This document provides an update on the Department of Health Care Services (DHCS) Medi-Cal palliative care policy as authorized by SB 1004 (Hernandez, Chapter 574, Statutes of 2014).

The DHCS Medi-Cal palliative care policy will be applicable to both managed care and fee-for-service delivery systems. Due to the specific focus of SB 1004, this document is oriented toward Medi-Cal only beneficiaries enrolled in Medi-Cal Managed Care Plans (MCPs). Further guidance will be provided for Medicare–Medi-Cal dually-eligible beneficiaries, and Medi-Cal only fee-for-service beneficiaries not enrolled in MCPs.

Section 1: SB 1004 Medi-Cal Palliative Care, and Overall Context

The Centers for Medicare and Medicaid Services (CMS) defines palliative care as: “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.” Many physicians and practitioners note that palliative care is an overall approach to the practice of medicine that is broader than end-of-life care, and is for “any age and any stage” of illness.

For purposes of SB 1004 guidance, DHCS proposes a Medi-Cal palliative care policy that is guided by the CMS definition of palliative care and the substantial body of research on palliative care programs, and with specific definitions of eligible conditions, services, and providers. The purpose of defining Medi-Cal palliative care more narrowly for a specific set of conditions is to meet the specific requirements of SB 1004, and to recognize that long-term success in implementing a new program to improve end of life care for Medi-Cal beneficiaries is more likely to be achieved through an incremental approach.

At the same time, a number of Medi-Cal managed care health plans (MCPs), hospitals and health systems, and other providers are already incorporating broader palliative care principles and strategies into their models of care. DHCS encourages those strategies to improve patient satisfaction and outcomes for Medi-Cal beneficiaries at all stages of life and illness, and to help meet the goals of Let’s Get Healthy California and the DHCS Quality Strategy.

Early Palliative Care
At initial diagnosis of serious illness, early palliative care may accompany disease modifying care (curative care or restorative intent). Early palliative care is often advance care planning and can include palliative care consultation or pain and symptom management as needed, but may not reflect the full array of services listed below for SB 1004 palliative care. Research indicates patients and families have higher satisfaction and alignment of care with treatment wishes when advance care planning conversations occur earlier in the disease process. For example, a patient with a recent diagnosis of Stage II cancer, who is proceeding with initial chemotherapy, does not have related emergency department visits or inpatient stays, and whose condition is stable, should be offered early palliative care, but may not be eligible for SB 1004 palliative care.

Hospice Care
Note that hospice care also serves seriously ill patients, but is distinct from SB 1004 Medi-Cal palliative care. Hospice care is a Medi-Cal benefit that is available to both managed care and fee-for-service beneficiaries who have a medical prognosis of six months or less to live, and is
provided in lieu of curative treatment for the terminal condition. Palliative care may be provided concurrently with curative care while hospice care may not, and palliative care is not limited to beneficiaries with a medical prognosis for life expectancy of six months or less. Further information about hospice care in Medi-Cal can be found in the DHCS All-Plan Letter 13-014 for managed care, and in Title 22 of the California Code of Regulations, Section 51349.

**Figure 1**

![Care Model for SB 1004 Medi-Cal Palliative Care](image)

* Patients with serious illness can complete a Physicians Authorization for Life-Sustaining Treatment (POLST) form with their provider. The POLST is a statewide standard form for seriously ill patients to indicate to medical personnel whether the patient desires or declines resuscitation, intubation, feeding tubes and other interventions.

Figure 1 above provides an overview of the care model for SB 1004 Medi-Cal palliative care. The design is adapted from the National Consensus Project for Quality Palliative Care.

At initial diagnosis of serious illness, early palliative care may accompany disease modifying care (curative care or restorative intent). Early palliative care is often advance care planning and/or palliative care consultation, and can include pain and symptom management as
needed. The wavy line indicates that the proportion of palliative care varies based on individual patient choices and needs. As the patient’s illness progresses, those with serious illness who meet specific clinical eligibility criteria can enroll in SB 1004 palliative care programs and also continue to access disease modifying care. As the patient’s illness progresses further, those who meet hospice eligibility criteria can disenroll from SB 1004 palliative care, and enroll in hospice to receive additional comfort care and forego further disease modifying care. Note that specific services for individual patients are based on medical necessity, and this figure is for general descriptive purposes only. Also, additional options are available for children.

