Community-Based Palliative Care for Seriously Ill Members: Lessons from a Multi-Plan Pilot

Presentation to the California Association of Health Plans
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COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

California Health Care Foundation

Agenda

1. Brief introduction to palliative care
2. Why standards are needed
3. Findings from demonstration project
4. Supporting optimal implementation
5. Reflections and recommendations

Introduction to Palliative Care

What is Palliative Care

- Specialized medical care for people with **serious illnesses**
- **Relieves symptoms, pain, and stress** of a serious illness—whatever the diagnosis
- Improves quality of life for **both the patient and the family**
- Provided by a **team** of doctors, nurses and other specialists who provide an extra layer of support.
- Appropriate at **any age** and at **any stage** in a serious illness along with curative treatment

Center to Advance Palliative Care

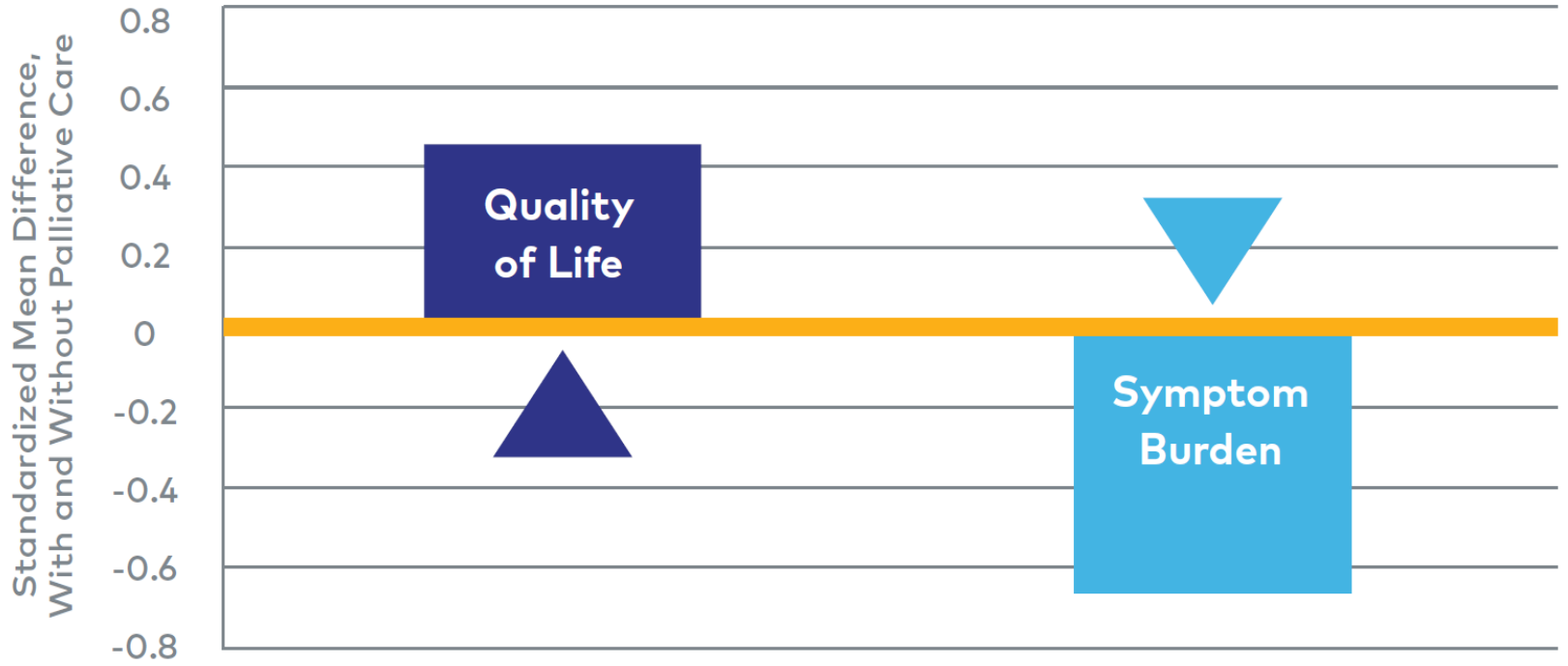
Key Components of Palliative Care

When Palliative Care Can Help

- **Patient using hospital or ED to manage advanced illness**
- Significant changes in functional status
- Difficult to control symptoms
- Travelling to care becomes prohibitive
- Patient and/or family unsure of or in conflict about treatment goals
- Patient needs extra support understanding disease progression, how to manage safely at home
- Patient needs more support than can feasibly be delivered in the office setting

Benefits to Members

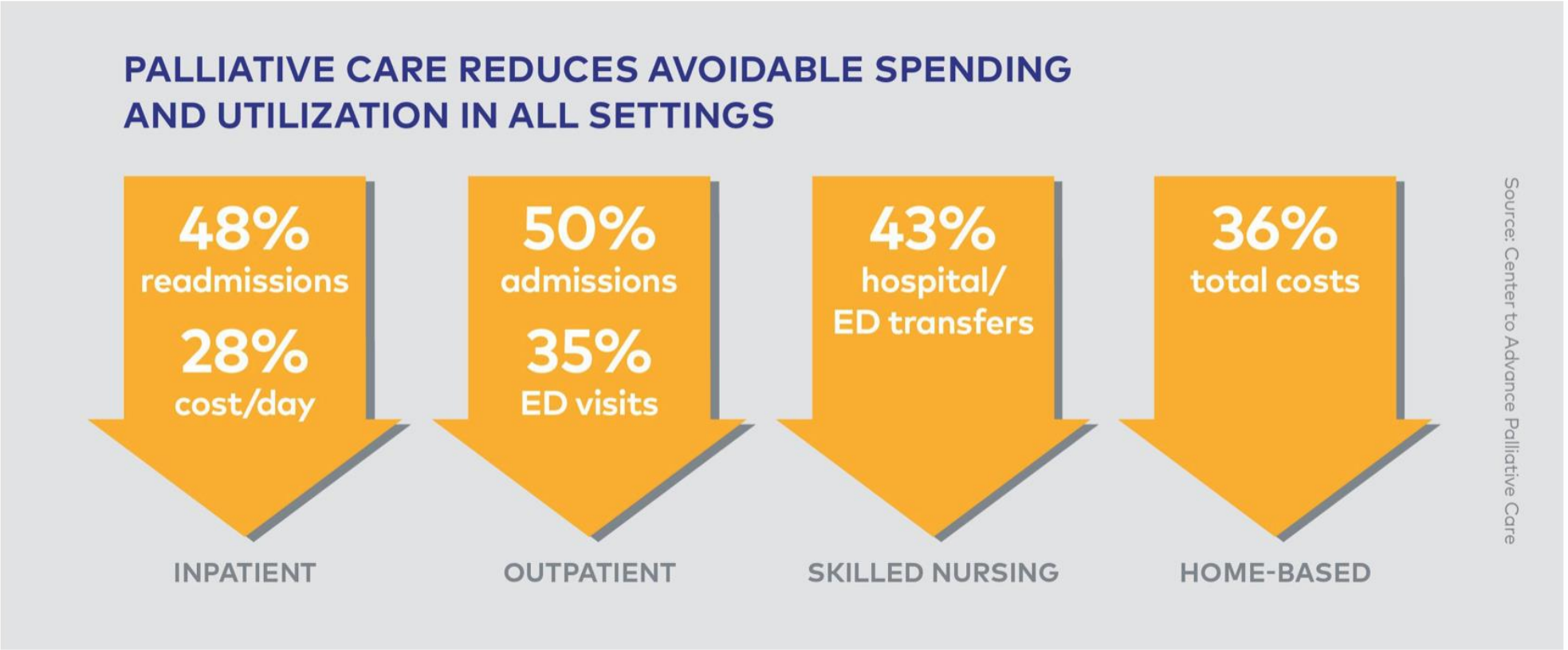
Improvements in Quality of Life and Reduced Symptom Burden through Palliative Care



