PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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<tr><td colspan="4">Policy/Procedure Title: Palliative Care: Intensive Program (Adult)</td><td colspan="3">☒ External Policy
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<tr><td colspan="3">Original Date: 06/21/2017</td><td colspan="4">Next Review Date: 01/10/2025
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 01/10/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3020 – Hospice Service Guidelines
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3124 – Referral to Specialists (RAF) Policy
D. MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist
E. MPCR300 – Physician Credentialing and Re-credentialing Requirements
F. MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements
G. CGA024 – Medi-Cal Member Grievance System
H. MPQP1022 – Site Review Requirements and Guidelines
I. MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Member Services
D. Claims

III. DEFINITIONS:

A. ED: Emergency Department
B. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course.
C. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
D. Palliative Care: Patient and family-centered care that optimizes qualify of life by anticipating, preventing, and treating suffering.
E. Palliative Care Team: A group of healthcare individuals such as a Doctor of Medicine (MD) or Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Medical Social Worker (MSW) and/or Chaplain who work together to meet the physical, medical, psychological, emotional and spiritual needs of a member and the member's family and assist in identifying sources of pain and discomfort.
F. RAF: Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California (PHC) to refer a PHC member to a specialist for evaluation and/or treatment.
G. TAR: Treatment Authorization Request – A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.

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IV. ATTACHMENTS:

A. Adult Palliative Care Eligibility Assessment
B. Palliative Care Patient Summary
C. Engagement and Enrollment Process for Outpatient Palliative Care
D. Application to be a Contracted Outpatient Palliative Care Provider

V. PURPOSE:

To define Partnership HealthPlan of California's (PHC's) Palliative Care services to PHC Medi-Cal eligible beneficiaries ages 21 or older.

VI. POLICY / PROCEDURE:

A. ADULT GENERAL ELIGIBILITY CRITERIA
   1. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment D) and have a palliative care contract in place with PHC.
   2. The Intensive Palliative Care Management benefit is limited to members who have Partnership HealthPlan of California as their primary insurance.
   3. A member must meet all criteria below and at least one of the covered disease-specific criteria outlined in Section VI.B.5 to be eligible for Intensive Palliative Care services. Exceptions for other diagnoses will be made on a case by case basis as described below:
      a. The member is likely to or has started to use the hospital or emergency department as a means to manage unanticipated decompensation in their late stage of illness.
      b. Member is in a late stage of illness (section VI.B.1.a.) and is not eligible for or declines hospice enrollment.
      c. The member's death within a year would not be unexpected based on clinical status, as documented on the patient summary (Attachment B)
      d. Member has received maximum member-desired medical therapy, or for whom treatment is no longer effective. Member should be evaluated in their best compensated state after receiving or being offered appropriate treatments to manage their underlying illnesses. Member is not in reversible acute decompensation.
      e. Patient has a Palliative Performance Scale or Karnofsky Performance Scale score of 70 or less or an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4.
      f. Member, and if applicable, family/patient-designated support person agree to both of the following:
         1) Willing to attempt in-home, residential or outpatient disease management as recommended by the Palliative Care team instead of first going to the emergency department.
         2) Willing to participate in Advance Care Planning discussions.

B. ADULT MEMBER ENGAGEMENT AND ENROLLMENT PROCESS
   1. Patient Palliative Care Assessment and Consultation (Engagement):
      a. No prior authorization is required for the engagement process before speaking with a member who meets one or more of the following diagnostic categories.
         1) Congestive Heart Failure (CHF)
         2) Pulmonary Disease
         3) Advanced Cancer
         4) Advanced Liver Disease
         5) Progressive Degenerative Neurologic Disorder
         6) Hematologic Disease
         7) Cerebrovascular Accident
         8) Renal Disease