Case Example: Provision of Palliative Care and Hospice through the Course of Illness¹

**Primary/Early Palliative Care**

Patient A is a 55 year-old woman diagnosed with stage IIA breast cancer, who is being evaluated in oncology clinic for initial treatment with chemotherapy and hormone therapy. She has been working for several years, is a single mother of 3 adult children, including one about to enter college. She reports feeling stress and anxiety in juggling work, treatment, and support for her child entering college.

- Considerations for early palliative care:
  - Psychosocial and spiritual support in coping with the diagnosis
  - Practical assistance with paperwork for Family Medical Leave Act, disability, etc.
  - Education and support for family members
  - Symptom management during treatment
  - Introduction of advance care planning and identification of surrogate decision-maker

**SB 1004 Palliative Care**

Patient A underwent mastectomy, 4 cycles of chemotherapy and hormone therapy, and seemed to have no evidence of disease progression. She returned to work and had resumed her normal activities, with some modifications, for 18 months; however, she has recently become more fatigued and has had to take days off of work to rest. She returned to see her primary care doctor for progressive back pain, which she attributed to strain while moving furniture; unfortunately, x-rays of her spine showed a lesion suspicious for a metastasis, as well as lung nodules. Patient was diagnosed with advanced cancer and referred back to her oncologist for follow-up, who presents options of palliative radiation and chemotherapy to potentially extend and improve the quality of her life.

- Considerations for palliative care
  - Psychosocial and spiritual support in coping with disease progression
  - Practical assistance with applying for disability and counseling regarding financial planning, insurance issues
  - Education and support for family members
  - Discussion of benefits/burdens of treatment options and goals of care
  - Symptom management during treatment

¹ Example developed by Anne Kinderman, MD, Director of the Supportive & Palliative Care Service Program at Zuckerberg San Francisco General and Associate Professor of Medicine at the University of California San Francisco.
Focused advance care planning and designation of durable power of attorney for healthcare, if not already done

**Hospice Care**
Patient A chose to undergo both palliative radiation and chemotherapy for her stage IV breast cancer, and experienced some relief from her back pain. Unfortunately, she had difficulty tolerating the chemotherapy regimen, due to fatigue and nausea. Nevertheless, she completed an additional 4 cycles of chemotherapy in the hopes that this would provide her with more time with her family. Unfortunately, on follow-up CT scans, the metastatic disease in her lungs had continued to progress, in spite of treatment. Patient A’s palliative care and oncology providers discuss this bad news with her, and inform her of options to try 3rd line chemotherapy, or enroll in hospice. Based on the difficulty she had tolerating the 2nd line chemotherapy, she decided to enroll in hospice care at home.

➢ Considerations for hospice:
  o Psychosocial and spiritual support in coping with end of life
  o Practical assistance with caregiving services, health aides, meal services, etc.
  o Counseling regarding financial planning, insurance issues
  o Education and support for family members
  o Transition to inpatient hospice or skilled nursing facility if needed
  o Symptom management through disease progression and end of life
  o Focused advance care planning and designation of durable power of attorney for healthcare, if not already done
  o Completion of POLST form

**Palliative Care Options for Children**
Additional options for children include the Section 1915(c) Home and Community Based Services waiver known as **Partners for Children (PFC)**, to provide hospice-like services in addition to Medi-Cal State Plan services for seriously-ill children. Also, Section 2302 of the Patient Protection and Affordable Care Act (ACA) provides authority for hospice care concurrently with curative care for beneficiaries under age 21. Information regarding the concurrent care policy for children is available in DHCS All Plan Letter 13-014, California Children’s Services Numbered Letter 06-1011, and Managed Care Policy Letter 11-004. Concurrent care for children is a statewide benefit, and PFC waiver enrollment is available in several counties in the state.

DHCS policy for SB 1004 is without regard to age, so beneficiaries under age 21 may be eligible for SB 1004 palliative care services if they meet the general and disease-specific eligibility criteria. However, both concurrent care under Section 2302 of the ACA and the PFC waiver provide additional services and broader eligibility criteria for children than SB 1004. Further, since enrollment in SB 1004 and either Section 2302 concurrent care or the PFC waiver would result in redundant services, children enrolled in either of those programs cannot enroll in SB 1004 palliative care.