Analysis and graphic from *Serious Illness Strategies for Health Plans and Accountable Care Organizations*. Center to Advance Palliative Care

Source: *Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis*. D Kavalieratos, et al. JAMA. 2016;316(20):2104-2114. doi:10.1001/jama.2016.16840

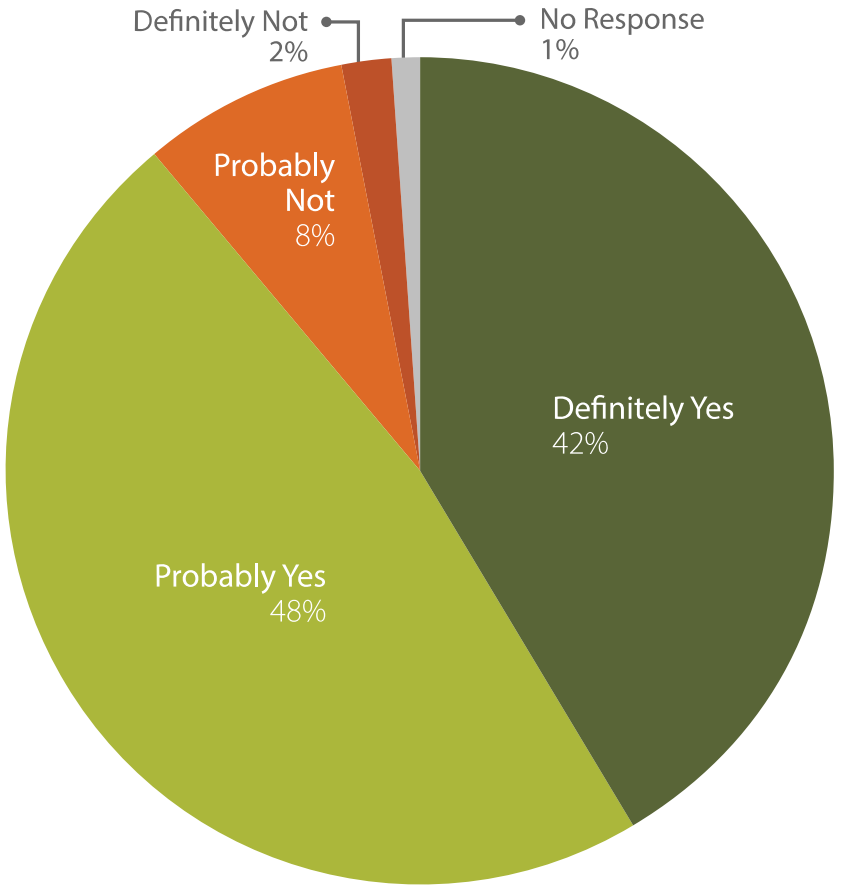
Better Care Reduces Costs

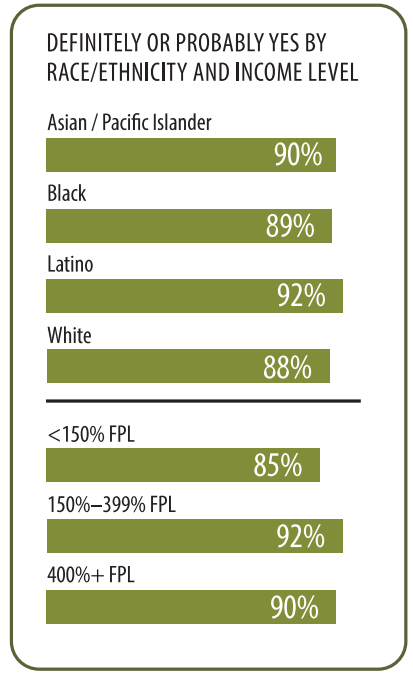


Analysis/graphic from *Serious Illness Strategies for Health Plans and Accountable Care Organizations*. Center to Advance Palliative Care

Care People Want

Would you want this type of help if you had a serious illness?

