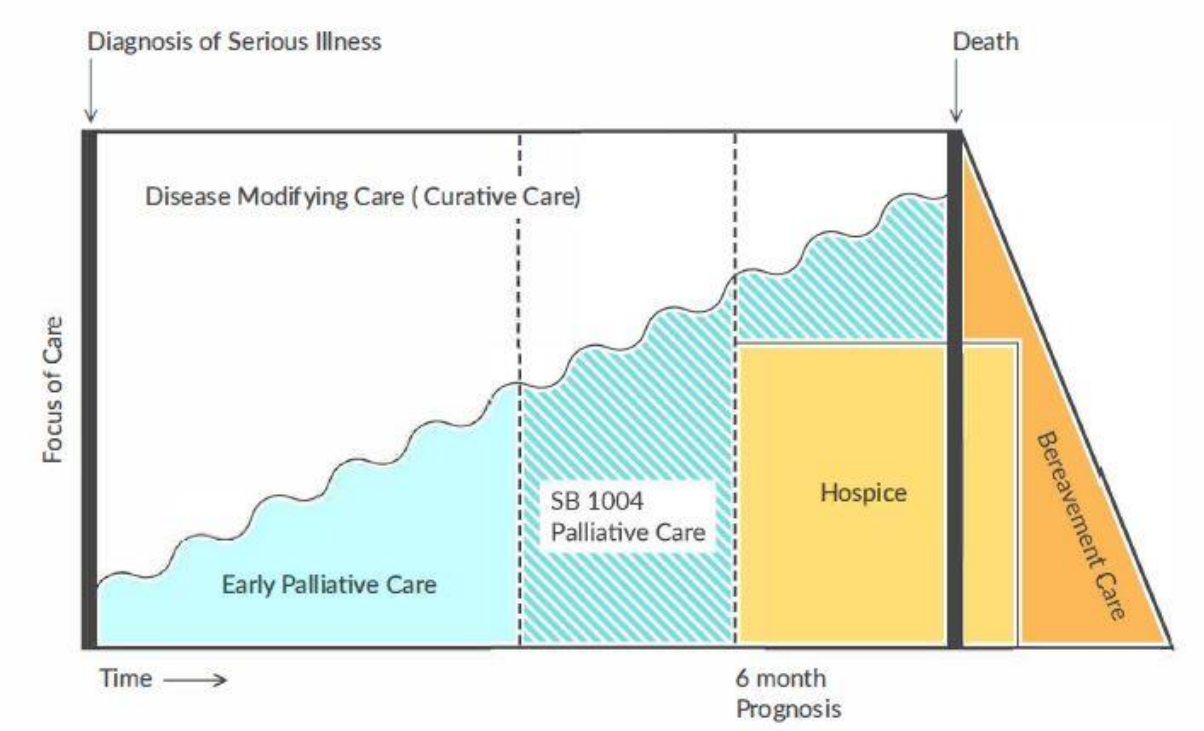
Palliative Care as defined in SB 1004

While palliative care can be delivered at any stage of a serious illness, SB 1004 PC focuses on patients with advanced disease, where life expectancy is about 1 year.



Source: DHCS Palliative Care and SB 1004

Medi-Cal palliative care: Who qualifies?

General Criteria

- Using hospital / ED to manage illness
- Death within a year would not be unexpected
- Willing to engage with PC team, participate in ACP

Qualifying Diagnosis

- Cancer
- COPD
- CHF
- Liver Disease

Evidence of Advanced Disease

- Utilization Criteria
- Bio-markers
- Functional status

*For details see All Plan Letter:
https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Provider requirements

Providers

- "Qualified providers for palliative care based on the setting and needs of a beneficiary"
- DHCS recommends using providers with current palliative care training and/or certification

Organizations

- "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"

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*For details see All Plan Letter:
https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Interdisciplinary Team

Disciplines	California	NCHPC*
Physician	Recommended	x
Registered Nurse or Advanced Practice Nurse	Recommended	x
Social Worker	Recommended	x
Access to Chaplaincy	Recommended	x
Access to Pharmacist		x
Community Health Worker/Lay Navigator		Recommended
At least one team member must be certified in hospice and palliative care, preferably a prescriber.		x

*Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models | Center to Advance Palliative Care

Services

Services	California	NCHPC
Proactive Identification		x
Comprehensive Assessment & Consultation	x	x
Care Plan Development & Implementation	x	Implied
Interdisciplinary Team	x	x
Pain and Symptom Management	x	x
Care Coordination	x	x
Advance Care Planning	x	x
Provide/Refer to Mental Health & Medical Social Services	x	x
Family Caregiver Assessment/Support		x
Aide services to meet personal care needs		x
24/7 Access, including Telemedicine Access	Recommended	x

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Seven years into California's Medicaid PC mandate: Where are we now?

