

Department of Health Care Services  
SB 1004/Palliative Care Services  
October 5 , 2015

**STAKEHOLDER COMMENTS TO THE “SB 1004 MEDI-CAL PALLIATIVE CARE” POLICY PAPER  
As of October 22, 2015**

<b>Comment Period:</b>	October 5 – October 19, 2015
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Stakeholder	Category	Comment/Question
Martha Tasinga <i>Care1st Health Plan</i>	<b>Proposed Eligible Conditions</b>	State needs to provide clarification of what specifically defines late stage/high grade cancer.
	<b>Proposed Providers</b>	State needs to clearly define criteria for inclusion into network for palliative care.
Teri Boughton <i>Consultant Senate Health Committee Staff to Senator Hernandez</i>	<b>Proposed Eligible Conditions</b>	<p>I appreciate why the department has chosen to limit eligibility for Medi-Cal palliative care to beneficiaries with late-stage/high grade cancer with significant functional decline or limitations. However, such a narrowing is inconsistent with SB 1004. First, the legislation clearly establishes intent that palliative care is appropriate for any stage of serious illness. Second, the bill charges the department, in consultation with interested stakeholders, to establish guidance on the medical conditions and prognoses that render a beneficiary eligible for palliative care services. The implication and intent was not to limit palliative care services this narrowly. If the department must limit its guidance in this way initially I would encourage the development of a timeframe or work plan for implementing palliative care services more broadly in line with evidence and research available in the field.</p> <p>Additionally, I support and encourage the department to continue to encourage MCOs already covering palliative care to continue to do so. It was never the intent that SB 1004 result in the limiting or narrowing of palliative care currently being provided.</p>
	<b>Proposed Providers</b>	The department’s paper correctly points out that the legislation calls for the inclusion of licensed hospice agency and home health agencies as providers authorized to provide palliative care services when contracted with MCOs. Authorized providers should not be limited to licensed hospice and home health providers. I agree with the department that other community based providers should also be included as authorized providers.
Lishaun Francis <i>Center for Medical &amp;</i>	<b>Proposed Eligible Conditions</b>	While focusing on “late-stage/high grade” cancer may make sense in terms of drawing reasonable and rational boundaries around a pilot we would prefer broader language

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<p><i>Regulatory Policy California Medical Association</i></p>	<p><b>Proposed Palliative Care Services</b></p>	<p>allowing eligibility for all those with a diagnosis of cancer to participate.</p> <p>Under section 3, DHCS asks for comment about qualified personnel. This is an important question as many potentially participating organizations, like home health organizations, claim to provide "palliative services" but have no qualified staff. On-staff physicians with hospice &amp; palliative medicine board certification OR hospice medical director certification should be a required component of any qualified service. Other staff members should have additional training and certification in hospice or palliative care including nurses, social workers and chaplains (who all have defined pathways to education/certification). Many of these organizations currently providing "palliative" services are not physician-led (and definitely not specialist-trained physician led) and are corporate entities with conflicted interests. We strongly urge the department to implement a physician-led environment with hospice and palliative medicine board certification.</p> <p>Section 3.B.2 should include "advance directives" and "living wills" as advance care planning documents for POLSTs are not always applicable to this population.</p> <p>Under 3.C, CMA is concerned with the following statement: "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." CMA requests that this be better defined as to whether the palliative care organization is to be responsible for this coordination.</p>
	<p><b>Proposed Providers</b></p>	<p>We feel it prudent to note that there is a dire workforce need for physicians to provide palliative care. Currently, there is no state or federal support for fellowship training for palliative care physicians. Therefore, funding is presently contingent on health system support or philanthropy which we find to be largely inadequate. As a component of guaranteeing access to these services, consideration should be given to stabilizing/supporting funding of these training opportunities.</p>
	<p><b>Performance Measure and Monitoring Outcomes</b></p>	<p>We urge DHCS to review the American Academy of Hospice and Palliative Medicine' quality metric set: Measuring What Matters, <a href="http://aahpm.org/quality/measuring-what-matters">http://aahpm.org/quality/measuring-what-matters</a>. We believe these physician-developed quality metrics have undergone a highly scientific process and should be considered.</p>
	<p><b>Other</b></p>	<p>Overall, these initial guidelines are well considered and crafted.</p>
<p>Reverend Eric J. Hall <i>HealthCare Chaplaincy Network (HCCN)</i></p>	<p><b>Proposed Palliative Care Services</b></p>	<p>As an organization interested in advancing sound public policy in spiritual health care services, HCCN supports efforts to increase access to palliative care. For far too long, spiritual care has been disregarded and devalued as a vital component of our health care delivery system. Yet the role spirituality plays for most people with a chronic or fatal</p>