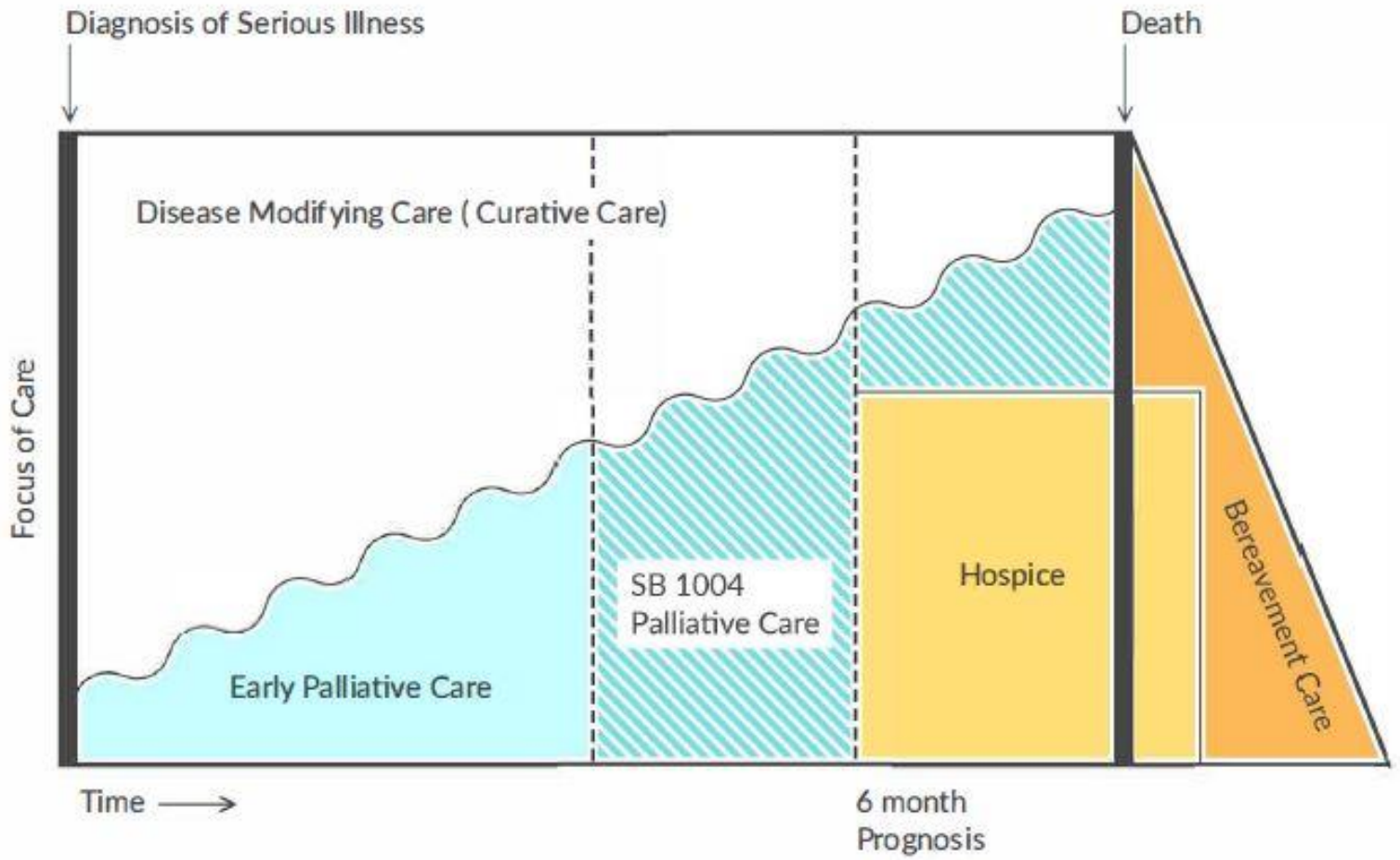




Notes: Respondents without a serious illness are those who do not report emphysema or chronic obstructive pulmonary disease, heart failure, cancer, a stroke, HIV/AIDS, cirrhosis or late-stage liver disease, chronic or end-stage kidney disease, or another serious illness. In 2019, the federal poverty level (FPL) was $12,490 for a single person and $25,750 for a household of four. Segments may not total 100% due to rounding.

Source: *Californians' Attitudes Toward and Experiences with Serious Illness and End-of-Life Care*, statewide survey of 2,588 adult Californians, PerryUndem, 2019.

Medi-Cal Palliative Care



Source:[DHCS Palliative Care and SB 1004]

Why Standards Are Needed

CBPC Landscape in 2016

NATIONAL CONTEXT

- Community-based (in-home) palliative care (CBPC) an emerging treatment model
- National consensus guidelines describing best practices available
- Growing body of literature showing positive outcomes
- No federal requirements or standards for CBPC

CALIFORNIA CONTEXT

- Law requiring access to CBPC for Medicaid beneficiaries signed but not implemented
- Some early-adopters offering CBPC to members/patients
- Significant variation in payer requirements and provider offerings

Consequences of Unnecessary Variation

PALLIATIVE PROVIDERS

- Managing multiple contracts with different requirements
- Extremely difficult from operational perspective

PLANS

- Time-consuming contracting process
- Uncertainty re what to offer to members or require of providers, appropriate payment model, how to assess impact/quality

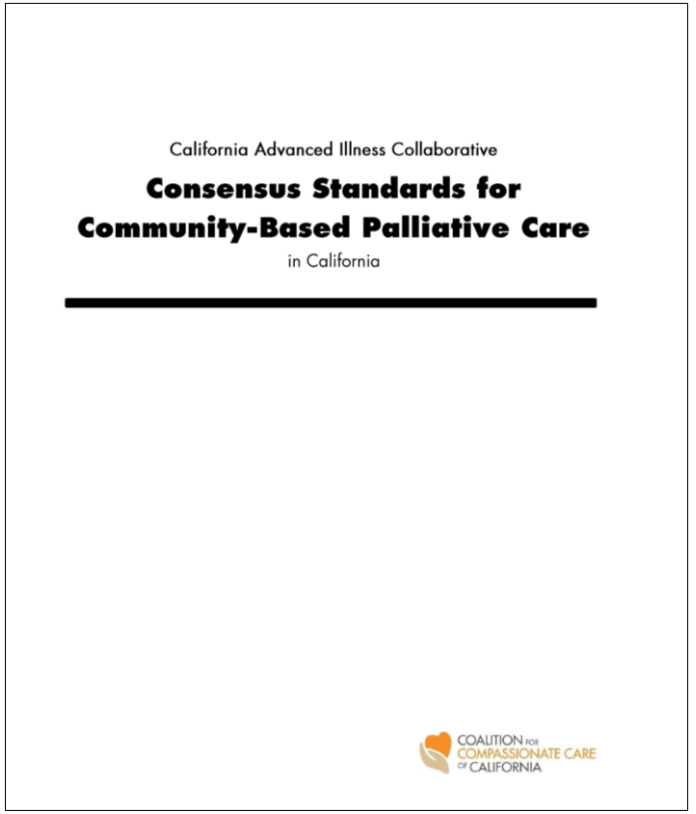
REFERRING PROVIDERS

- Uncertain what getting if refer a patient to CBPC, or if hear patient is getting CBPC