State required plans to submit data only for the first 2 years of implementation

CHCF/CCCC team supported implementation and monitored progress

- Technical assistance
- Community building
- Yearly surveys of MCPs and PC Providers

Thousands of Medi-Cal beneficiaries have received home-based palliative care

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10 Recommendations Based on the California Experience

Recommendations: Pre-Implementation

01

Require care delivery by an appropriately trained, interdisciplinary team

02

Mandate a bundled payment

03

Err on the side of inclusivity for eligibility

04

Develop an implementation plan

05

Consider a small pilot

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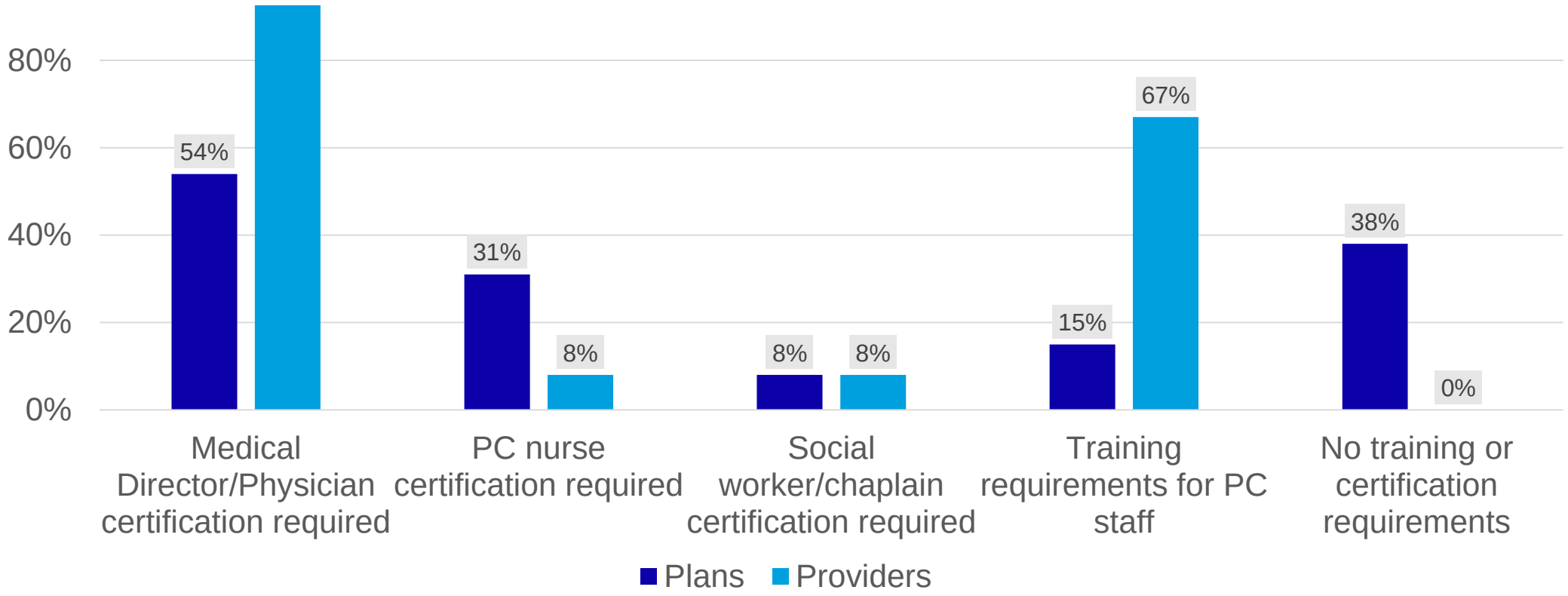
01

