

# Department of Health Care Services

## SB 1004 Medi-Cal Palliative Care

### October 2, 2015

This document provides an update on the efforts of the Department of Health Care Services (DHCS) to implement Medi-Cal palliative care, as authorized by SB 1004 (Hernandez, Chapter 574, Statutes of 2014). DHCS requests feedback on this document via the comment format posted on our [website](#), no later than October 19, 2015.

### Medi-Cal Palliative Care Goals

In accordance with SB 1004, as stated in Welfare and Institutions Code (WIC) Section 14132.75, DHCS has the following goals:

- a. “Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.” (WIC 14132.75 (b))
- b. “Establish guidance on the medical conditions and prognoses that render a [Medi-Cal] beneficiary eligible for the palliative care services.” (WIC 14132.75 (d))
- c. Develop a Medi-Cal palliative care policy that, to the extent practicable, is “cost-neutral to the General Fund on an ongoing basis.” (WIC 14132.75 (f))
- d. Define Medi-Cal palliative care services, to include but are not limited to “those types of services that are available through the Medi-Cal hospice benefit.” (WIC 14132.75 (c)).
- e. Provide access to both hospice-type services and curative care at the same time, to the extent the services are not duplicative, for beneficiaries eligible for Medi-Cal palliative care. (WIC 14132.75 (c)(1))

Further, DHCS intends for this policy to promote and facilitate advanced care planning conversations between patients and providers.

### Key Components of the Medi-Cal Palliative Care

#### Section 1: General Definition of Palliative Care and Medi-Cal Palliative Care

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. The DHCS SB 1004 website provides additional background and resources on a broad range of palliative care topics. Palliative care programs oriented toward specific medical conditions have significant evidence of increased consumer satisfaction and improved health care.

DHCS proposes to develop 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, but with more 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 requirements of SB 1004 and the department’s quality strategy, and to recognize that long-term success in implementing palliative care in Medi-Cal is more likely through an incremental approach. At the

same time, some Medi-Cal managed care health plans (MCPs) and providers are already incorporating broader palliative care principles and strategies such as advance care planning into their models of care. DHCS encourages those strategies to improve patient satisfaction for the broader Medi-Cal population and help meet the Triple Aim.

At this time DHCS is considering how to develop a Medi-Cal palliative care policy that is applicable for both managed care and fee-for-service delivery systems. However due to the specific focus of SB 1004, much of this document is oriented toward managed care. Further analysis will be forthcoming regarding policy options for fee-for-service Medi-Cal.

In addition to palliative care, hospice is a Medi-Cal benefit that is available to managed care and fee-for-service beneficiaries with a medical prognosis of six months or less, in lieu of curative treatment for the terminal condition. While palliative care and hospice include similar services and are both for beneficiaries with serious illness, palliative care maybe provided concurrently with curative care, and palliative care is not limited to beneficiaries with a medical prognosis of six months or less. Further information about hospice in Medi-Cal can be found in DHCS All-Plan Letter 13-014 for managed care, and in Title 22 of the California Code of Regulations, Section 51349.

## **Section 2: Proposed Eligible Conditions for Medi-Cal Palliative Care**

Based on the significant body of national research on palliative care, DHCS proposes that beneficiaries with late-stage/high grade cancer with significant functional decline or limitations would be eligible for Medi-Cal palliative care. Based on results of existing palliative care programs, this condition is the most promising for improved patient satisfaction and health outcome, and cost-effective implementation of palliative care in Medi-Cal. DHCS seeks stakeholder feedback on this condition, as well as its specific definitions.

Across palliative care programs in California, the specific clinical criteria used to evaluate suitability for palliative care among patients with this condition varies somewhat (see examples in Addendum A), and may also include functional status or additional criteria. DHCS seeks feedback on whether the state should provide more specific standardized clinical criteria for Medi-Cal palliative care eligibility purposes, or allow Managed Care Organizations (MCO) to use one of several existing screening protocols.

Although some research supports additional conditions as appropriate and cost-effective for palliative care referral, at this time DHCS is not proposing any additional medical conditions for statewide implementation of Medi-Cal palliative care, due to the challenges in some parts of the state of implementing palliative care for even this condition. However, MCOs that authorize palliative care consults and services for patients with other medical conditions may continue to do so. The department anticipates that once results are available from initial implementation of Medi-Cal palliative care for this condition, the list of eligible conditions may be amended to include additional conditions.