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	<p><b>Proposed Providers</b></p>	<p>condition is vital in increasing overall fulfillment, finding satisfaction in their care plan, and facing the adversities that these conditions provide in both body and mind. Moreover, services and counseling provided by spiritual care professionals provide assistance not only to the individual with chronic or fatal conditions, but to their family caregivers as well. Access to spiritual health professionals provides better outcomes while often lowering care costs. Professional chaplains facilitate end-of-life care discussions for advanced care beneficiaries that can influence satisfaction, increase hospice enrollment, and provide a better quality of life through the end-of-life experience.</p> <p>Access to spiritual counseling will help beneficiaries make more informed choices that could lead to increased hospice enrollment and lower costs at end-of-life.</p> <p>We urge DHCS to insure that spiritual care support is appropriately defined and the intent of SB1004 to include spiritual support in this new benefit is quickly and fully implemented.</p> <p>In implementing SB1004, we encourage you to specify that professional board-certified chaplains provide spiritual care to patients receiving palliative care, and their families. Professional multi-faith chaplains are the spiritual care specialists, having undergone extensive clinical training and making valuable contributions to interdisciplinary teams. While we recognize that financial constraints must be taken into consideration, there are technological solutions available that can cost-effectively help extend access to professional chaplains, especially in rural and underserved areas, and to the elderly and homebound. Such programs can be utilized by licensed home health and hospice agencies to provide valuable and necessary spiritual care services to Medi-Cal beneficiaries across all California localities.</p>
	<p><b>Other</b></p>	<p>As an organization that continues to witness the centrality of spiritual support to the coping and welfare of those who are sick and their loved ones, we urge DHCS to insure that spiritual care support is appropriately defined and the intent of SB1004 to include spiritual support in this new benefit is quickly and fully implemented.</p>
<p>Linda Gibson <i>Napa Valley Hospice Adult Day Services</i></p>	<p><b>Definition of Palliative Care</b></p>	<p>I am generally supportive of the definition the Department suggests using. However, I would suggest using the definition from the Center to Advance Palliative Care (CAPC), as it more fully describes palliative care and clearly establishes it as separate from Hospice care.</p> <p>“Palliative care, also known as palliative medicine, is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of</p>

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		<p>a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.</p> <p>Palliative care is provided by a team of palliative care doctors, nurses and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.” CAPC website.</p> <p>I see the palliative care benefit as a unique service, apart from the hospice benefit, offered to patients with chronic illness, significantly earlier than the six month criteria for Hospice. To truly meet the Triple Aim, palliative care must be offered much earlier in the course of illness to ensure that the plan of care is aligned with the patient’s goals of care.</p>
	<b>Proposed Eligible Conditions</b>	<p>I am concerned that eligibility with “late stage / high grade cancer with significant functional decline or limitations” is too limiting, because a patient with this diagnosis is already eligible for hospice care. The intent of SB 1004 is to provide palliative care, not hospice care. To meet the palliative care definition of “anticipating, preventing, and treating suffering,” and in order to adequately address the physical, intellectual, emotional, social, and spiritual needs as well as advance care planning, an earlier intervention is necessary.</p> <p>I suggest that eligibility not be linked to the stage of cancer but rather the condition and severity of signs and symptoms.</p> <p>I highly encourage the department to use the diagnoses that are being studied in the California Healthcare Foundation Palliative Care project: Congestive Heart Failure, COPD, Cirrhosis, Dementia, Frailty Syndrome and Cancer.</p>
	<b>Proposed Palliative Care Services</b>	<p>Palliative care services must be provided by qualified personnel who possess experience and training in palliative and end of life care.</p> <p>While hospice care is palliative in nature, the hospice benefit provides care and services beyond palliative care. The hospice benefit as defined by CMS includes a wide range of services for terminally ill patients with a prognosis of 6 months or less. The hospice benefit is inclusive of all care and services related to the terminal illness, including but not limited to provision of medications, medical supplies, equipment, short term inpatient care, continuous care, and respite care. The comprehensive services of the hospice benefit vary significantly from palliative care. It seems that the intent of SB 1004 is to offer some of the services of hospice and to align the Medi-Cal palliative care program with the philosophy of hospice which addresses the physician, emotional, spiritual, and practical needs of the patient and family through an interdisciplinary</p>