**Section 2: Eligible Conditions**

DHCS proposes that eligible conditions for SB 1004 Medi-Cal palliative care include Cancer, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), or Liver Disease. Based on the significant body of national research on palliative care, and the results
of existing palliative care programs, these four conditions are most promising for improved patient satisfaction and health outcomes, and permit cost-effective implementation.

Although DHCS initially proposed that eligibility would be limited to beneficiaries with late-stage/high grade cancer with significant functional decline or limitations, stakeholder feedback suggested that this eligibility limit was too restrictive, these patients may already be hospice eligible, and palliative care is more appropriate and effective earlier in the disease progression.

Based on feedback from a panel of palliative care experts, DHCS proposes that beneficiary eligibility for SB 1004 Medi-Cal palliative care be determined through a clinical review consisting of general eligibility criteria and disease-specific criteria.² Beneficiaries would need to meet all items in the general eligibility criteria in subsection A and at least one of the four disease-specific criteria in subsection B below.

A. General Eligibility Criteria:

1. Patient is likely to or has started to use the hospital or emergency department as a means to manage their late stage disease. This refers to “unanticipated decompensation” and does not include elective procedures. For example, a patient with two or more inpatient admissions or Emergency Department visits in the past six months and meeting the disease-specific criteria below should be strongly considered for palliative care assessment.

2. Patient in the late stage of illness, as defined in subsection B, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.

3. The patient’s death within a year would not be unexpected based on clinical status.

4. Patient has received appropriate patient-desired medical therapy, or for whom treatment is no longer effective.³ Patient is not in reversible acute decompensation. For example, patient with advanced tonsillar cancer had undergone tumor debulking and neck dissection followed by adjuvant chemotherapy and external beam radiation therapy. Despite this appropriate therapy, the patient developed locally recurrent disease. This patient could pursue additional surgery and radiation therapy, likely for symptom relief, while still qualifying for SB 1004 palliative care referral and services.

5. Patient and, if applicable, family/patient-designated support person agree to both of the following:

² The SB 1004 palliative care criteria are based on the Sharp HealthCare Transitions Guidelines for Advanced Illness Management, developed by Daniel R. Hoefer, MD, Chief Medical Officer of Outpatient Palliative Care and Hospice for Sharp HealthCare, and guidelines for the Partnership Health Plan Partners in Palliative Care Program developed by Robert Moore, MD, Chief Medical Officer.

³ This language is intended to distinguish between patients undergoing well-tolerated and effective treatment (early palliative care) and patients for whom treatment is not effective or well-tolerated (SB 1004 palliative care). Examples of this situation cited by the Advanced Illness Management (AIM) palliative care model include: ineffective chemotherapy or radiation for cancer; refractory fluid overload for CHF; severe or frequent exacerbations of COPD. Note that in lieu of “appropriate patient-desired medical therapy,” the Sharp Transitions Guidelines indicate that “patients should have received maximum medical therapy,” according to the Medicare definition of maximum medical therapy, which includes any of the following: “1) No further traditional therapy is available, 2) Patient is intolerant to further therapy, 3) Patient declines further therapy, 4) Patient repeatedly decompensates due to severe non-compliance.” This criteria is also permissible under SB 1004.
a. Willing to attempt in-home, residential-based or outpatient disease management as recommended by the MCP Palliative Care team instead of first going to the emergency department.
b. Willing to participate in Advance Care Planning discussions.

B. **Disease-Specific Eligibility Criteria**

1. **Congestive Heart Failure (CHF)**
   a. Any patient who is hospitalized due to CHF as the primary diagnosis. No further invasive interventions planned although access to curative care is maintained, or
   b. NYHA III (Definition of NYHA III: Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.)

   AND one of the following:

   a. Ejection Fraction < 30 for systolic failure
   b. Significant comorbidities: e.g. renal disease, diabetes, dementia, or poor biomarkers including rising BNP, pro-BNP, hsCRP, BUN/ Creatinine (patient is in their best compensated state), and CAD.