9) Acquired Immunodeficiency Syndrome
10) Other Conditions

b. If the member has one of the covered diagnoses listed, and does not meet the general or specific criteria or life expectancy for enrollment, submit a retroactive TAR for the engagement only.
c. If the member meets the criteria for engagement AND enrollment criteria, submit a TAR for engagement along with the TAR for enrollment. Submit the TAR for engagement with progress or consultation notes documenting the following:
   1) One of the five covered diagnoses or other pre-terminal conditions as defined in section VI.B.5
   2) Date of face to face or telemedicine visit with Doctor of Medicine (MD) or Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN)
   3) Advanced care discussion with goals of care document
   4) Care Plan addressing medical, social, emotional and spiritual needs
   5) Include consultation or hospital discharge notes that confirm the member's diagnosis, extent of disease, prognosis, functional status and goals of care
d. A multidisciplinary comprehensive assessment is required.
e. Engagement will occur after discharge from the hospital.
f. When requested, PHC will generate regional lists of members who may qualify for palliative care services, providing these to community primary care and specialty providers to evaluate for potential referral to locally available palliative care clinicians and/or intensive palliative care providers. If PHC determines that an intensive palliative care provider has the demonstrated capacity and capability to do active direct outreach to potential recipients of palliative care, PHC will provide the list of local members potentially qualifying for intensive palliative care services to the intensive palliative care provider, for the provider to perform this direct engagement coordinated with the member's primary providers.
g. PHC intensive care management teams may identify and refer care managed members who are potentially eligible for this benefit, to a contracted PHC palliative care provider

2. Adult Enrollment Criteria (see Attachment C for detailed requirements)
   a. For members who meet the disease specific criteria (VI.B.5)
      1) Submit a TAR for the member's enrollment into the Intensive Home Based Palliative Care program to PHC in accordance with PHC policy MCUP3041 TAR Review Process. With an enrollment TAR, the Provider must submit the information required for the engagement TAR [VI.B.1.c. 1) thru 4)] as well as:
         a) Eligibility Assessment Form (Attachment A)
         b) Patient Summary document (Attachment B)
   b. For members in the hospital, enrollment will take place after discharge. The Palliative Care Management TAR will be approved for three months.
   c. The health plan will monitor and collect enrollment, network and utilization data, through the Palliative Care Quality Collaborative (PCQC) tracking system, which contracted intensive palliative care providers will be required to use.
   d. Enrolled members must have at minimum:
      1) One in-person or video visit by an RN every month
         a) The registered nurse must see the patient face to face a minimum of once in every 12-week period
         b) If face-to-face visits with the RN are not possible due to distance or other operation issues, palliative care providers may submit charges under the "virtual only care" billing code T2025 GT.
      2) One in-person or video visit by a social worker every month
      3) Standardized assessments of symptoms must be done approximately every 14 days.

Assessments may be completed face to face, via telemedicine or telephonically.