Require care delivery by an appropriately trained, interdisciplinary team

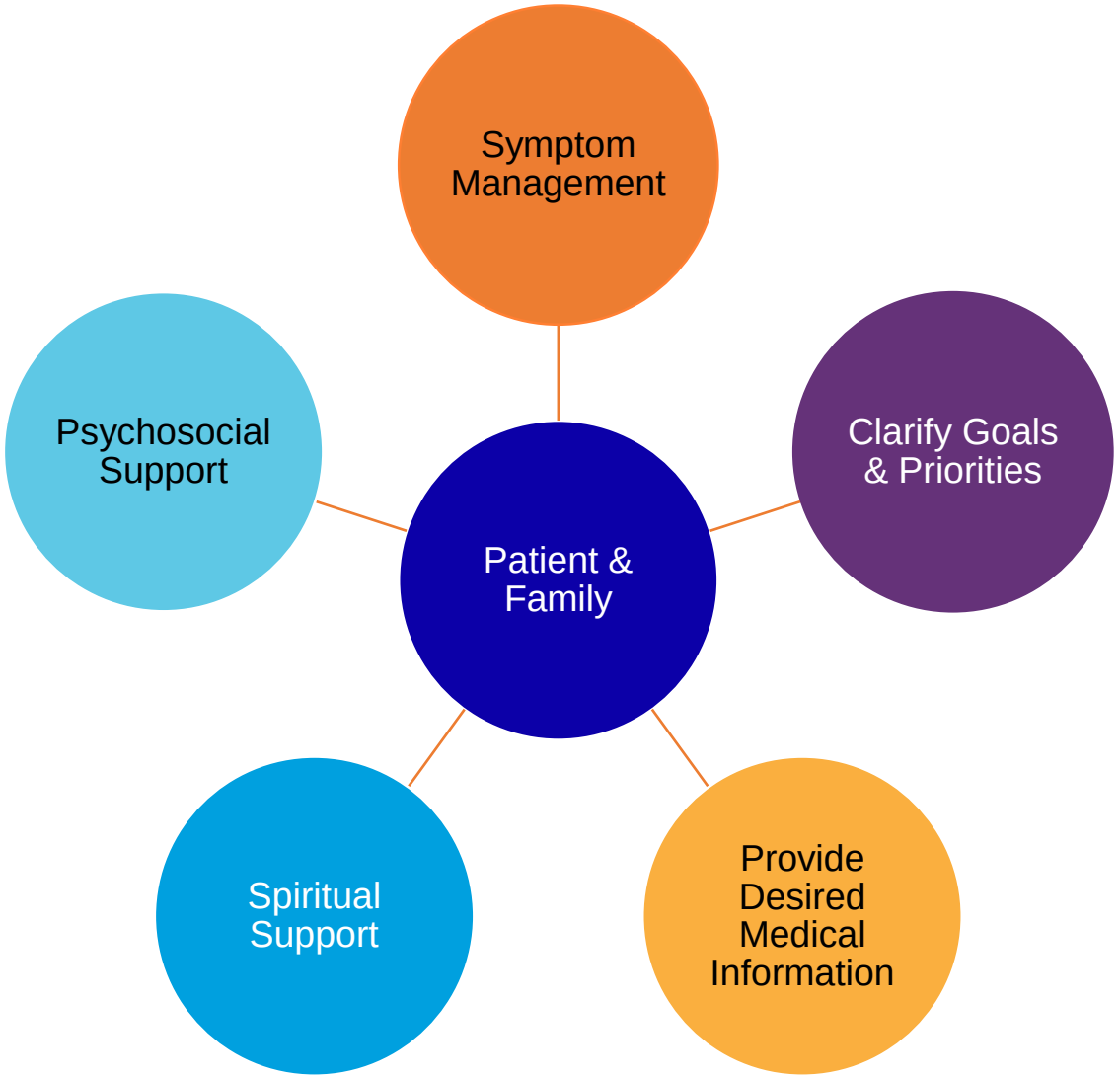
- Quality palliative care programs are interdisciplinary
- Appropriate training
  - Specialist-level palliative care skills/experience
  - Orientation to the needs of the Medicaid population
  - Aligned services available from plans and community organizations

Certification & training requirements

Medi-Cal Palliative Care requirements specify that plans work with "qualified" providers and recommend they possess current certification and/or training. How have plans and palliative care organizations responded?

