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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, Statutes 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>

Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if the member meets the hospice eligibility criteria. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care.

A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018.⁴ Information regarding the concurrent care policy is available in Policy Letter (PL) 11-004, titled “The Implementation of Section 2302 of the Affordable Care Act, titled ‘Concurrent Care for Children’”; APL 13-014; and the appropriate California Children’s Services (CCS) Numbered Letter (NL), including any future iterations of these letters.^{5, 6} Additionally, members who are eligible for EPSDT may receive other services.⁷ Accordingly, MCPs must provide EPSDT eligible members with any other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services, whether or not such services are covered under the California State Plan. Services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and promote physical, and mental health and efficiency.⁸ Information regarding the policy for EPSDT services is available in APL 18-007, titled “Requirements of Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Who Transition into Medi-Cal Managed Care,” including any future iterations of this APL.

POLICY:

DHCS’ SB 1004 Medi-Cal Palliative Care Policy specifies the minimum types of palliative care services that MCPs must authorize when medically necessary for members who meet the eligibility criteria.⁹ MCPs must either adopt DHCS’ minimum

⁴ CMS Letter #10-018 is available at: <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10018.pdf>

⁵ PLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx>

⁶ CCS Numbered Letters is available at: <http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx>

⁷ Social Security Act (SSA) Section 1905(r). SSA Section 1905 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

⁸ 42 Code of Regulations (CFR) Section 440.130(c). 42 CFR Section 440 is available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=5f07d61ecd1e2d138f81e7c2e597e172&mc=true&node=pt42.4.440&rqn=div5>

⁹ DHCS’ SB 1004 Medi-Cal Palliative Care Policy, dated November 2017, is available at: <http://www.dhcs.ca.gov/provgovpart/Documents/SB1004PalliativeCarePolicyDoc11282017.pdf>

eligibility criteria for palliative care, or they may submit broader eligibility criteria to DHCS for approval.

I. Eligibility Criteria

Members of any age are eligible to receive palliative care services if they meet all of the criteria outlined in Section I.A. below, and at least one of the four requirements outlined in Section I.B.

Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section I.C. below, consistent with the provision of EPSDT services.

A. General Eligibility Criteria:

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section I.B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
 - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
 - b. Participate in Advance Care Planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
 - a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher;¹⁰ and
 - b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)
 - a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
 - b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
 - a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
 - b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone
 - a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
 - b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
 - c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.¹¹

¹⁰ NYHA classifications are available at:

http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.WefN7rpFxxo

¹¹ The MELD score calculator is available at: <https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator>

C. Pediatric Palliative Care Eligibility Criteria:

Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.¹²

- a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
- b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
 1. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
 2. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
 3. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
 4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. MCPs must have a process to identify members who are eligible for palliative care, including a provider referral process.¹³ MCPs must periodically assess the member for changes in the member's condition or palliative care needs. MCPs may discontinue palliative care that is no longer medically necessary or no longer reasonable.

For children who have an approved CCS-eligible condition, CCS remains responsible (in non-Whole Child Model counties) for medical treatment for the CCS-eligible condition, and the MCP is responsible for the provision of palliative care services related to the CCS-eligible condition.

¹² CMS Letter #10-018 is available at: <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10018.pdf>

¹³ MCPs may receive referrals from in-network or out-of-network providers, such as primary care providers, specialty providers, and Specialty Care Centers. MCPs must review all referrals received to make medical necessity determinations for palliative care services.

II. Palliative Care Services

Effective January 1, 2018, when a member meets the minimum eligibility criteria for palliative care, MCPs must authorize palliative care without regard to age. Palliative care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

- A. **Advance Care Planning:** Advance care planning for members enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms. Please refer to the section on advance care planning in the Provider Manual for further details.¹⁴
- B. **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. 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
 - Legally-recognized decision maker
- C. **Plan of Care:** A plan of care should be developed with the engagement of the member and/or the member's representative(s) in its design. If a member 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. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care. The plan of care

¹⁴ Medi-Cal Provider Manual Evaluation and Management is available at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval_m00o03.doc.

must not include services already received through another Medi-Cal funded benefit program (e.g. CCS Program).

- D. **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 a member and of the member's family and are able to assist in identifying the member's sources of pain and discomfort. 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 all authorized palliative care. DHCS recommends that the palliative care team include, but is not limited to the following team members: a doctor of medicine or osteopathy (Primary Care Provider if MD or DO); a registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker. DHCS also recommends that MCPs provide access to chaplain services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.
- E. **Care Coordination:** A member of the palliative care team must provide coordination of care, ensure continuous assessment of the member's needs, and implement the plan of care.
- F. **Pain and Symptom Management:** The member's plan of care must include all services authorized for 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 a member's pain and other symptoms.

Mental Health and Medical Social Services: Counseling and social services must be available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services must not duplicate specialty mental health services provided by county Mental Health Plans (MHPs). Furthermore, provision of medical and social services does not change the MCP's responsibility for referring to, and coordinating with, county MHPs, as delineated in APL 17-018 "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services," including any subsequent revisions.

MCPs must have a process to determine the type of palliative care that is medically necessary or reasonable for eligible members. MCPs must have an adequate network of palliative care providers to meet the needs of their members.

Furthermore, MCPs may authorize additional palliative care not described above, at the MCP's discretion and cost. Examples of additional services offered by many community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/7 days a week, and expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population.

III. Providers

MCPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. MCPs must utilize qualified providers for palliative care based on the setting and needs of a member, so long as the MCP ensures that its providers comply with existing Medi-Cal contracts and policy. DHCS recommends that MCPs use providers who possess current palliative care training and/or certification to conduct palliative care consultations or assessments.

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 with experience and/or training in palliative care. MCPs may contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services facilities may be considered palliative care partners for facilitating advance care planning or palliative care referrals. Palliative care provided in a member's home must comply with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans. MCPs must inform and educate providers regarding availability of the palliative care benefit.

IV. MCP Policies and Procedures

The MCP's written policies and procedures for palliative care must describe the MCP's policy to meet the requirements for the palliative care benefit as indicated within this APL, including how MCPs will monitor and collect palliative care enrollment, provider, and utilization data to report to DHCS, as specified.

MCPs are responsible for ensuring that their delegates and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other

All Plan Letter 18-020
Page 9

DHCS guidance, including APLs and PLs. MCPs must communicate these requirements to all their delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment

Attachment A: Palliative Care Resources

DHCS SB 1004 Palliative Care Website: Materials available related to SB 1004. Please send questions to: SB1004@dhcs.ca.gov

California HealthCare Foundation (CHCF): Wide range of online materials and resources, as well as in-person technical assistance events.

Coalition for Compassionate Care of California: Consumer and provider resources on advance care planning and palliative care. Also frequent webinars and training programs.

California State University Institute for Palliative Care: Instructor-led and self-paced online training in [palliative care](#), [advance care planning](#), and [case management](#) for health care professionals, including [health plan case managers](#), as well as for patients and families.