

Department of Health Care Services

SB 1004 Medi-Cal Palliative Care Policy

November 2017 – Update

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). This November 2017 version reflects minor updates, and is consistent with DHCS All Plan Letter 17-015, published October 19, 2017¹.

The DHCS Medi-Cal palliative care policy is 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 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.

¹ APL 17-015 can be found at:

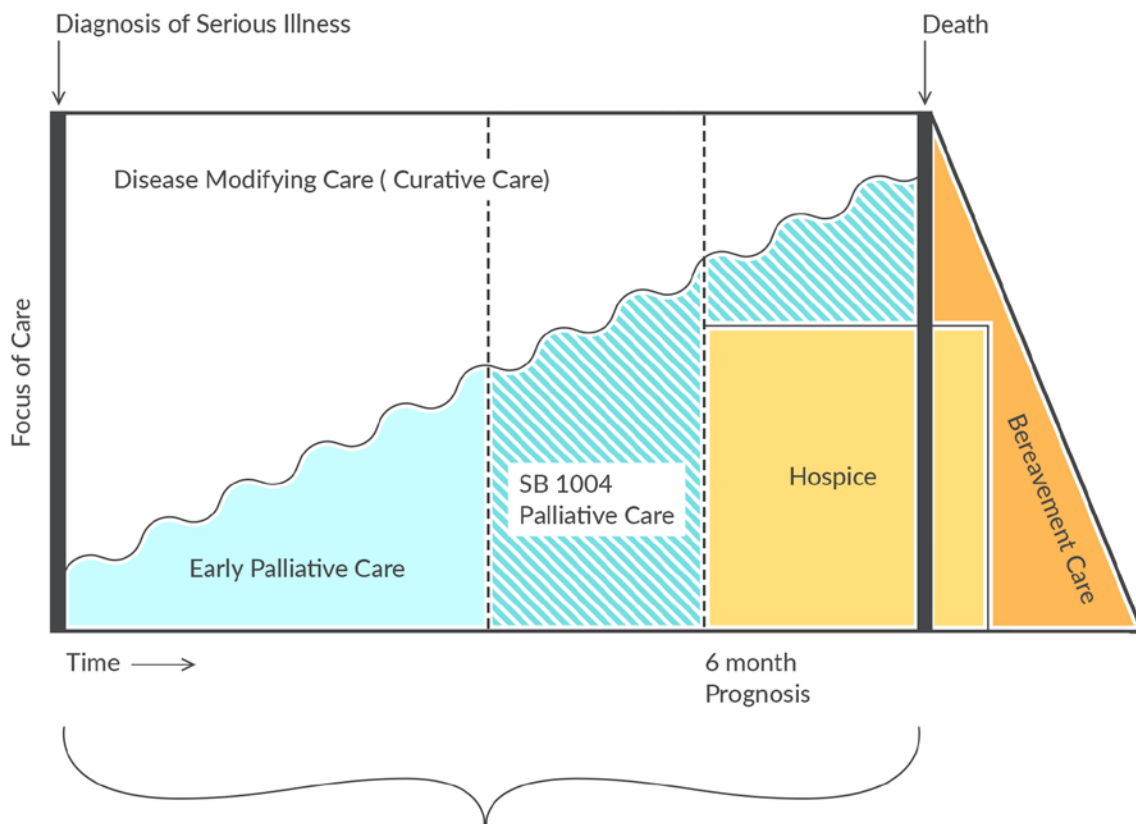
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-015.pdf>

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



Advance Care Planning can occur at any time, including the POLST* form for those with serious illness.

* 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 Illness²

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 three 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, four 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.

² 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.

- 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
 - 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 four 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 third line chemotherapy, or enroll in hospice. Based on the difficulty she had tolerating the second line chemotherapy, she decided to enroll in hospice care at home.

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

Section 2: Eligible Conditions

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.

Based on feedback from a panel of palliative care experts, beneficiary eligibility for SB 1004 Medi-Cal palliative care should be determined through a clinical review consisting of general eligibility criteria and disease-specific criteria.³ 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. The beneficiary is likely to or has started to use the hospital or emergency department as a means to manage his/her advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
2. The beneficiary has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The beneficiary's death within a year would not be unexpected based on clinical status.
4. The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective.⁴ Patient is not in reversible acute decompensation.
5. The beneficiary and, if applicable, the family/patient-designated support person, agrees to:
 - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or

³ The SB 1004 palliative care criteria are based on the Sharp HealthCare Transitions Guidelines for Advanced Illness Management, developed by Daniel R. Hofer, 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.

⁴ 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.

- 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 beneficiary 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;⁵ and
 - b. The beneficiary has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.
2. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
 - a. The beneficiary has a Forced Expiratory Volume (FEV)₁ less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
 - b. The beneficiary 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 beneficiary has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
 - b. The beneficiary has a Karnofsky Performance Scale (KPS) score less than or equal to 70⁶ 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 beneficiary has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
 - b. The beneficiary has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
 - c. The beneficiary has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.⁷

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

⁵ NYHA classifications are available at:

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

⁶ "Performance Scales: Karnofsky and ECOG Scores," <http://oncologypro.esmo.org/Guidelines-Practice/Practice-Tools/Performance-Scales>

⁷ MELD score calculator is available at: <https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator>

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 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

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 policy provides 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.

A. Palliative Care Services:

Effective January 1, 2018, when a beneficiary 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:

1. **Advance Care Planning:** Advance care planning for beneficiaries 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.⁸ Please refer to the section on Advanced Care Planning in the Provider Manual for further details.⁹

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. 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
3. **Plan of Care:** A plan of care should be developed with the engagement of the beneficiary and/or his/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. A beneficiary'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 must not include services already received through another Medi-Cal funded benefit program.¹⁰
4. **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 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 (Primary Care Provider if NP), and a social

⁸ POLST forms are available at: <http://capolst.org/>

⁹ Medi-Cal Provider Manual "Evaluation and Management (E&M)." Available at https://www.google.com/url?q=https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval_m00o03.doc&sa=U&ved=0ahUKEwi1w7-e2KPPAhVV7GMKHclmCkUQFggEMAA&client=internal-uds-cse&usq=AFQjCNH1-XcVgZ-ooCK-OzJhLYgZ1sMslA. Accessed September 22, 2016.

¹⁰ Examples include, but are not limited to, APL 13-014; California Children's Services Numbered Letter 06-1011; Managed Care Policy Letter 11-004.

worker. Chaplain Services: DHCS 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.

5. Care Coordination: A member of the palliative care team should provide coordination of care, ensure continuous assessment of the beneficiary's needs, and implement the plan of care.
6. 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.
7. Mental Health and Medical Social Services: Counseling and social services must be available to the beneficiary 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 shall not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs) and does not change the MCP's responsibilities for referring to, and coordinating with, county MHPs as delineated in APL 13-021.¹¹
8. 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

¹¹ APL "Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services" available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf>

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

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 beneficiary so long as the MCP ensures that its providers comply with existing Medi-Cal contracts and policy. DHCS recommends that MCPs use providers with 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 (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. Palliative care provided in a beneficiary'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.

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 Medi-Cal providers. 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.