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		<p>approach.</p> <p>It would be unrealistic to expect providers to deliver palliative care services to the extent provided through the hospice benefit without a revenue stream comparable to the current hospice benefit.</p> <p>Reimbursement for palliative care services should be adequate to cover the costs of care, and provide a reasonable surplus so that the program is sustainable for the provider.</p>
	<b>Proposed Providers</b>	It is vital that providers of palliative care services have experience and training in palliative and end of life care.
	<b>Delivery System and Dual Eligible Considerations</b>	I urge the department to implement this benefit with fee-for-service health plans and dually eligible beneficiaries as soon as possible. The palliative care benefit should include patients in skilled nursing facilities.
	<b>Performance Measure and Monitoring Outcomes</b>	I am strongly supportive of the use of performance measures; the measures should be clear, measureable, and realistic. I am a strong supporter of pay for performance.
Abbie Totten <i>Health Net, Inc.</i>	<b>Proposed Eligible Conditions</b>	<p>Health Net supports DHCS’s approach to set an eligibility minimum for the palliative care benefit while providing plans the flexibility to expand criteria if the plan believes such an expansion is financially feasible. The varying degrees of palliative care availability will impact the plans’ ability to serve the full Medi-Cal population. Limiting to a core set of beneficiaries will allow the state to test the feasibility of such an expansion and the potential for long-term cost savings to the program without making large capital outlay.</p> <p>We do caution that allowing for different degrees of implementation may have an impact on risk mix if plans in the same county are not aligned. This potential population migration should be monitored closely should plans identify a shift in membership after implementation of the benefit.</p> <p>Health Net also recommends DHCS provide a simplified and standardized assessment tool for eligibility in order to allow for an apples-to-apples comparison of outcomes among plans. Based on our experience, we recommends DHCS utilize as the minimum:</p> <ul style="list-style-type: none"> <li>•Diagnosis of late stage/high grade cancer with significant decline or limitations as defined by: <ul style="list-style-type: none"> <li>o Decrease in cognitive status</li> <li>o Decrease in performing complex tasks</li> <li>o Decrease of ability to ambulate</li> <li>o Decrease in performance of ADLs (dressing, bathing, toileting, etc.)</li> </ul> </li> </ul>

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		<ul style="list-style-type: none"> <li>o Re-current infections</li> <li>o Increase in symptom duration/ intensity</li> <li>o Symptoms poorly controlled</li> </ul> <p>These criteria should be used by providers when referring patients for palliative care services. DHCS may also consider use of the FAST – Functional Assessment Staging Tool – which allows providers to perform a quick and accurate determination of functional decline. See attachment below.</p> <p>Overall, we recommend DHCS provide a single standardized form available on the DHCS website for providers to use to assess patient eligibility for palliative care unless the plan already has a palliative care program in place and receives DHCS approval to use an alternative.</p>
	<b>Proposed Palliative Care Services</b>	<p>Health Net recommends DHCS remove the reference to services under the Hospice benefit. Many of the services listed under subdivision A are within the scope of the Medi-Cal Managed Care benefit package. However, respite care and in home aides are not standards Medi-Cal Managed Care benefits, therefore, expanding access to these services outside of the hospice care benefit may result in significant uncompensated costs to the plans. The benefits listed under subsection B should be included as a part of a standardized palliative care benefit.</p> <p>DHCS also requested feedback on how to define “qualified personnel” under the palliative care benefit. Health Net recommends DHCS provide plans the flexibility to determine those professionals qualified to provide palliative care based on the regional need and capacity. In defining qualified personnel, plans should be allowed to include those individuals with appropriate clinical expertise or training, such as through the California State University Institute for Palliative Care’s professional development programs, in palliative care. If providers are limited to only those with board certification or fellowship experience, access will be severely limited as palliative care is a new and slowly growing field.</p>
	<b>Proposed Providers</b>	<p>While we appreciate that SB 1004 requires inclusion of licensed hospice and home health providers in the palliative care network, Health Net request DHCS provide clarification that plans are not required to contract with any and all providers in these categories. Plans should have flexibility to develop a palliative care network that aligns with the needs and capacity within the county. Submission and review of these networks to DHCS will ensure inclusion of the appropriate providers.</p>