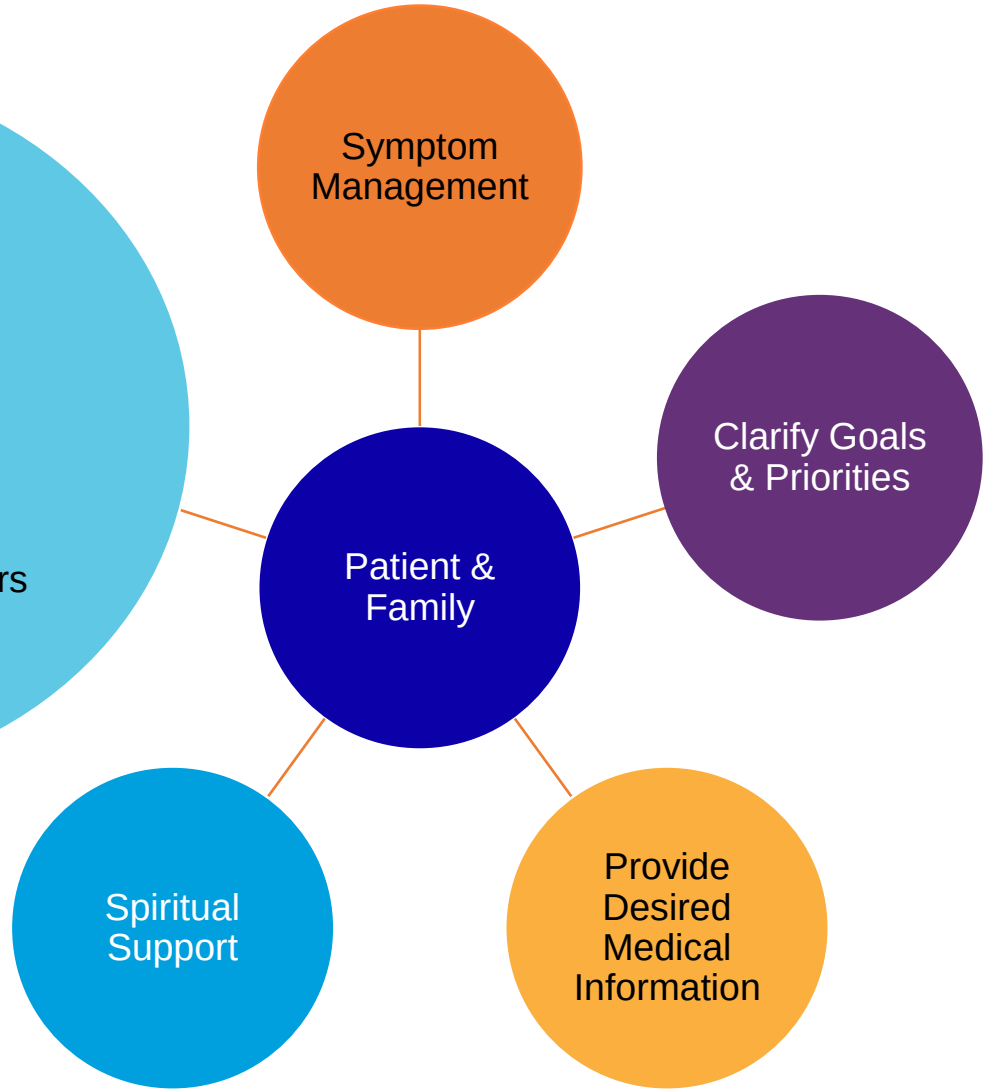


Areas of focus in palliative care



Areas of focus in palliative care: Medicaid Population

- Transportation access
- Health literacy
- Technology literacy
- Housing security
- Caregiving needs
- Financial security
- Language/cultural barriers
- Mental health/trauma



Mandate a bundled payment

- There’s no way to deliver effective longitudinal team-based care with a FFS payment model
  - *Most MCPs in California use a bundled payment*
- Additional incentive payments may help with quality and sustainability
- Payment amount needs to align with the scope expected of PC providers

How MCPs pay for palliative care

Assessment fee (25%)

Per enrolled member per month (PMPM) case rate (67%)

FFS supplement to PMPM for ultra-high-need members (17%)

Incentives (8%)
- ED visits or hospitalizations
- Data collection
- Completing ACP documents

Fee For Service (33%)

