



JENNIFER KENT  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

**DATE:** October 19, 2017

ALL PLAN LETTER 17-015

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** PALLIATIVE CARE AND MEDI-CAL MANAGED CARE

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their obligation to provide palliative care to their beneficiaries pursuant to Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014).<sup>1</sup> The requirements discussed in this APL specifically apply to Medi-Cal managed care beneficiaries who are not Medicare/Medi-Cal, dually-eligible beneficiaries.

**BACKGROUND:**

SB 1004 requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to MCPs for the delivery of palliative care as codified in the Welfare and Institutions Code (WIC) Section 14132.75.<sup>2</sup> Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care shall not result in the elimination or reduction of any covered benefits or services under the MCP contracts and shall not affect a beneficiary's eligibility to receive any services, including home health services, for which the beneficiary would have been eligible in the absence of receiving palliative care.

Hospice care is a Medi-Cal benefit that serves terminally ill beneficiaries and consists of interventions that focus primarily on pain and symptom management rather than cure or prolongation of life. To qualify for hospice care, a Medi-Cal beneficiary must have a life expectancy of six months or less. Further information regarding Medi-Cal hospice care can be found in APL 13-014.<sup>3</sup>

<sup>1</sup> SB 1004 (Hernandez, chapter 574, statutes of 2014) is available at:

[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140SB1004](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1004)

<sup>2</sup> WIC section 14132.75 is available at:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14132.75.&lawCode=WIC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.75.&lawCode=WIC)

<sup>3</sup> APL 13-014 can be found at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-014.pdf>

Palliative care does not require the beneficiary to have a life expectancy of six months or less and may be provided concurrently with curative care. A beneficiary with a serious illness who is receiving palliative care may choose to transition to hospice care if they meet the hospice eligibility criteria. A beneficiary may not be concurrently enrolled in hospice care and palliative care.

A beneficiary under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care through other existing programs such as the Section 1915(c) Home and Community Based Services waiver, known as Pediatric Palliative Care waiver, or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA). Information regarding the concurrent care policy is available in APL 13-014, California Children's Services Numbered Letter 06-1011,<sup>4</sup> and Managed Care Policy Letter 11-004.<sup>5</sup>

## **POLICY:**

DHCS' SB 1004 Palliative Care Policy<sup>6</sup> specifies the types of palliative care services MCPs must at a minimum authorize when medically necessary for a beneficiary who meets the minimum eligibility criteria. MCPs may either adopt DHCS' minimum eligibility criteria for palliative care, or submit broader eligibility criteria to DHCS for approval.

### **I. Eligibility Criteria**

DHCS' minimum eligibility criteria requires a beneficiary to meet all requirements for the general eligibility criteria and at least one of the four disease-specific eligibility requirements.

#### **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.

---

<sup>4</sup> California Children's Services Numbered Letter 06-1011 can be found at <http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf>

<sup>5</sup> Managed Care Policy Letter 11-004 can be found at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-004.pdf>

<sup>6</sup> DHCS' SB 1004 Medi-Cal Palliative Care Policy, dated September 1, 2016, can be found at: <http://www.dhcs.ca.gov/provgovpart/Documents/SB1004PallCarePolicyDoc090116.pdf>

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. 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 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;<sup>7</sup> 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)<sub>1</sub> 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.

---

<sup>7</sup> NYHA classifications are available at:

[http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure\\_UCM\\_306328\\_Article.jsp#.WefN7rpFxxo](http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.WefN7rpFxxo)

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 70<sup>8</sup> 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.<sup>9</sup>

If a beneficiary continues to meet the above minimum eligibility criteria, he or she may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. MCPs must have a process to identify the beneficiaries eligible for palliative care, including a provider referral process. MCPs should periodically assess the beneficiary for changes in his/her condition or palliative care needs. MCPs may discontinue palliative care that is no longer medically necessary or reasonable.

## **II. 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

---

<sup>8</sup> "Performance Scales: Karnofsky and ECOG Scores," <http://oncologypro.esmo.org/Guidelines-Practice/Practice-Tools/Performance-Scales>

<sup>9</sup> MELD score calculator is available at: <https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator>

place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.<sup>10</sup> Please refer to the section on Advanced Care Planning in the Provider Manual for further details.<sup>11</sup>

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.<sup>12</sup>
  
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

---

<sup>10</sup> POLST forms are available at: <http://capolst.org/>

<sup>11</sup> 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-ooK-OzJhLYgZ1sMslA](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-ooK-OzJhLYgZ1sMslA). Accessed September 22, 2016.

<sup>12</sup> Examples include, but are not limited to, APL 13-014; California Children's Services Numbered Letter 06-1011; Managed Care Policy Letter 11-004.

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 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.<sup>13</sup>

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

Furthermore, MCPs may authorize additional palliative care not described above, at the MCP's discretion and cost. An example of an additional service offered by many

---

<sup>13</sup> 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>

community-based palliative care programs is a telephonic palliative care support line, separate from a routine advice line, that is available 24 hours a day, 7 days a week.

### **III. Providers**

MCPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. MCPs must utilize qualified providers for palliative care based on the setting and needs of a 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.

### **IV. MCP Policies and Procedures**

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

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations and other contractual requirements as well as DHCS guidance, including APLs and Dual Plan Letters. DHCS' readiness review process includes a review of each MCP's delegation oversight. MCPs must receive prior approval from DHCS for each delegate.

All Plan Letter 17-015  
Page 8

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division  
Department of Health Care Services



## **Attachment A: Palliative Care Resources**

**[DHCS SB 1004 Palliative Care Website](#)**: Materials available related to SB 1004. Please send questions to: [SB1004@dhcs.ca.gov](mailto:SB1004@dhcs.ca.gov)

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

**[Coalition for Compassionate Care of California](#)**: Consumer and provider resources on advance care planning and palliative care. Also frequent webinars and training programs.

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