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		Some plans, including Health Net, already have developed palliative care programs which we would like to use as the model for the expansion to Medi-Cal. However, a single statewide model may not be appropriate or feasible given geographic variation. In some areas, palliative care may best be provided through a hospice care vendor while other areas may have clinical staff on site in facilities. Plans will need to assess current network capacity and develop a contracting model accordingly. Flexibility will be necessary to ensure access to services.
	<b>Delivery System and Dual Eligible Considerations</b>	Health Net appreciates the deliberate approach DHCS is taking in implementing the palliative care benefit. In order to ensure savings accrues to the Medi-Cal program in the long term, a focus on those with all benefits under the same system of care will be required.
	<b>Performance Measure and Monitoring Outcomes</b>	<p>Health Net also appreciates DHCS’ desire to have performance metrics and monitoring activities in place related to the palliative care benefit. Given the level of potential variation among the plans in experience, DHCS should consider reporting only on the limited population currently specified by DHCS. Plans may expand eligibility for additional categories based on internal validation of the value of the program. As a result, if plans report on palliative care as a whole, DHCS may not have an apple-to-apples comparison. Setting a base across all plans will provide a more accurate picture of the outcomes.</p> <p>Health Net also recommends a limited and specific set of reporting requirements to minimize the administrative burden on plans and providers. Implementing new reporting metrics may be difficult and a resource intensive, manual process if the data is not currently collected..</p>
	<b>Other</b>	Health Net recommends DHCS lead a statewide educational effort with providers and the Medi-Cal members about the palliative care benefits including discussion on what palliative care is and is not, and how to access services. Additional funding either directly to plans for education and outreach efforts or through community based organizations may assist in disseminating best practices and increase access to care.
Leah Morris (CCCC) on behalf of: <i>Anne Kinderman ,MD, Kathleen Kerr, Kate O’Malley, RN,MS , Judy Thomas, JD and Leah Morris, RN, MPH, NP and Michael Rabow, MD</i>	<b>Definition of Palliative Care</b>	We support the CMS definition that specifies that palliative care should be delivered concurrently with other appropriate medical treatments, and is “appropriate for any age and for any stage of serious illness” per SB 1004 14132.75 (a), (4), emphasis added. Palliative care under SB 1004 is not dependent on a medical prognosis of any specific length of time (such as 12 months, 2 years, etc.) Palliative care is for people experiencing a serious advanced illness.