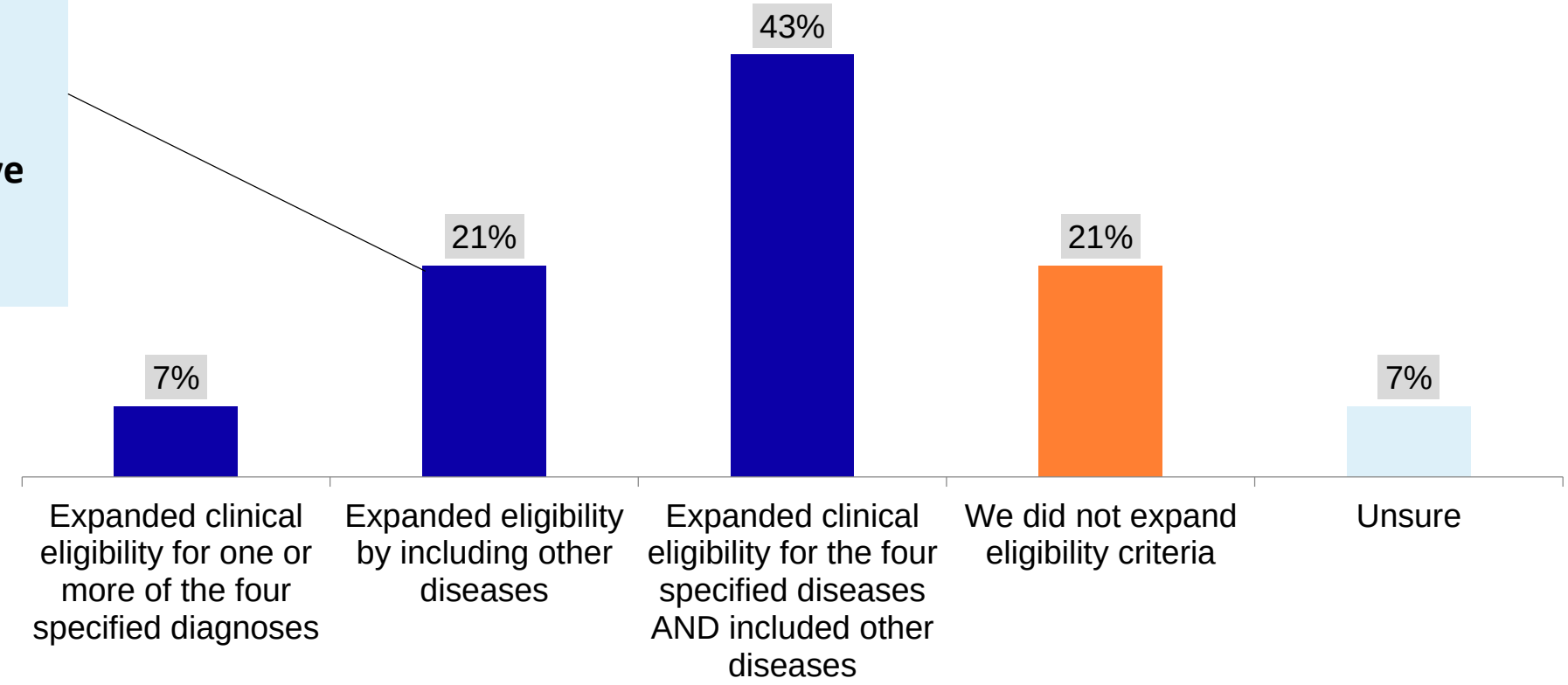
Err on the side of inclusivity

- Concerns about overwhelming demand led to unnecessarily narrow eligibility criteria
- Most successful plans now specify 9-10 eligible diseases
- Specifying encourages enrollments, is more efficient, and reduces variation across plans and regions
- Inadequate enrollment is identified by plans and providers as a sustainability threat

Most MCPs go beyond state requirements

Commonly Added Diseases:
Renal Disease
CVA/Stroke
Neurodegenerative
Dementia
AIDS