Impediment to development, sustainability, use and spread of CBPC

CCCC Consensus Standards

- Released March 2017
- Development team, the California Advanced Illness Collaborative (CAIC), included payers, CBPC providers, policy advocates, researchers
- Based on current understanding of best practices
- Intended to specify **minimums** acceptable to any payer or provider
- Intended to inform contracting for **home-based** palliative care
- Generally aligned with Medi-Cal palliative care mandate (SB 1004)



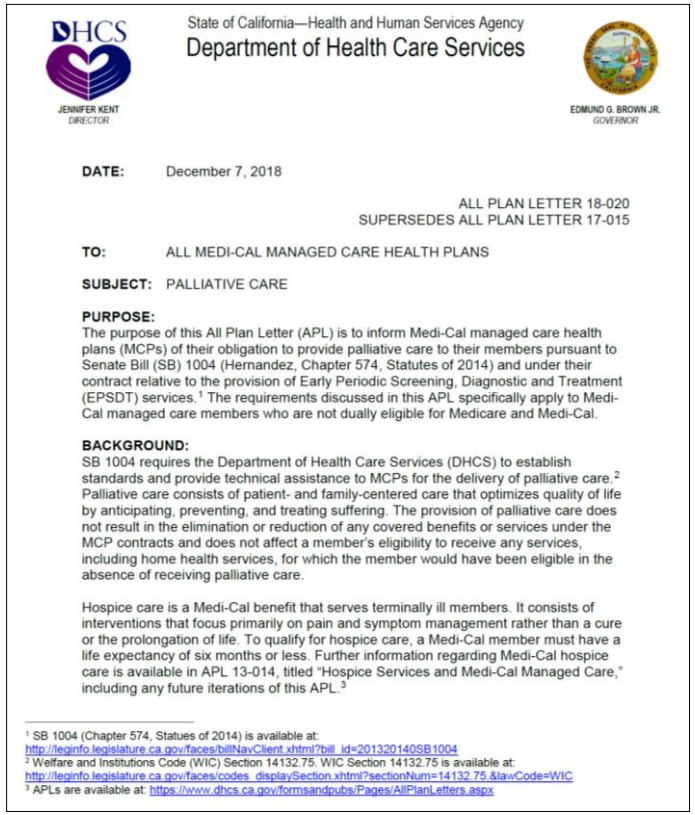
California Advanced Illness Collaborative

Consensus Standards for Community-Based Palliative Care

in California

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Link to Consensus Standards



DHCS

JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 7, 2018

ALL PLAN LETTER 18-020
SUPERSEDES ALL PLAN LETTER 17-015

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PALLIATIVE CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their obligation to provide palliative care to their members pursuant to Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014) and under their contract relative to the provision of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.[1] The requirements discussed in this APL specifically apply to Medi-Cal managed care members who are not dually eligible for Medicare and Medi-Cal.

BACKGROUND:
SB 1004 requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to MCPs for the delivery of palliative care.[2] Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the MCP contracts and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

Hospice care is a Medi-Cal benefit that serves terminally ill members. It consists of interventions that focus primarily on pain and symptom management rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care is available in APL 13-014, titled "Hospice Services and Medi-Cal Managed Care," including any future iterations of this APL.[3]

[1] SB 1004 (Chapter 574, Statues of 2014) is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1004
[2] Welfare and Institutions Code (WIC) Section 14132.75. WIC Section 14132.75 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.75.&lawCode=WIC
[3] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Link to Medi-Cal Palliative Care (SB 1004) Site

What the Standards Address

Eligibility

Services

Staffing / Providers

Payment Model*

Measurement and Reporting*

- Intended to set minimums, but invited to do more (expected variation)
- Specify “what” but not “how” (expected variation)

** Not addressed in Medi-Cal palliative care (SB 1004) guidance*

Findings from Demonstration Project

Demonstration Project 2018-2021

Focus

- Evaluate outcomes and variation in care delivery
- Assess experiences of plans and providers
- Are we achieving balance?
  - ***Acceptable to plans?***
  - ***Acceptable to providers?***
  - ***Outcomes that justify the investment?***

Features

- Multiple payers and providers delivering CBPC in Sacramento and/or Los Angeles
- Multiple lines of business
- Contract requirements met or exceeded the Standards or SB 1004 requirements
- Claims analyses looking at fiscal outcomes
- Qualitative data collection and group activities through Dec 2021
- Project led by CCCC, funded by CHCF

Outcomes are Driven by ‘What’ and ‘How’

Hoped for Effects of Setting Minimum Standards

	Promote	Prevent
Eligibility	Appropriate population receives services	Overly restricted or loose access
Services	Comprehensive intervention aligned with national consensus guidelines	Narrow/incomplete scope
Staffing/Providers	Use of trained IDT that includes appropriate disciplines	No team / wrong team / no training
Measurement/Reporting	Meaningful and feasible for plans and providers	No monitoring or excessive, burdensome monitoring
Payment Model	Covers entire team and cost of all core services; aligned incentives	Un-reimbursable effort for core team members/services; mis-aligned incentives

If hoped for effects not achieved could be result of:

- Failure to adhere to the Standards
- Flaws in the Standards
- Implementation issues/choices not addressed in the Standards