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	<b>Proposed Eligible Conditions</b>	<p>An incremental approach starting with cancer diagnoses is reasonable, so long as there is a stated plan to move forward with other non-cancer diagnoses over time. There is a large evidence base demonstrating the benefits of early palliative care for patients with metastatic cancer, and these diagnoses tend to demonstrate a rather steady and predictable decline towards death, making patients who might benefit easier to identify. However, patients with other diagnoses (such as organ failure, dementia or frailty) may be equally benefitted by palliative care, even though prognostication is often more challenging. In fact, those diagnoses may be opportune for palliative care as they may have a longer life expectancy with well anticipated decline and symptom exacerbation.</p> <ul style="list-style-type: none"> <li>•Some cancer patients may have high symptom burden without “significant functional decline or limitations” and would certainly benefit from palliative care. Furthermore, the experience of community-based palliative care programs is that the greatest opportunity for cost savings occurs when palliative care services are introduced earlier (&gt;90 days before death), likely prior to the terminal phase of “significant functional decline or limitations.” Plans may find it difficult to meet cost neutrality if services are only available to patients with functional decline or limitations. We recommend using language that mirrors the provisional clinical opinion put forth by the American Society of Clinical Oncology, which states that palliative care be offered alongside standard oncologic care for patients with metastatic disease or heavy symptom burden (American Society of Clinical Oncology. American Society of Clinical Oncology Provisional Clinical Opinion, The Integration of Palliative Care into Standard Oncology Care (2012). Available at (accessed August 2014): <a href="http://jco.ascopubs.org/content/30/8/880.full">http://jco.ascopubs.org/content/30/8/880.full</a>)</li> <li>•The focus on late stage cancers places this intervention at end of life even though the initiative overall correctly defines palliative care as appropriate at any age and any stage of serious illness.</li> </ul> <p>Feedback on specific standardized clinical criteria for eligibility purposes</p> <ul style="list-style-type: none"> <li>•Given the diversity of patient populations, settings of care, and plan size, we favor a strategy which allows plans to choose from a menu of existing screening protocols. For example, Partnership HealthPlan of California has found that existing screening protocols needed to be adapted to meet the unique needs of their Medi-Cal patients.</li> <li>•Requiring adherence to specific clinical criteria may not work well across the different health plan models. Flexibility may encourage MCOs to better engage in developing programs that meet their particular network model, geographic setting and administrative processes.</li> <li>•It would be helpful for the state to offer examples of standardized clinical criteria (which MCOs could adopt).</li> </ul>
	<b>Proposed Palliative Care Services</b>	Feedback on Proposed Palliative Care Services and definition of “qualified personnel”



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		<ul style="list-style-type: none"> <li>•Given the well-documented shortage of board certified palliative care specialists in California (and across the United States), some (and in some settings most) palliative care will need to be provided by non-specialty providers who demonstrate competence to deliver the core components of palliative care. We look forward to working with DHCS to develop ways to assess competency and qualification to provide palliative care services for Medi-Cal members. Educational certificate programs, such as those available through the California State University Institute for Palliative Care, may provide appropriate high-quality training for non-palliative care specialists.</li> <li>•SB 1004 directs palliative care services to include, but not be limited to, the types of services available through the Medi-Cal hospice benefit. Therefore, qualified personnel would be, at minimum, those agencies (and personnel) currently licensed to provide hospice services. However, SB 1004 also directs that palliative care be provided concurrently with curative care. Ensuring that ongoing curative treatment is available will require additional coordination to assure patients receive both curative and palliative care. The hospice benefit includes (among many services) physical, emotional and spiritual care. It also includes management of medical supplies and equipment, and some hospice patients are appropriate for rehabilitative services, such as physical therapy or other services. Palliative patients who are continuing to receive curative care will require close care coordination between the curative care providers and the palliative care providers – and identification of who is responsible and financially at risk for what services. For example, ordering and managing oxygen could fall under either curative or palliative provider responsibilities.</li> <li>•Ensuring cultural competency for care delivery deepens the responsibility to identify qualified personnel across a continuum of disciplines.</li> <li>•Standards developed by national accreditation organizations, such as the Community-Based Palliative Care Certification Standards recently proposed by The Joint Commission, may provide direction and support as the State considers methods to define program adequacy.</li> </ul>
	<b>Proposed Providers</b>	<p>Feedback on Proposed Providers</p> <ul style="list-style-type: none"> <li>•Given the disparities in access to specialty palliative care services across the state [Ref: CHCF Uneven Terrain – <a href="http://www.chcf.org/publications/2015/02/palliative-care-data">http://www.chcf.org/publications/2015/02/palliative-care-data</a>], we recommend that DHCS provides additional time for plans serving under-resourced counties (i.e. those which currently have minimal to no reported palliative care services) to develop a Community Based Palliative Care provider network.</li> <li>•A special focus on how the Medi-Cal plans relate to their oncology network providers and their relationships with them would be valuable. What kind of leverage does the plan have to ensure that palliative care is integrated into oncologic care? How will DHCS determine if palliative care services (either specialty or primary) have been offered to</li> </ul>