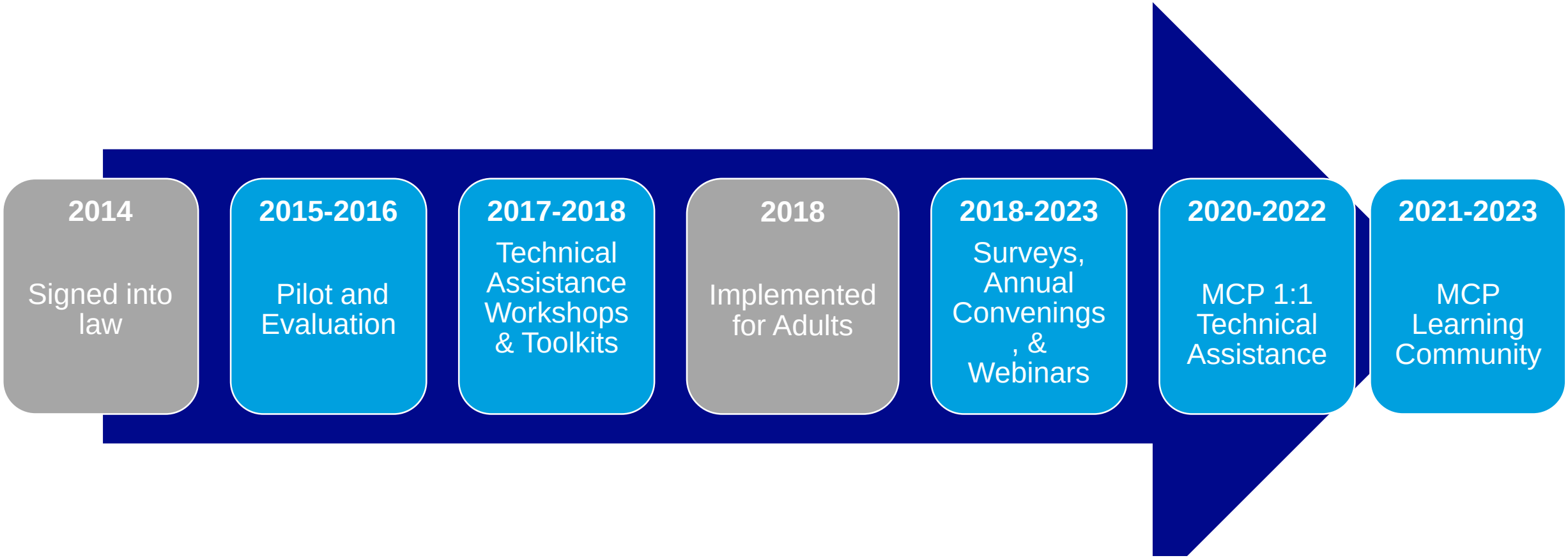
% of plans that expanded on DHCS' minimum eligibility criteria



Develop an implementation plan

- Key groups bring unique knowledge and experience to the table:
  - Plans may have little experience with palliative care
  - Providers may have limited experience with Medicaid members
- Identify coordinating entity to organize implementation efforts
- Gather payer and potential provider groups together to anticipate challenges
- Strategic investments help to equip and engage plans and providers through implementation