3. Adult Re-Enrollment Criteria
   A new TAR is required every 3 months for all patients receiving Intensive Outpatient Palliative Care services. The TAR must include documentation and submission of the following items:
   a. Palliative Care Patient Summary (Attachment B) completed by the palliative care physician, nurse practitioner or physician's assistant
   b. Detailed progress notes completed by the palliative care physician, nurse practitioner or specialist documenting relevant specific clinical information showing continued decline in functional status and clinical condition as evidenced by decreasing palliative performance scale scores, weight loss or other specific documentation of decline in function and health (e.g. labs and imaging, include results if completed in the previous 3 months)
   c. Medical records must include a recent face to face visit by the registered nurse, medical provider (MD or DO, nurse practitioner, or physician assistant) that documents the patient's current clinical condition.
   d. For remote members seen only through telemedicine visits, the medical records must include a recent detailed visit by the RN, NP or physician that clearly documents the patient's current clinical condition and functional status.
4. Remote Hospice Level Care
   A member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate. The member must be pre-approved via PHC's TAR review process for palliative care to allow for billing under code T2025-TN.
   a. The member must live more than 30 miles from the nearest Medi-Cal Hospice or the palliative care provider must submit documentation that although the member meets hospice criteria, the local hospice is not able to enroll the member for non-medical reasons.
   b. The member must be seen in-person at least once a month by the palliative care RN.
5. Adult Disenrollment Criteria
   a. Member is not eligible for PHC for more than 30 days
   b. Member moves out of the service area
   c. Member declines participation after enrollment
   d. Member refuses to be contacted
   e. Member cannot be reached or is lost to follow-up for 30 days
   f. Member exhibits inappropriate or threatening behavior towards staff
   g. Member is under the influence or illegal drugs or alcohol during visits
   h. Member poses a safety or security risk to staff, other patients or clinic property
   i. Member is deceased
   j. Member is incarcerated for more than 30 days
   k. Member enters a different equally intensive care management program
   l. Member enters hospice
   m. Member's condition stabilizes and/or is unlikely to meet 1 year life expectancy criteria
   n. Member enrolls in Medicare: A member who becomes eligible for Medicare after enrollment may continue to receive palliative care services until the current TAR expires.
6. Adult Disease Specific Criteria
   a. **Congestive Heart Failure (CHF)**:
      1) The member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher, AND
         a) The member has an ejection fraction of < 30% for systolic failure OR
         b) Significant comorbidities such as stage IV renal disease, coronary artery disease with persistent angina, severe lung disease, diabetes with significant vascular or neurologic complications, severe dementia OR

c) Heart failure due to advanced diastolic dysfunction with preserved ejection fraction OR
d) Other severe cardiomyopathy or non-operable severe valvular heart disease.

b. **Pulmonary Disease:**
1) **Chronic Obstructive Pulmonary Disorder (COPD)**: Member must meet 1) or 2)
a) The member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
b) The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
2) Other Progressive Pulmonary Disease:
a) Idiopathic Pulmonary fibrosis, Primary Pulmonary Hypertension, or Cystic Fibrosis WITH
i. Disabling dyspnea at rest AND
ii. Hypoxemia (oxygen saturation < 88%) on 2 LPM AND
iii. Poorly response or unresponsive to standard treatment.

c. **Advanced Cancer**: Member must meet 1) and 2)
1) The member has a diagnosis of stage III or IV cancer, AND
2) The member has a Palliative Performance Scale (PPS) or Karnofsky Performance Scale (KPS) score less than or equal to 70, Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 OR has failure of two lines of standard of care therapy (chemotherapy or radiation therapy) OR
3) Member refuses further treatment for the cancer

d. **Advanced Liver Disease**: Member must meet 1) and 2) combined, or 3) alone
1) The member has evidence of irreversible liver damage, serum albumin less than 3.0, and Internal Normalized Ratio (INR) greater than 1.3, AND
2) The member has a history of ascites, bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, OR
3) The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

e. **Progressive Degenerative Neurologic Disorder**
1) Neurodegenerative condition such as multiple sclerosis, muscular dystrophy, end-stage myasthenia gravis, Parkinson's disease or other progressive neurologic condition with significant deterioration as evidenced by dysphagia, aspiration pneumonia, unintentional weight loss of 10% or more, recurrent infections, significant cognitive decline or dependency on ventilator support.
2) Amyotrophic Lateral Sclerosis (ALS) with a PPS score of 70 or less and a vital capacity of less than 55% predicted.
3) Late stage dementia with progressive decline with both:
a) FAST scale score of 7a or more AND
b) Complications such as unintentional weight loss, dysphagia, aspiration pneumonia or a PPS score of 40% or less.

f. **Hematologic Disease**
1) Myelodysplastic syndrome dependent on transfusion and unresponsive to treatment **OR**
2) Sickle cell disease with organ failure, severe pulmonary hypertension, stage IV or worse renal disease, or other significant severe vascular disease.

g. **Cerebrovascular Accident**
1) PPS score of 50% or less **AND**
2) Progressive unintentional weight loss of 10% or more, **OR**
3) Recurrent infections such as aspiration pneumonia or sepsis.