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		<p>patients who meet the minimum criteria of late stage/high grade cancer?</p> <ul style="list-style-type: none"> <li>•California is comprised of both densely populated urban areas as well as rural and frontier areas. Generally, Medi-Cal Managed Care plans are required to assure access to services under the covered benefit design. It seems reasonable to ask health plans to respond to questions about access to palliative care services and potential development of innovative models (e.g., telemedicine and telehealth) to serve their enrollees across regions. Avoiding absolute definitions of services allows flexibility for those health plans serving remote areas, however, asking health plans to ensure access to covered benefits and services (such as hospice or palliative care) could promote creativity.</li> <li>•Also, what is the role of the Department of Managed Health Care (DMHC) as it relates to “managed care network adequacy”? As the regulator of HMOs serving Medi-Cal Managed Care, what role (if any) does DMHC have in the discussion of network adequacy?</li> <li>•Please clarify that, under SB 1004 14132.75. (4), (e), MCOs shall include licensed hospices and home health providers licensed to provide hospice care. The October 2, 2015 paper does not specify that home health providers must be licensed to provide hospice services; was that intentional? Not all home health providers are licensed to provide hospice care and may not, for example, have expertise in care coordination or symptom management, or social, spiritual and emotional care services.</li> </ul>
	<p><b>Performance Measure and Monitoring Outcomes</b></p>	<p>Feedback on linking a portion of palliative care payment to performance and patient outcomes.</p> <ul style="list-style-type: none"> <li>•We agree that linking payment to performance can be a powerful mechanism for ensuring high-quality care, and it can drive resource allocation and focus. Similar to how other Pay-For-Performance mechanisms have been initiated, and given the initial investment that plans will need to make before cost savings can be realized, we recommend considering payment for completion of process measures in the initial implementation phases of SB 1004.</li> <li>•Specific measures will need to be carefully outlined to assure that attention aligns with priorities. Process measures (e.g., completed advance care plans, implementation of quality tracking tools and regular reporting) are a good starting point, but ultimately improved quality care (e.g., improved pain control, care consistent with preferences) is the goal and should be assessed and rewarded, once programs are mature enough to be tracking and achieving these ends. A reduction in ER visits or preventable hospitalizations, while important, might be a later performance measure. Development costs for both health plans and clinical providers cannot be underestimated. New medical record reporting requirements, costs for care coordination personnel (clinical and non-clinical), contracting for new payment relationships with medical providers, etc. will all require investment by the different participants.</li> </ul>

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		<ul style="list-style-type: none"> <li>•Payment models for palliative care services need to be very clear and based on expectations of the program. This model likely cannot fully mirror the hospice structure which puts the hospice at financial risk for the majority of the hospice patient’s medications, medical equipment, treatments, etc. The palliative care services payment structure must be thoughtfully considered and defined, apart from additional incentive payments for performance. MCOs may need direction about how to structure their payments, their Division of Financial Responsibilities, and their performance monitoring programs. Generally, MCOs will need guidance about any expectations to maintain financial responsibility for medications, medical equipment, rehabilitative therapies, and even certain palliative therapies (such as palliative radiation at thousands of dollars a treatment). Who pays for what will be critical baseline information consideration, prior to or in addition to delineating incentive payments for quality or process outcomes.</li> <li>•Does SB 1004 create a new benefit in the Medi-Cal program that would be universally applied to all Medi-Cal beneficiaries with serious illness and are discussions underway to actually increase Medi-Cal rates to pay for these services? Some clarity on this issue would be appreciated.</li> </ul>
Autumn Ogden, <i>American Cancer Society Cancer Action Network</i>	<b>Definition of Palliative Care</b>	We thank the Department for allowing us time to respond to the proposals to this critical program. Along with our comment below, we would like to emphasize the importance of carefully evaluating the roll-out and definition of the benefit and continuous engagement with the palliative care stakeholders to ensure that highly symptomatic Medi-Cal beneficiaries with cancer who would benefit from palliative care aren’t being left out of the chosen criteria.
	<b>Proposed Eligible Conditions</b>	<p>The language in this section is too limiting as it refers to only late-stage/high grade cancer with significant functional decline. The problem with this criteria is research has shown that some problematic symptoms amenable to palliative care intervention, such as fatigue, do not differ by stage and grade. With the Department’s recommended criteria, many people with significant fatigue or other symptom management needs would not qualify for palliative care. We propose the Department expand this to take symptoms into consideration and not depend just on the late-stage diagnosis.</p> <p>We also find the functional decline criterion problematic. There are many people in need of palliative care who would not qualify under the “significant functional decline” criterion (such as people with significant pain management needs). We would like to see the Department broaden this definition to include other components such as significant pain as part of the standardized assessment tools for qualification.</p> <p>We believe the Department should provide specific standardized clinical criteria for</p>