California Implementation Activities



California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

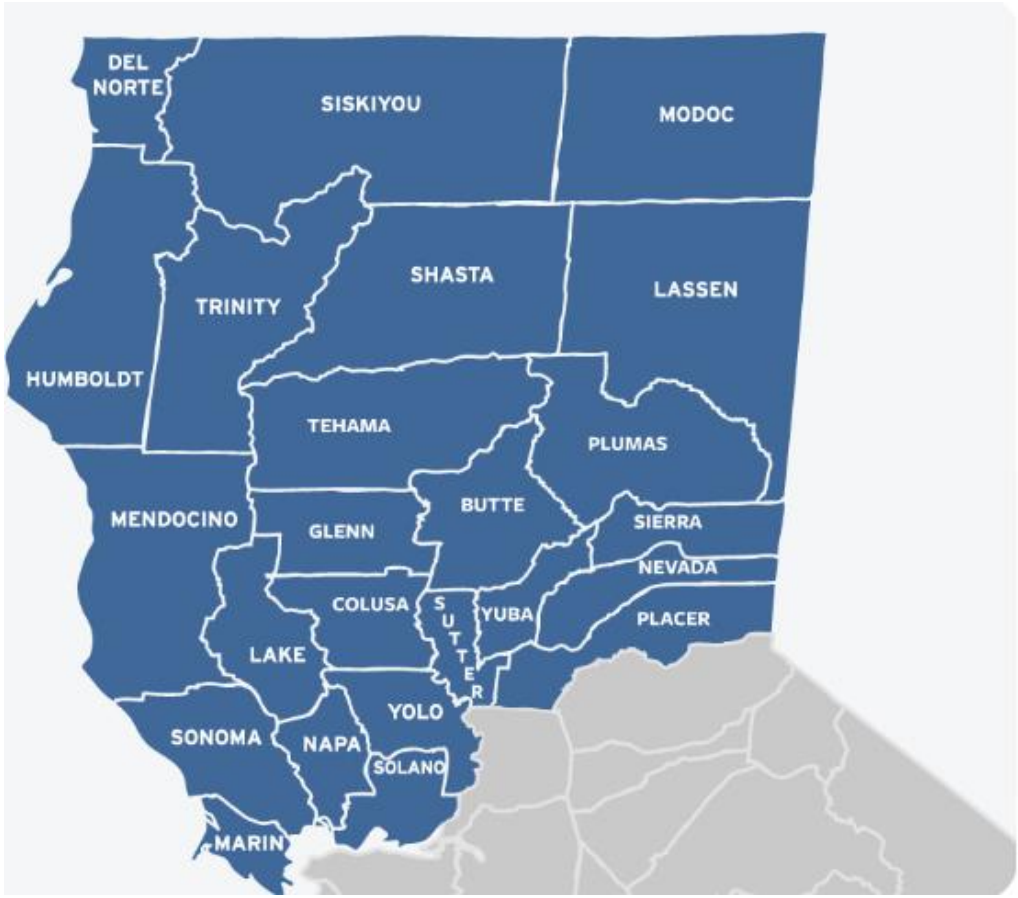
Consider small pilot programs

- Early adopters can positively impact broader implementation:
  - Identify challenges
  - Share promising practices
  - Reassure peers who have less experience with PC/Medicaid population

Example Pilot Program

- Partnership Health Plan
- 6-month pilot
- 4 PC Provider Organizations
- 81 enrolled members
- Quantitative & qualitative evaluation

Serving 24 counties in northern California



https://www.chcf.org/wp-content/uploads/2019/06/PartnershipHealthPlanPartnersPalliativeCarePilot.pdf

Pilot program: Early outcomes

Provider learnings	Plan financial analysis
• High burden of psychosocial needs • Lower rates of ACP completion	• Total cost of care (including program cost) was 33-50% less for members that received palliative care • Primarily due to a marked decrease in hospital days while enrolled in the program • **$3 saved for every $1 spent on the program**