Perspectives on Standards

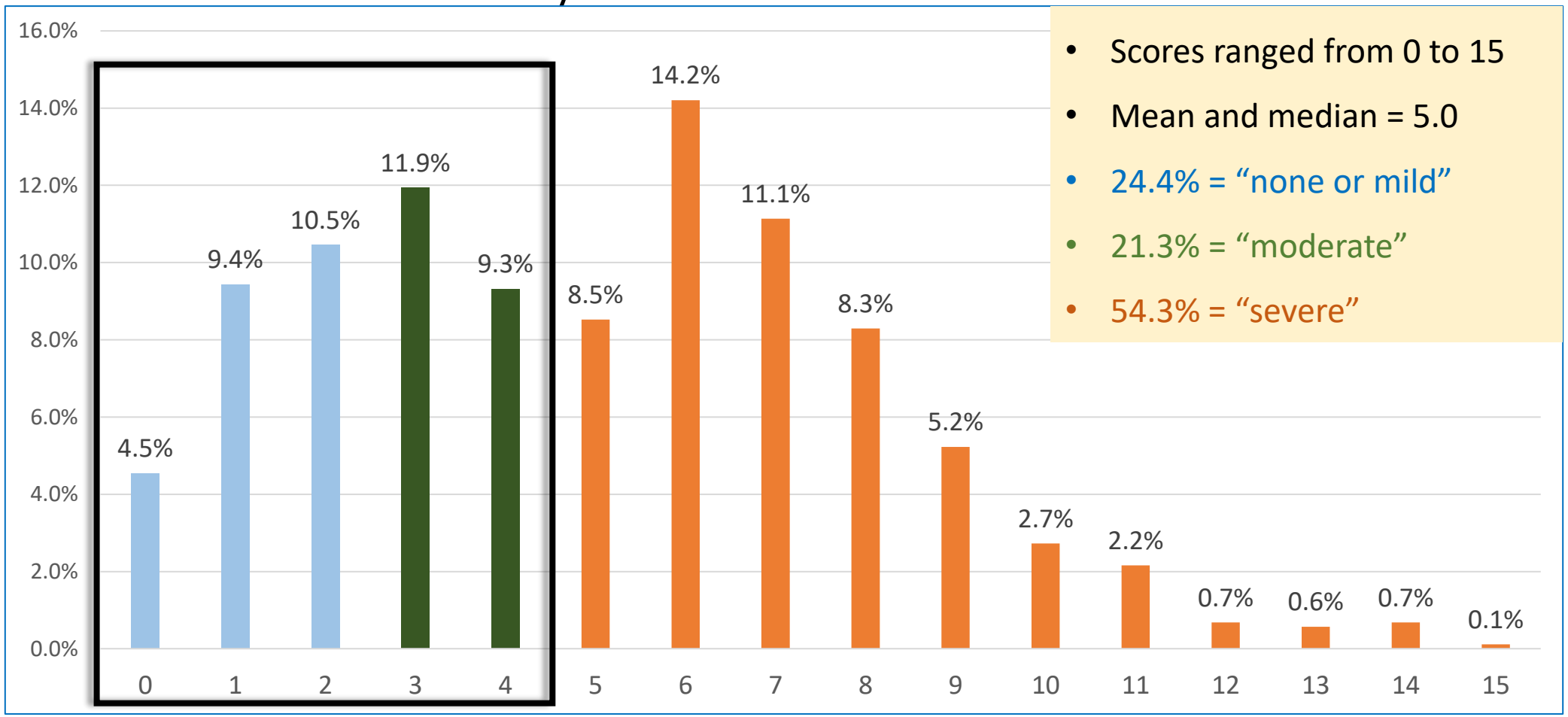
	Payer Experiences	Provider Experiences
Eligibility	Standards perceived as missing important diseases	Most feel too restrictive
Services	Importance of adding 24/7, spiritual supports, caregiver support	**NO ISSUES**
Staffing / Providers	**NO ISSUES**	**NO ISSUES**
Measurement / Reporting	Mixed perceptions re meaningful and feasible	Some felt too burdensome
Payment Model	**NO ISSUES**	**NO ISSUES**

Perspectives on Implementation

	Plans	Providers
Eligibility	Inadequate surveillance allowed non-compliance for 1 payer.	**NO ISSUES.**
Services	**NO ISSUES.**	Difficulties when contracts specified frequency and mode of contact
Staffing/ Providers	Need for more training in early PC; improve communication with PCPs	Some training & meeting requirements deemed burdensome
Measurement / Reporting	Missing patient experience data; incomplete adherence	Issues with consistency, burden, pertinence, sustainability
Payment Model	Evolving financial expectations for early PC	Issues with payment amount/sustainability