h. **Renal Disease:**

1) Creatinine clearance of 15 ml/min or less **AND**
2) Discontinuing or declining dialysis and not seeking kidney transplant

i. **Acquired Immunodeficiency Syndrome (AIDS):** A patient with a CD4 count less than 200 or a positive HIV test and an AIDS defining condition who chooses to forego antiviral treatment or has one of these AIDS related conditions:
1) Advanced AIDS dementia complex
2) CNS lymphoma or systemic lymphoma unresponsive to treatment
3) Kaposi's sarcoma unresponsive to treatment
4) Mycobacterium avium complex infection unresponsive to treatment
5) Progressive wasting syndrome

j. **Other patients may be considered for the palliative care benefit on a case-by-case basis.** Consideration will depend upon the patient's functional status, pre-terminal condition and disease trajectory, hospital and emergency department utilization or the patient declining hospice services.

7. Providers of Services
a. PHC will contract with qualified palliative care providers such as hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and Community Based Adult Service (CBAS) facilities who utilize providers with current palliative care training and/or certification to deliver authorized palliative care services to members in accordance with this policy, existing Medi-Cal contracts and/or All Plan Letters. Certification of qualified palliative care providers shall occur in accordance with PHC policies MPCR300 Physician Credentialing and Re-credentialing Requirements and MPCR301 Non-Physician Clinician Credentialing and Re-credentialing Requirements. PHC will authorize palliative care services to be provided in a variety of settings including, but not limited to, inpatient, outpatient or community-based settings. Palliative care provided in a member's home must comply with existing PHC policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.
b. All approved Palliative Care service providers shall be listed in PHC's Provider Directory.
c. PHC contracted intensive palliative care providers will contact members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
d. Provider organization must submit an application to become contracted Intensive Home Based Palliative Care Providers (See Attachment D for application). Criteria for consideration includes the following:
1) Completed application (Attachment D)
2) Organization or all providers are contracted Medi-Cal providers
3) Organization must have the capacity to bill PHC for services provided
4) Organizations that are already contracted with PHC for other services must be providers in good standing
5) Clinical staff are trained in palliative care. Minimum training is the Cal State San Marcos Institute for Palliative Care Training Curriculum, or equivalent, which must be completed by a staff member no later than 3 months after beginning to work for the Intensive Outpatient Palliative Care Organization. Medical Director may be board certified, board eligible or have one year (at least 200 hours) in hospice or palliative care experience.
6) Ability to collect and submit data using the Palliative Care Quality Collaborative system (PCQC) (system access is purchased by PHC for contracted providers). Provider will be required to enter into a Data Sharing Agreement with PCQC in order to submit data through the PCQC System.
7) Core staffing identified (hired or contracted to be hired by contract start date):
a) Medical Director

b) Registered Nurse
c) Social Worker
d) Administrator

8) Organization or Medical Director already providing services in the region for at least 6 months prior to contracting.

e. Submission of an application does not guarantee that PHC will contract with an organization. Submitted applications will be evaluated based on a variety of criteria including, but not limited to, the quality and completeness of the application, geographic network adequacy, and history of the organization submitting the application.

f. Contracted sites must pass a PHC facility and medical record site audit within 3 months of contract start date, and every 3 years afterwards. Sites which do not pass the audit may have their contract terminated for cause, or may be required to submit and complete a corrective action plan. Timelines and appeals process for this audit will follow the general standards defined in PHC policy MPQP1022 Site Review Requirements and Guidelines.

VII. REFERENCES:

A. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
B. Centers for Medicare & Medicaid Services (CMS) *Medicare Benefit Policy Manual*
C. Department of Health Care Services, *SB 1004 Medi-Cal Palliative Care October 2, 2015* (2015).
D. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
E. Social Security Act 1812(d)(1)
F. Welfare and Institutions Code Section 14132.75
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

11/15/17; *02/14/18; 02/13/19; 02/12/20; 02/10/21; 05/11/22: 06/14/23; 01/10/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
MCUP3122 - Palliative Care policy was archived 06/21/2017

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.