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		<p>Medi-Cal palliative care eligibility purposes.</p> <p>In Section 3.A.8 the Department proposes that counseling services be provided by appropriately trained personnel, implying licensed mental health practitioners who have training in behavioral medicine/palliative care. While we agree this would be ideal, counselors with this specific background are not easy to come by and it would take years to retrain enough counselors to fit this need. We would like to see the Department take this into consideration as they further develop guidance to define “qualified personnel” and consider the immediate need of current patients to have access to counselors in the course of their palliative care.</p>
<p>Susan E. Negreen <i>California Hospice and Palliative Care Association</i></p>	<p><b>Definition of Palliative Care</b></p>	<p>Overall, CHAPCA is supportive of the definition the Department suggests using. We note that this definition comes from the CMS Hospice certification standards.</p> <p>CHAPCA sees the palliative care benefit as a unique service, apart from the hospice benefit, offered to patients with life threatening illness, significantly earlier than the six months criteria for hospice. We see this as an important opportunity to establish protocols for the wide-spread implementation of palliative care.</p>
	<p><b>Proposed Eligible Conditions</b></p>	<p>While CHAPCA understands the department’s goal of defining Medi-Cal palliative care more narrowly initially and implementing with an incremental approach in order to achieve long-term success, we have significant concerns that “late stage/high grade cancer with significant functional decline” is too limiting, as a patient with this condition and diagnosis would already be hospice eligible. The intent of SB 1004 is to provide palliative care, not hospice care. To meet the palliative care definition of “anticipating, preventing, and treating suffering,” and in order to adequately address the physical, intellectual, emotional, social, and spiritual needs as well as advance care planning, an earlier intervention is necessary.</p> <p>CHAPCA suggests that eligibility not be linked to the stage of cancer but rather the condition and severity of signs and symptoms. Some patients are diagnosed with stage 4 cancer with few signs and symptoms of the disease, while others diagnosed with stage 2 cancer may experience considerable distress.</p> <p>If you decide to choose one diagnosis, we suggest advanced cancer, with some functional decline. Cancer patients may have significant problems with pain, complex symptoms and may still be ambulatory with little functional decline. Functional decline may be more appropriate for determining prognosis with non-cancer diagnoses.</p> <p>CHAPCA strongly suggests the department use the six diagnoses from the Partners in Palliative Care Services pilot - Congestive Heart Failure, COPD, Cirrhosis, Dementia, Frailty Syndrome and Cancer.</p>

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		<p>Regardless of the actual eligible condition(s) you use, we strongly believe that the clinical criteria for eligibility and assessment must be standardized in order to ensure consistent implementation statewide. CHAPCA has grave concerns with Managed Care plans being allowed to determine screening protocols because eligibility for palliative care would subsequently vary between the MCOs throughout CA. Standardization is essential to ensure that the program will be implemented equitably and that patient outcomes and performance measures will be evaluated consistently throughout all counties.</p> <p>CHAPCA supports the department’s proposal to require MCOs to use a standardized tool in the administration of palliative care. We recommend the Palliative Performance Scale (PPS), a widely utilized tool for measurement of performance status in palliative care. It is useful for purposes of identifying and tracking potential care needs of palliative care patients, particularly as these needs change with disease progression.</p>
	<p><b>Proposed Palliative Care Services</b></p>	<p>Palliative care services must be provided by qualified personnel. Qualified personnel must possess experience and training in palliative and end of life care. SB 1004 requires that authorized providers include licensed hospice agencies and home health agencies <i>licensed to provide hospice care.</i></p> <p>CHAPCA believes palliative care consultation, performed by qualified physicians, nurses and social workers; advance care planning and patient-involved decision making including but not limited to the completion of Physician Orders for Life Sustaining Treatment (POLST); and care coordination, assessment, interdisciplinary care team, and development of a care plan, should be the required services offered under the palliative care benefit. We believe this is consistent with the intent of the legislation.</p> <p>Payers should be able to contract for additional hospice – like visits, such as counseling, nursing, medical social services, and/or dietary and spiritual counseling, as determined by the needs of the patient and the scope of the contract.</p> <p>While hospice care is palliative in nature, the hospice benefit provides care and services beyond palliative care. The hospice benefit as defined by CMS includes a wide range of services for terminally ill patients with a prognosis of 6 months or less, as outlined in Section 3 A in your document. This hospice benefit is inclusive of all care and services related to the terminal illness, including but not limited to provision of medications, medical supplies, equipment, short term inpatient care, and continuous care. The comprehensive services of the hospice benefit vary significantly from palliative care.</p>