Variation in Enrolled Population

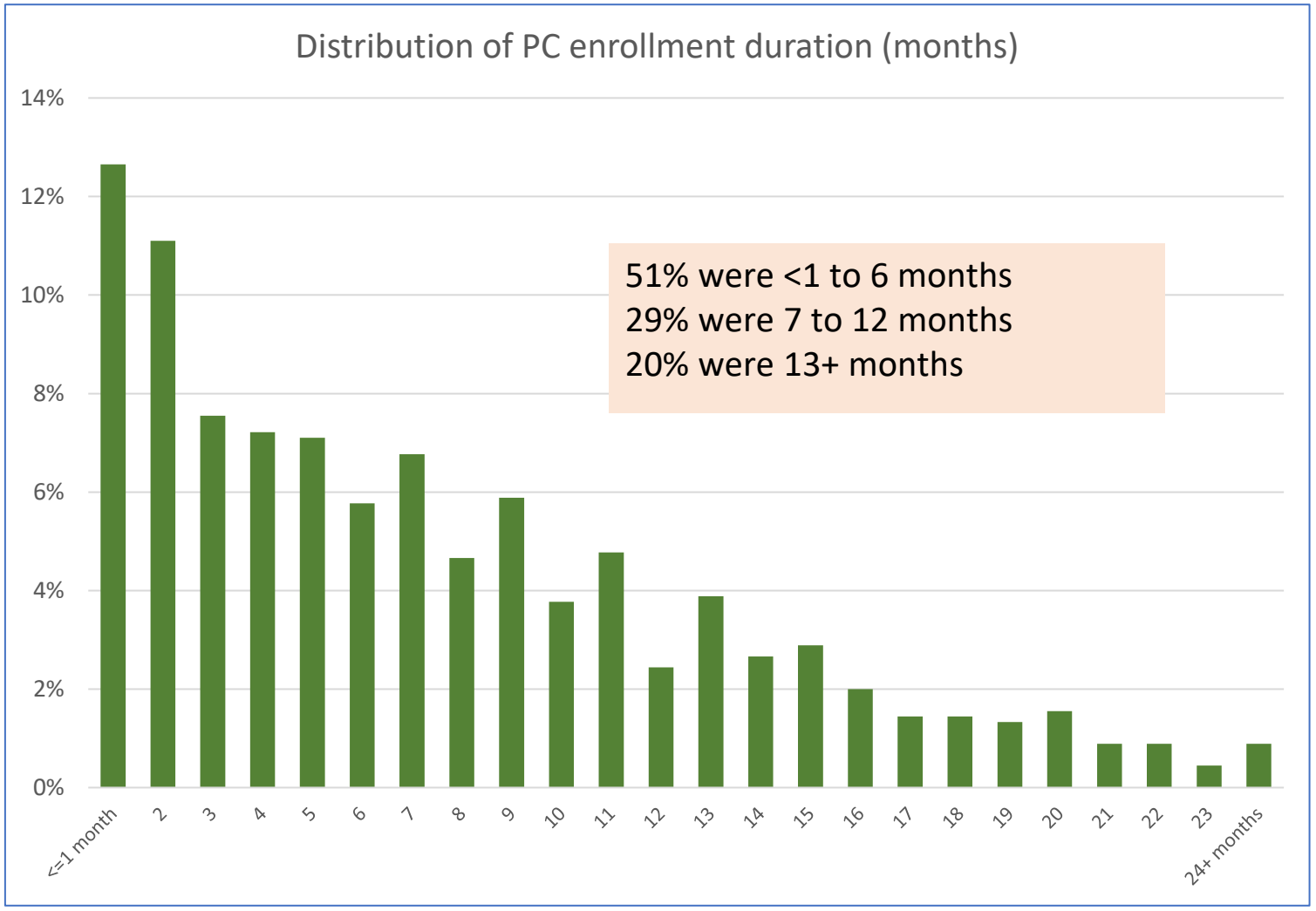
Charlson Comorbidity Index

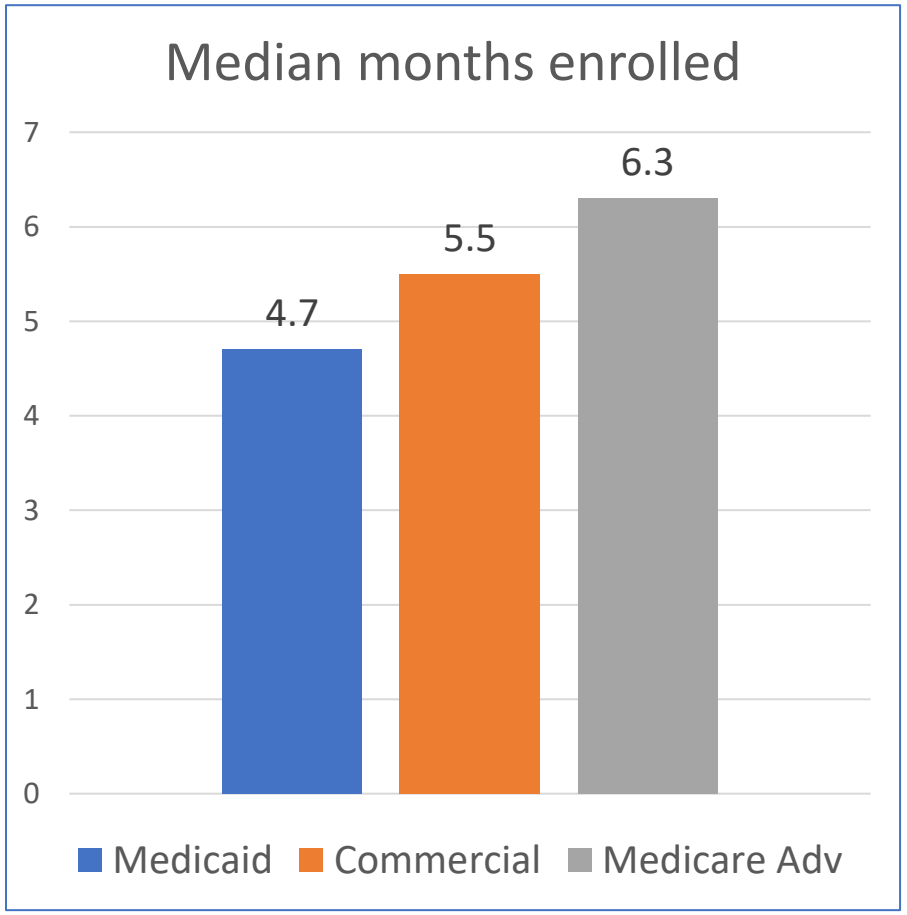


- Scores ranged from 0 to 15
- Mean and median = 5.0
- 24.4% = “none or mild”
- 21.3% = “moderate”
- 54.3% = “severe”

CCI is a weighted score of 17 conditions evaluated from top 4 diagnosis codes on all claims in year prior to palliative care enrollment.

Variation in PC enrollment (months)

