Palliative Care

In Medicare Dual Special Needs Plans (D-SNPs)

D-SNPs and Medi-Medi Plans

D-SNPs, including Medi-Medi Plans, are a type of Medicare Advantage plan in California that are only available to beneficiaries dually eligible for both Medicare and Medi-Cal. D-SNPs must coordinate all Medicare and Medi-Cal services for their members. Medi-Medi Plans provide even more integrated care, including all Medicare Part A, B, and D services, specialized care coordination, and wrap-around Medi-Cal services. For additional information about D-SNPs and Medi-Medi Plans, view the Department of Health Care Services (DHCS) D-SNPs in California website and Medi-Medi Plan website.

What Is Palliative Care?

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and suffering of the illness and can be provided along with curative treatment. The goal is to improve the quality of life for both the member and the family.

Palliative care is provided by a specially trained team of doctors, nurses, and other specialists who work together with a member's other doctors to provide an extra layer of support. Qualified providers must be used based on the setting and needs of a member. Palliative care can be provided in a variety of settings, including, but not limited to, inpatient, outpatient, and community or home-based settings. Palliative care is based on the needs of the member, not on the member's prognosis. It is appropriate at any age and any stage in a serious illness.

Since 2018, Medi-Cal Managed Care Plans have been required to offer palliative care to Medi-Cal members under All Plan Letter (APL) 18-020.

Beginning in 2024, DHCS will require all D-SNPs, including Medi-Medi Plans, to offer palliative care services to dually eligible members. Requirements for D-SNPs around palliative care are in the 2024 CalAIM D-SNP Policy Guide.

Criteria for Palliative Care Referrals

The following general and disease-specific criteria are intended to define the minimum of who should be referred for palliative care services. Plans are welcome to establish broader referral criteria to reach additional members who may benefit from these services.

General Criteria

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

Disease-Specific Criteria

A member must also meet the general **and** disease-specific criteria of one of the four conditions below:

1. Advanced Cancer
2. Congestive Heart Failure (CHF)
3. Chronic Obstructive Pulmonary Disease (COPD)
4. Liver Disease

Refer to the 2024 CalAIM D-SNP Policy Guide for more information regarding the disease-specific criteria for palliative care eligibility.

What Services Are Offered Under Palliative Care?

At a minimum, palliative care includes the following seven services if medically necessary and reasonable for the member:

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Plan of Care
- Palliative Care Team
- Care Coordination
- Pain and Symptom Management
- Mental Health and Medical Social Services

All D-SNPs have a process to determine the type of palliative care services that are medically necessary or reasonable for eligible members. Refer to the 2024 CalAIM D-SNP Policy Guide for additional details about these services.

D-SNPs and Palliative Care

All D-SNPs, including Medi-Medi Plans, are responsible for providing and coordinating inpatient and outpatient/community-based palliative care referrals and services for dual eligible members with serious illnesses that meet the criteria described above and detailed in the 2024 CalAIM D-SNP Policy Guide. D-SNP responsibilities include:

- Establishing a referral process, including identifying eligible members and assessing for medical necessity;
- Contracting with an adequate palliative care provider network; and
- Coordinating the delivery of palliative care services.

Additional information about each requirement is described below.

Referrals to Palliative Care

D-SNPs must have a process to identify members who meet the criteria for palliative care, including a provider referral process. D-SNPs may receive referrals from in-network or out-of-network providers, such as primary care providers, specialty providers, and Specialty Care Centers. D-SNPs must review all referrals received to make medical necessity determinations for palliative care services. D-SNPs must also periodically assess the member for changes in the member's condition or palliative care needs. D-SNPs may discontinue palliative care that is no longer medically necessary or no longer reasonable.

Palliative Care Provider Network

D-SNPs must have an adequate Medicare network of palliative care providers to meet the needs of their members. D-SNPs 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 or training in palliative care. Providers should contact their patient's D-SNP for additional information about palliative care.

Care Coordination

Coordination of palliative care services should be included in a member's individualized care plan (ICP) and addressed by their interdisciplinary care team (ICT). A member's ICP should reflect any changes resulting from palliative care consultation. During the initial and/or subsequent palliative care consultation or assessment, topics may include patient goals and legally-recognized decision makers, among other topics. Members of the palliative care team should be included in the member's ICT meetings, and the palliative care coordinator should serve as the lead care manager for the member.

For members with serious illnesses participating in a palliative care program, the D-SNP must use a palliative care ICT. This is a group of providers who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and their family. Types of providers in a palliative care ICT may include a primary care provider, registered nurse, licensed vocational nurse or nurse practitioner, chaplain, and/or social worker.