2. **Chronic Obstructive Pulmonary Disease (COPD):**
   a. Severe airflow obstruction: FEV1 < 35 % predicted AND
   b. 24-hour oxygen requirement at less than 3L/minute

   OR

   c. 24-hour oxygen requirement at greater than or equal to 3 L/minute

3. **Advanced Cancer:**
   a. Any Stage III or IV cancer, locally advanced or metastatic cancer, leukemia or lymphoma

   AND one of the following:

   b. Karnofsky Performance Scale (KPS) score < or equal to 70 (KPS 70= Cares for self; unable to carry on normal activity or do active work)
   c. Being failed by two lines of standard chemotherapy.

4. **Liver Disease:**

   Irreversible Liver Damage
   AND

   BOTH of the following:
   1. Albumin <3.0
   2. INR > 1.3
   PLUS one of the below

   a. Ascites
   b. Subacute bacterial peritonitis
   c. Hepatic encephalopathy
d. Hepatorenal syndrome

e. Recurrent esophageal bleeds

OR

1. Model for End Stage Liver Disease (MELD) score of greater than 19

To calculate MELD Score:
https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator/

Beneficiaries with serious illness who are receiving services under SB 1004 palliative care may choose to transition to hospice care if they meet the medical prognosis for hospice, or, if they also continue to meet the medical eligibility criteria for SB 1004, may remain in SB 1004 palliative care until their death. Beneficiaries with medical conditions that improve or stabilize, but still meet the eligibility criteria for SB 1004, may have palliative care services reduced as determined by medical necessity, but should continue to receive periodic assessments to monitor for a change in condition or needed services.

Note that research supports additional conditions for palliative care referral, and some MCPs are already authorizing palliative care consults and services for patients with other medical conditions. This draft policy reflects the minimum eligibility criteria for SB 1004 palliative care patients; MCPs would continue to have discretion to authorize palliative care services for patients with other medical conditions in addition to the four listed above.

Further, across existing palliative care programs in California, clinical eligibility criteria varies, and several approaches have been successful in improving patient satisfaction and health outcomes in a cost-effective manner for patients with serious illness. As a result, MCPs may propose alternative eligibility protocols for DHCS review. Those protocols may be no more restrictive, in terms of the eligible conditions, than the criteria listed above.

In addition, as noted on page 1 above, research indicates that beneficiaries diagnosed with serious illness have improved patient satisfaction and receive care better aligned with their preferences when they have early palliative care services, such as advance care planning, early in the disease progression. As a result, MCPs should consider working with specialists in targeted practice areas such as oncology and cardiology, so that early palliative care, particularly advance care planning, is offered to beneficiaries diagnosed with serious illness but who are not enrolled in SB 1004 palliative care.

Section 3: Services

DHCS proposes that Medi-Cal palliative care include the eight services listed below, when reasonable and necessary for the palliation or management of a qualified serious illness and related conditions, when provided by a qualified provider, and when provided according to existing Medi-Cal regulations, Provider Manuals, Provider Bulletins, or All-Plan Letters for the specific service. All of the services below, except for chaplain services, are included in existing Medi-Cal benefits.

Note that DHCS initially proposed that SB 1004 palliative care services include both palliative care-type services (such as advance care planning, consultation, and pain and symptom management) as well as all hospice care services. The Department has revised the list of palliative care services based on stakeholder and expert feedback, which indicated that including all hospice care services under SB 1004 palliative care was unnecessary and could delay hospice enrollment.
A. Palliative Care Services:

1. Advance Care Planning

Advance care planning includes discussions between a physician or other qualified healthcare professional and a patient, family member, or surrogate in counseling and discussing advance directives, including POLST forms.

MCPs must provide advance care planning to beneficiaries enrolled in Medi-Cal palliative care under SB 1004. Note that advance care planning is a Medi-Cal benefit available for all beneficiaries and is not limited to those with SB 1004 palliative care eligibility.

2. Palliative Care Assessment and Consultation

Palliative care assessment and consultation services may be provided at the same time as advance care planning, or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. In existing palliative care programs, providers usually complete an initial consultation, followed by periodic assessments. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:

- Treatment plans, including palliative care and curative care
- Pain and medicine side effects
- Emotional and social challenges
- Spiritual concerns
- Patient goals
- Advance directives, including POLST forms

3. Plan of Care

SB 1004 palliative care beneficiaries should have an individualized written plan of care. MCPs are required to develop a plan and engage the beneficiary and/or his or her representative(s) in its design. If a beneficiary already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion.