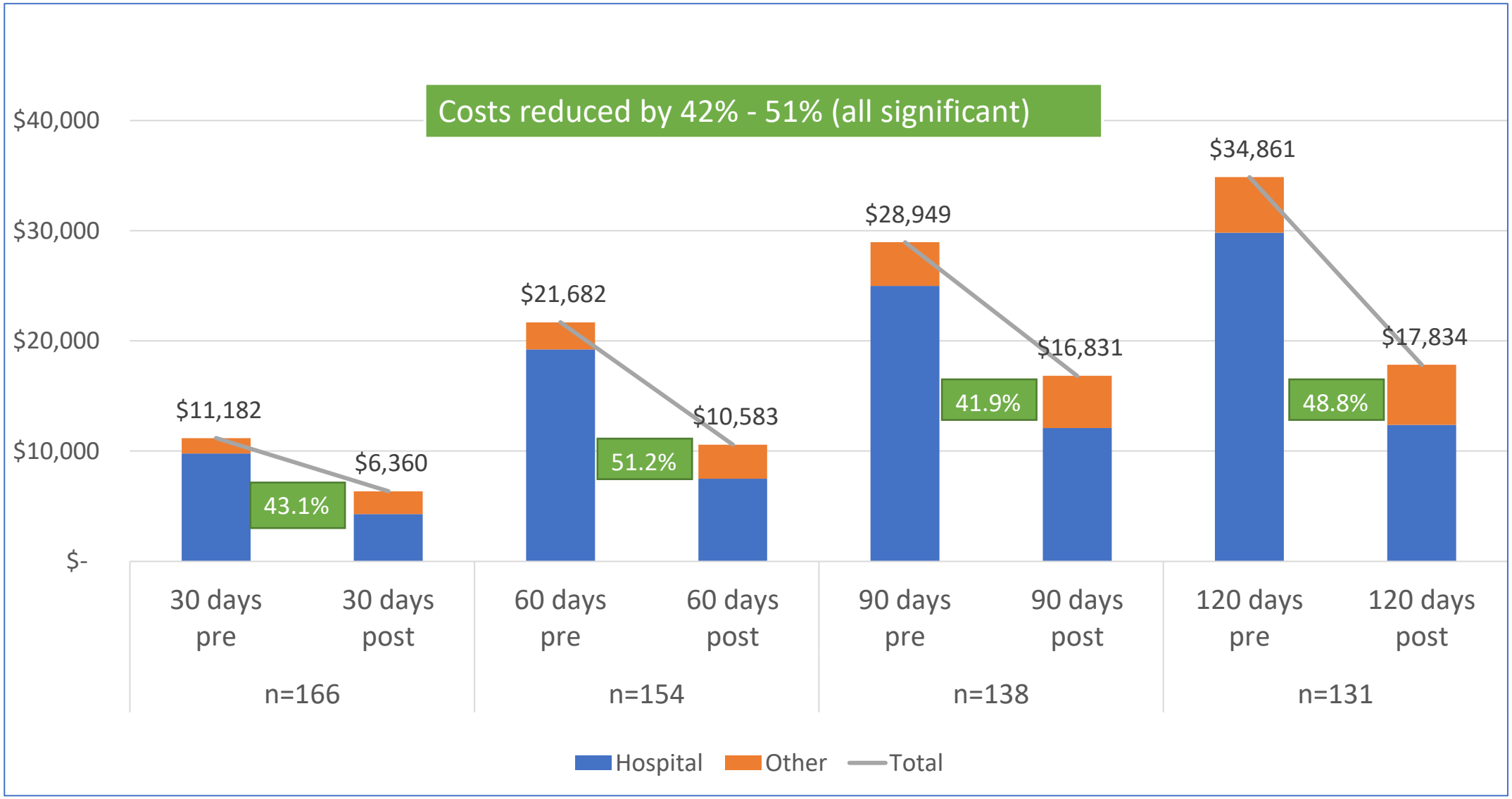




Medicaid by plan:
3.1, 5.7, 6.5 months

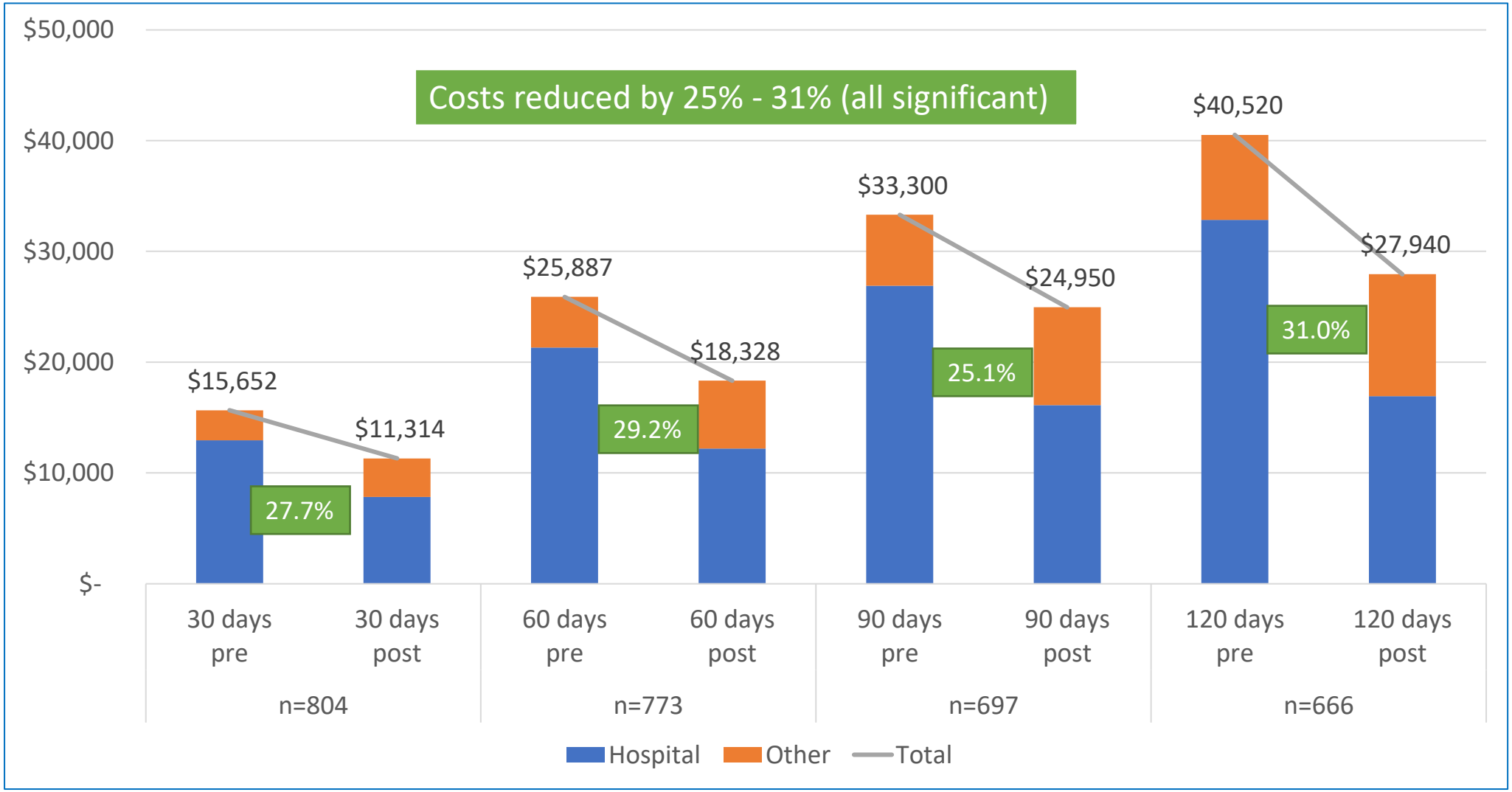
Fiscal Outcomes

Medi-Cal



Fiscal Outcomes

All insurance types combined



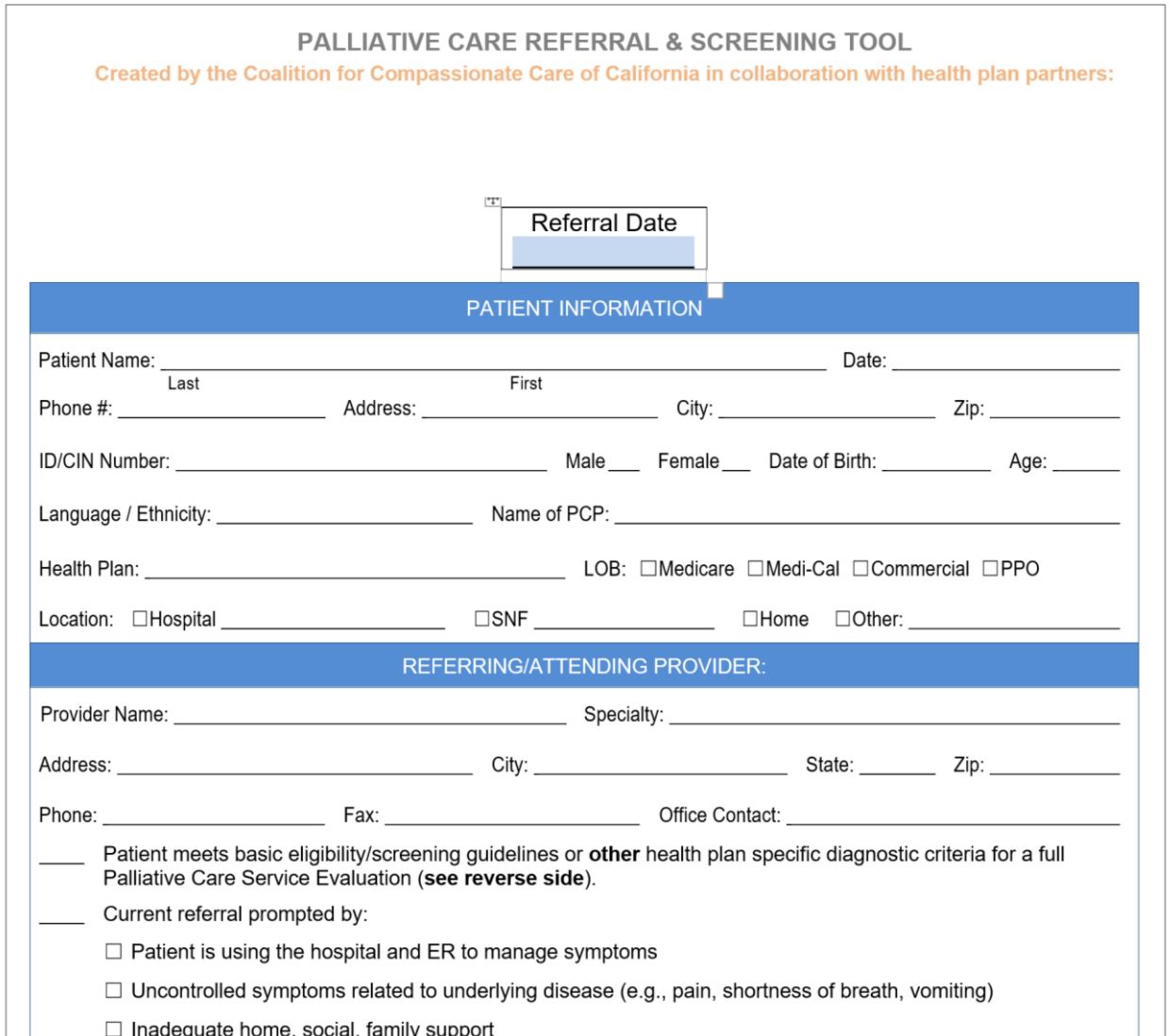
Standards are a Starting Point

	Enhancements to "What"	Choices for "How"
Eligibility	• Add specific diseases? • Relax dx-specific criteria?	• How to identify potentially eligible members • Method for verifying eligibility • Strategies for promoting referrals • Member engagement strategies

Supporting Optimal Implementation

Demonstration Project Implementation Supports

- In-person and virtual meetings
- Developed Universal Referral Form
- Qualitative and quantitative evaluation of standards in practice
- Cross-provider review of patient/family experience assessments



PALLIATIVE CARE REFERRAL & SCREENING TOOL

Created by the Coalition for Compassionate Care of California in collaboration with health plan partners:

Referral Date

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First

Phone #: _____ Address: _____ City: _____ Zip: _____

ID/CIN Number: _____ Male___ Female___ Date of Birth: _____ Age: _____

Language / Ethnicity: _____ Name of PCP: _____

Health Plan: _____ LOB: ☐Medicare ☐Medi-Cal ☐Commercial ☐PPO

Location: ☐Hospital _____ ☐SNF _____ ☐Home ☐Other: _____

REFERRING/ATTENDING PROVIDER:

Provider Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

____ Patient meets basic eligibility/screening guidelines or **other** health plan specific diagnostic criteria for a full Palliative Care Service Evaluation (**see reverse side**).

____ Current referral prompted by:

☐ Patient is using the hospital and ER to manage symptoms

☐ Uncontrolled symptoms related to underlying disease (e.g., pain, shortness of breath, vomiting)

☐ Inadequate home, social, family support

A Decade of Focus on CBPC

Implementation Supports for Medi-Cal Standards

PILOT TEST	• Test the standards and disseminate findings
MONITORING	• Monitor uptake and promising practices
PEER LEARNING	• Create peer-peer learning opportunities
TECHNICAL ASSISTANCE	• Offer practical /focused /flexible technical assistance that makes progress possible
RESOURCES	• Create or collate tools and resources that feature data, documents and approaches used by plans and providers, + access to external resources