Recommendations: Post Implementation

06

Track enrollment

07

Support active payer-provider relationships

08

Involve the entire, local healthcare ecosystem

09

Create a learning community

10

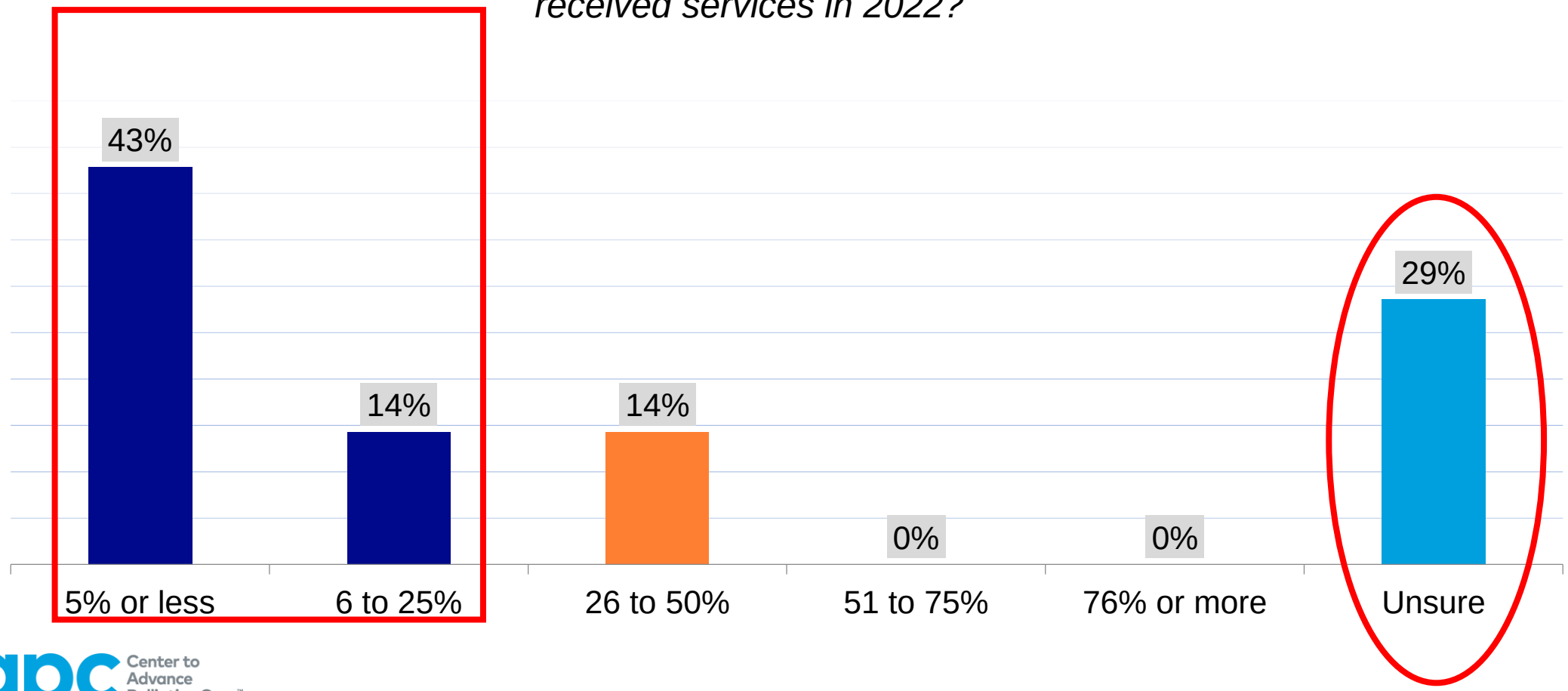
Keep the state engaged

Track Enrollments

- Tracking enrollment, preferably through a public dashboard, helps to encourage improvement
  - Recognize and/or reward plans that achieve optimal uptake
  - Consider defined action for plans that have minimal uptake or show minimal attention to program

Uptake: Eligible vs. enrolled members

What proportion of your adult Medi-Cal members who were eligible for PC received services in 2022?



Encourage active payer-provider relationships

- Regular communication/collaboration between plans and providers can contribute to success
  - Operational meetings to refine pathways for identification → referral → enrollment → payment
  - Clinical/patient-level collaboration to leverage organizational resources adjacent to the palliative care program
  - Reviewing program process and outcome measures led to QI
- Statewide learning opportunities allow best practices in payer-provider partnerships to spread more broadly

Consider the entire, local healthcare ecosystem

- **One size does not fit all** – rural vs. suburban or metropolitan often require different resources/models
- Patient identification may come from non-traditional sources, or be different from what has worked with the Medicare population
- Plans can be important connectors for PC providers:
  - Bring in resources from other programs
  - Introduce to key referral sources
- Education on the palliative care benefit needs to be multimodal and repeated

Create a learning community

- Peer learning was highly valued by plans and providers, before and after implementation
  - Level setting
  - Sharing/learning best practices
  - Highlighting innovation
- Regular convenings fostered continued engagement, focus on quality improvement, and opportunities to prepare for changes to the program (or related programs)

Learning Community: Structural Considerations

1. Have a central organization that stays connected and responds to needs/requests
2. Consider who needs to be engaged when
   - State
   - Plans
   - Providers
3. Create opportunities for small group learning, peer support
   - Workshops
   - Open fora/office hours
4. Create opportunities for dissemination of info, synchronous and asynchronous learning:
   - Toolkits
   - Webinars
   - Annual meetings
5. Monitor and share progress (e.g. surveys)

Keep the state engaged

- The state is often best positioned to track enrollments, support incentives or penalties that encourage use of benefit
- Continue the policy conversation – recognize that adjustments and expansion may be indicated after the first 2-3 years of implementation
- Connect palliative care with other relevant Medicaid programs as they roll out (or change)

10 Recommendations

Pre-Implementation

01
Require delivery by an appropriately trained IDT

02
Mandate a bundled payment

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Err on the side of inclusivity for eligibility

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Develop an implementation plan

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Consider small pilot

Post-Implementation

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Track enrollment

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Support active payer-provider relationships

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10
Keep the state engaged

Thank you and resources

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- Medi-Cal Managed Care Plan Learning Community Resources (coalitionccc.org)
- Palliative Care – National Academy of State Health Policy
- California's Palliative Care Evolution: Celebrating Progress and Shaping the Future - California Health Care Foundation (chcf.org)
- HEALTH PLAN TOOLKIT | Transforming Care (transformingcarepartners.com)

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