Stakeholder	Category	Comment/Question
		<p>We believe the intent of SB 1004 is to offer some of the services of hospice and to align the Medi-Cal palliative care program with the philosophy of hospice which addresses the physical, emotional and spiritual needs of the patient and family through an interdisciplinary approach. Palliative care, also known as palliative medicine, utilizes a multidisciplinary approach to specialized medical care focusing on the alleviation of symptoms and stress associated with a serious illness.</p> <p>CHAPCA strongly believes that it would be unrealistic to expect providers to deliver palliative care services to the extent provided through the hospice benefit without a revenue stream comparable to the current hospice benefit.</p> <p>Reimbursement for palliative care services for providers needs to be adequate in order to cover the cost of care.</p>
	<b>Proposed Providers</b>	<p>It's important to note that the law requires that authorized providers include licensed hospice agencies and home health agencies <i>licensed to provide hospice care</i>. It is vital that providers, wherever they are based, have experience and training in palliative and end of life care. CHAPCA urges the department to give every licensed and certified hospice provider the opportunity to contract with managed care providers.</p>
	<b>Delivery System and Dual Eligible Considerations</b>	<p>CHAPCA urges the department to implement this benefit with fee-for-service delivery systems and dually eligible beneficiaries as soon as possible. Palliative care should be available to all beneficiaries regardless of where they live. Nursing facility residents should be eligible for services upon implementation of this benefit.</p>
	<b>Performance Measure and Monitoring Outcomes</b>	<p>CHAPCA would like to be involved in the development of performance measures, as we believe they should be clear, measurable, and realistic. We strongly support pay for performance.</p>

Health Net, Inc. Attachment to Proposed Eligible Conditions

## 4

## FAST Functional Assessment Staging (for use with Dementia and related disorders)

<b>LEVEL</b>	<b>Check highest consecutive level of disability; usually a progressive pattern of decline occurs</b>
1.	No difficulty either subjectively or objectively.
2.	Complains of forgetting location of objects. Subjective work difficulties.
3.	Decreased job functioning evident to co-workers; difficulty in traveling to new locations; decreases organizational capacity.*
4.	Decreased ability to perform complex tasks, e.g., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.
5.	Requires assistance in choosing proper clothing to wear for the day, season or occasion, e.g. Patient may wear the same clothing repeatedly, unless supervised.* <i>FAST #6 &amp; #7 continued on next page</i>
<b>LEVEL</b>	<b>Check highest consecutive level of disability; usually a progressive pattern of decline occurs</b>
6.	A) Improperly putting on clothes without assistance or cueing (e.g., may put street clothes on over night clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.
	B) Unable to bathe properly (e.g., difficulty adjusting bath-water temperature) occasionally or more frequently over the past weeks.*
	C) Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*
	D) Urinary incontinence (occasionally or more frequently over the past weeks).*
	E) Fecal incontinence (occasionally or more frequently over the past weeks).*
7A	Ability to speak is limited to approximately a half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.
7B	Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).
7C	Ambulatory ability is lost (cannot walk without personal assistance).
7D	Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral [arm] rests on the chair).
7E	Loss of ability to smile.
7F	Loss of ability to hold up head independently.
<i>*Scored primarily on the basis of information obtained from knowledgeable informant and/or category.</i>	