DHCS also notes that some palliative care programs use functional status as a component of eligibility criteria, and most use functional assessments to develop individual care plans, assess the proper level of care and supportive services, and measure results of palliative care services. The department is proposing to require MCOs to use one of several standardized assessment tools in the administration of palliative care, once eligibility has been determined.

In addition, SB 1004 requires that palliative care services be provided to individuals with a serious illness whose conditions may result in death, “regardless of the estimated length of the individual’s remaining period of life.” As a result, eligibility for Medi-Cal palliative care is without regard to the estimated length of a beneficiary’s remaining period of life.

### **Section 3: Proposed Palliative Care Services**

SB 1004 states that Medi-Cal palliative care services shall include but not be limited to those types of services that are available through the Medi-Cal hospice benefit. In accordance with that requirement, DHCS proposes that Medi-Cal palliative care services include the following, when reasonable and necessary for the palliation or management of a qualified serious illness and related conditions, and when provided by qualified personnel: Note that DHCS will be developing further guidance to define “qualified personnel” for Medi-Cal palliative care, and welcomes any comments on this topic. DHCS is considering use of existing guidance on qualified personnel for hospice, with some level of palliative care training, and seeks feedback on that option as well.

#### **A. Hospice services, as defined in state and federal regulation, included within Medi-Cal Palliative Care:**

- 1) Nursing services when provided by or under the supervision of a registered nurse;
- 2) Physical, occupational, or speech-language pathology;
- 3) Medical social services under the direction of a physician;
- 4) Home health aide and homemaker services when provided under the general supervision of a nurse;
- 5) Medical supplies and appliances;
- 6) Drugs and biologicals when used primarily for the relief of pain and symptom control.
- 7) Physician services (as defined for hospice);
- 8) Counseling services related to the adjustment of the member’s approaching death; counseling, including bereavement, grief, dietary and spiritual counseling;
- 9) Continuous nursing services may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill member at home, as defined under hospice regulations;
- 10) Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing or hospice facility;
- 11) Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility;
- 12) Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the hospice (or palliative) plan of care; and
- 13) Bereavement counseling as necessary for the patient’s immediate family for up to one year after death (in accordance with hospice regulations, not reimbursable).

#### **B. Additional Medi-Cal Palliative Care services:**

- 1) Palliative care consultation, performed by qualified physician, nurse, or social worker;
- 2) Advance Care Planning and patient-involved decision making, including but not limited to completion of Physician Orders for Life Sustaining Treatment (POLST); and
- 3) Care coordination, assessment, interdisciplinary care team, and development of care plan. (Note: these services are currently within the hospice standard of care, but specified here to ensure they are identified as key components of Medi-Cal palliative care services.)

### **C. Curative Care:**

As specified in SB 1004, beneficiaries not electing to enroll in hospice, but who meet the eligibility criteria for Medi-Cal palliative care, may access both palliative care as specified above and curative care that is medically necessary as specified in current Medi-Cal statute and regulation. An essential role of the care coordination, interdisciplinary care team, and care plan under palliative care is to ensure coordination between curative care and Medi-Cal palliative care.

Additional notes regarding Medi-Cal Palliative Care services are listed below.

- Consistent with the approach in hospice care and overall approach for Medi-Cal managed care, identification of the palliative care services needed for a specific patient 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 patient.
- Research and discussions with palliative care experts indicate that the full range of palliative care services (physical, social, spiritual, and emotional) must be available to achieve the intended results in quality and cost effectiveness.
- DHCS encourages MCPs and providers to provide palliative care consultations and services to beneficiaries in a manner that is culturally competent. Resources and technical assistance on culturally competent palliative care is an emerging field, and the department strongly supports further training and development in this area.

### **Section 4: Proposed Providers**

Medi-Cal palliative care may be inpatient-based or outpatient/community-based, and therefore providers may vary based on the setting and needs of the patient. SB 1004 indicates that MCOs shall include licensed hospice and home health providers that are contracted with the Medi-Cal plans to provide palliative care services. Also, Community-Based Adult Services (CBAS) facilities may be an important partner in some communities for facilitating advance care planning, or palliative care services. DHCS will provide future guidance on managed care plan network adequacy requirements for inpatient and community-based palliative care providers.