Reflections and Recommendations

Reflections

- It is possible to develop and implement minimum standards for CBPC that are applicable across lines of business.
- The CCCC Standards and SB 1004 guidance were largely effective in promoting delivery of team-based care that aligned with expert guidelines and other descriptions of best practices.
- Even with Standards in place, there is still a lot of room for payers and providers to make implementation choices about structures and processes. That is what introduces variation in outcomes.
- Measurement and reporting was the area with the most problematic variation.
- Problematic variation is indicative of existing or impending imbalance that will threaten program efficacy/sustainability.

Recommendations

Developing programs and standards

- Seek and incorporate input from a diverse group
- Define a floor (minimum) and allow enhancements
- Balance specificity with need to accommodate reasonable variation

Implementation

- Provide a range of implementation supports for payers and providers
- Collect and share information about promising practices
- Create opportunities for peer-to-peer learning
- Integrate, coordinate, collaborate to achieve efficiencies and holistic support

Evaluation

- Assess acceptability, feasibility, impact, and sustainability
- Make standards and evaluation findings easily accessible to all

Acknowledgments

The CCCC team gratefully acknowledges the contributions of the health plans and palliative care providers that participated in the demonstration project, who shared their data, wisdom, perceptions, and recommendations.

References

CCCC Consensus Standards development	https://coalitionccc.org/CCCC/Our-Work/CAIC.aspx
CCCC Consensus Standards document	https://coalitionccc.org/common/Uploaded%20files/PDFs/CAIC-Standards-for-CBPC-Oct-2017.pdf
CCCC Standardizing and Scaling webinars	https://coalitionccc.org/CCCC/Our-Work/2022-CAIC-Webinar-Series.aspx
Calif Medi-Cal palliative care legislation	https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1004
Calif Medi-Cal palliative care "All plan letter"	https://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx
Calif Medi-Cal palliative care implementation resources	https://www.chcf.org/resource/sb-1004/