4. Pain and Symptom Management

Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address beneficiary pain and other symptoms. The beneficiary’s plan of care must include all services authorized for pain and symptom management.

5. Mental Health and Medical Social Services

Counseling services must be available to the beneficiary to assist in minimizing the stress and problems that arise from the serious illness, related conditions, and the dying process. Counseling services must include, but are not limited to psychotherapy,
bereavement counseling, medical social services (within Home Health Agency services), and discharge planning.

6. Care Coordination

The MCP’s Medi-Cal palliative care program must designate a member of the Palliative Care Team to provide coordination of care, ensure continuous assessment of the patient’s needs, and implement the plan of care.

7. Palliative Care Team

The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of beneficiaries and their families and are able to assist in identifying sources of pain and discomfort of the beneficiary. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide the care and services offered by palliative care.

DHCS recommends that the Palliative Care Team include, but is not limited to:

- A doctor of medicine or osteopathy (Primary Care Provider if MD or DO)
- A registered nurse and/or nurse practitioner (Primary Care Provider if NP)
- A social worker
- A chaplain

8. Chaplain Services

MCPs must provide access to chaplain services as needed as part of the palliative care team. Chaplain services provided as a palliative care service are not reimbursable through the Medi-Cal program.

9. Recommended Service: 24/7 Telephonic Palliative Care Support (separate from a routine advice line).

Many palliative care programs include specialized telephonic support. This service is recommended but not required for MCPs, due to initial program development constraints.

Additional notes on palliative care services:

- Identification of the specific palliative care services needed for an individual beneficiary is dependent on a palliative care consult and/or needs assessment process. Palliative care services should be aligned with the needs and decisions of the beneficiary.

- Research and discussions with palliative care experts indicate that the full range of palliative care services (physical, social, spiritual, and emotional) should be available to achieve the intended results in quality and cost-effectiveness measures.

- DHCS encourages MCPs and providers to provide palliative care consultations and
services in a manner that meets beneficiaries’ cultural needs. Resources and technical assistance on culturally sensitive palliative care is an emerging field, and DHCS supports further training and development in this area.

B. Curative Care/Disease Modifying Care:

As specified in SB 1004, beneficiaries electing not to enroll in hospice care but who meet the eligibility criteria for SB 1004 Medi-Cal palliative care may access both palliative care and curative care services that are medically necessary, as specified in current Medi-Cal statute and regulation. Essential to care coordination, the palliative care team and a plan of care will ensure coordination between curative care and palliative care services, particularly including the beneficiary’s Primary Care Provider.

Section 4: Providers

Medi-Cal palliative care may be provided in a variety of settings, including inpatient, outpatient, or community-based, and therefore providers may vary based on the setting and needs of the patient. DHCS proposes that MCPs be provided flexibility in provider types, qualifications, and training requirements for palliative care, so long as the providers meet existing Medi-Cal regulations, Provider Bulletins, or All-Plan Letters.

MCPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff. MCPs generally work with existing local providers, and may need to contract with several different types of providers depending on local provider qualifications and the need to reflect the diversity of provider types. However, palliative care services provided in a beneficiary’s home must meet the applicable existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments, care plans, or home health agency regulations. Also, DHCS recommends that Community- Based Adult Services (CBAS) facilities be considered as a palliative care partner for facilitating advance care planning or palliative care referrals.

Also, DHCS is authorized to expend up to $244,000 for palliative care provider training, and will provide further guidance on this funding and training to MCPs. In particular, DHCS recommends that providers of palliative care consultations or assessments have current palliative care training or certification.

Further, results from existing palliative care programs highlight the importance of developing provider referral and education processes, as well as consumer information about palliative care. DHCS recommends that MCPs develop provider and consumer outreach plans when implementing SB 1004 palliative care programs.

Section 5: Monitoring Outcomes and Performance Measures

To track results from SB 1004, DHCS will require MCPs to periodically provide lists of SB 1004 palliative care beneficiary participants to the Department. Further guidance will be provided on any MCP requirements for additional data reporting, such as inpatient stays, emergency department visits, or hospice enrollment, as well as quality measures.