### **Section 5: Delivery System and Dual-Eligible Considerations**

This document primarily addresses Medi-Cal only beneficiaries (not dually eligible for Medicare) enrolled in MCOs. DHCS is considering policy options for beneficiaries in home- and community-based waiver programs, nursing facility residents, and potentially Medicare – Medi-Cal dually-eligible beneficiaries enrolled in Cal Medi-Connect.

### **Section 6: Performance Measures and Monitoring Outcomes**

DHCS is in the process of developing performance measures for SB 1004 that may be applicable in both managed care and fee-for-service delivery systems. The department is also considering linking some portion of palliative care payment to performance and patient outcomes for palliative care, particularly in the fee-for-service delivery system.

## Section 7: Technical Assistance and Resources

Palliative care technical assistance and resources for health plans and providers are available from several sources:

- [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 for health care professionals, as well as patients and families.
- [DHCS SB 1004 Palliative Care Website](#): Materials available related to SB 1004 implementation, as well as links to other resources.

## **Appendix A Palliative Care Research and Resources**

### **Conditions**

Cancer is among the most frequently cited condition that shows improved outcomes and cost effectiveness for palliative care. For example, early palliative care for patients with metastatic, non-small lung cancer led to significant improvements in both quality of life and mood. In addition, by receiving early palliative care, these patients had less aggressive care at the end of life and longer survival rates.

Key findings for this condition indicates there is greater satisfaction with hospital care and providers, a longer hospice length of stay, more advanced directives at hospitalization discharge, reduced intensive care unit (ICU) admissions on hospitalization, and lower health costs. For multiple aspects of care including adequacy of communication, respect for treatment preferences, emotional and spiritual support, management of symptoms and care, palliative care patients had higher scores for almost all domains.

### **Examples of Palliative Care Eligibility Criteria and Assessment Tools**

The following palliative care program examples are provided for consideration and reference:

- [Sharp HealthCare Transitions Program](#)
- [Sutter Advanced Illness Management Program](#)
- [Kaiser Permanente Northwest Hospital Palliative Care](#)
- [Partnership HealthPlan Offering and Honoring Choices](#)

### **Results**

Multiple studies have documented positive impacts on patient satisfaction, utilization and fiscal outcomes. According to many research sources on palliative care, patients who received palliative care had lower rates of Emergency Department (ED) visits and hospital admissions and were more likely to die at home compared to patients who received usual home care services.

Examples of several of the many studies:

Brumley et al, Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care, J Am Geriatr Soc. 2007 Jul;55(7):993-1000.

Casarett D, et al. Do palliative consultations improve patient outcomes? J Am Geriatr Soc 2008;56:593–599.

Gade G. et al. Impact of an Inpatient Palliative Care Team: A Randomized Controlled Trial. J Palliat Med. 2008 Mar;11(2):180-90.

Brumley et al, Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care, J Am Geriatr Soc. 2007 Jul;55(7):993-1000.

Gade G. et al. Impact of an Inpatient Palliative Care Team: A Randomized Controlled Trial. J Palliat Med. 2008 Mar;11(2):180-90.

- Greer JA, et al. Effect of early palliative care on chemotherapy use and end-of-life care in patients with metastatic non-small-cell lung cancer. *J Clin Oncol* 2012;30:394-400.
- Lukas L, et al. Hospital outcomes for a home-based palliative medicine consulting service. *J Palliat Med* 2013;16:179– 184.
- Morrison, R.S. et al, Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries, *Health Affairs*,2011; 30(3), 1-9.
- Morrison, R.S., et al., Cost Savings Associated With US Hospital Palliative Care Consultation Programs. *Archives of Internal Medicine*, 2008;168(16), 1783-1790.
- Norton SA, et al. Proactive palliative care in the medical intensive care unit: Effects on length of stay for selected high- risk patients. *Crit Care Med* 2007; 35:1530–1535 (University of Rochester).
- Temel J et al, Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer, *New England Journal of Medicine*, 2010;363:733-42.
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