PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3140</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Palliative Care: Pediatric Program for Members Under the Age of 21</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 05/08/19
Effective Date: 01/01/2019 per DHCS</td><td colspan="3">Next Review Date: 09/11/2025
Last Review Date: 09/11/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 09/11/2024</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. MCUP3137 – Palliative Care: Intensive Program (Adult)
E. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
F. MPCR300 – Physician Credentialing and Re-credentialing Requirements
G. MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements
H. MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist
I. CGA024 – Medi-Cal Member Grievance System
J. MPQP1022 – Site Review Requirements and Guidelines
K. MCUP3106 – Waiver Programs
L. 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. For children, curative services may be provided concurrently with hospice services.
C. Outpatient Pediatric Palliative Care (OPPC): A Partnership HealthPlan of California-defined outpatient palliative care program for members under age 21 years, provided by a team over an extended period of time, usually in the home. Defined by the Department of Health Care Services (DHCS) as covered as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
D. 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.
E. Palliative Care: Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care can be provided as part of Hospice Care at the end of life, or as a set of supportive services for individuals with life-threatening conditions who have a life expectancy that is longer than 6 months.

F. 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 his/her family and assist in identifying sources of pain and discomfort.
G. RAF: Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California to refer a Partnership member to a specialist for evaluation and/or treatment.
H. 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.

IV. ATTACHMENTS:

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

V. PURPOSE:

To define Partnership HealthPlan of California's Palliative Care services to Partnership Medi-Cal eligible beneficiaries under age 21. See policy MCUP3137 for a description of palliative care for members age 21 and over.

VI. POLICY / PROCEDURE:

A. Range of palliative care services available for pediatric members.
   1. In its general definition, palliative care services may range in intensity and be provided in different settings and by different configurations of teams. Any level of palliative care services may be part of the care plan for a member under age 21, as developed by the primary care provider, specialist, case management team, or specialty care center. Members under age 21 may have concurrent curative and palliative treatments. The major categories that may apply for members under age 21 are:
      a. Primary palliative care
      b. Outpatient specialty palliative care—low intensity
      c. Outpatient pediatric palliative care—high intensity
      d. Hospice
   2. Primary palliative care is provided by primary care clinicians or by specialists who are not board certified or specialty trained in palliative care. It may be provided in the inpatient or outpatient setting. Partnership considers such services as integral parts of usual evaluation and management services; no prior authorization is required; no special billing codes apply.
   3. Outpatient specialty palliative care—low intensity is provided by specialty trained palliative care physicians outside the hospital setting, independent of a supporting team. Board Certified Palliative Care Physicians may apply to be a credentialed Palliative Care Specialist (See policy MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist). Like other outpatient specialist consultation, Partnership's specialty referral policies apply (See policy MCUP3124 – Referral to Specialists (RAF) Policy).
   4. Outpatient pediatric palliative care is provided by a team over an extended period of time, usually in the home. Services are similar in scope to hospice, but the eligibility criteria are different. Sections VI. B. through F. define criteria and services for outpatient palliative care for Partnership members under age 21.
   5. Hospice services are limited to members with a life expectancy of 6 months or less but may also include curative care. (See policy MCUP3020 Hospice Services Guidelines)

B. Outpatient Pediatric Palliative Care Eligibility Criteria
   1. Members must meet criteria stated in a. through f. below:
      a. Have Partnership HealthPlan of California as their primary insurance, or Partnership as secondary coverage with a rejection of coverage by the primary insurance.
      b. Are under 21 years of age
      c. The parent(s) or legal guardian and the child (if cognitively able) agree to the provision of pediatric palliative care services; and
      d. The parent or legal guardian declines hospice enrollment or the member is not eligible for hospice enrollment
      e. Documentation of an Eligible Medical Condition: Member must have a life-threatening diagnosis. Conditions may include but are not limited to:
         1) Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
         2) Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
         3) Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
         4) Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms)
      f. Projected Level of Care: At least one of the following
         1) The member has started to use the hospital or emergency department as a means to manage the unanticipated decompensation of the member's disease.
         2) The attending physician estimates that the member would be expected to be hospitalized for at least 30 days in the next year.
   2. If the member continues to meet eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

C. Outpatient Pediatric Palliative Care Engagement and Enrollment Process
   1. Palliative Care Assessment and Consultation (Engagement):
      a. Partnership contracted Outpatient Pediatric Palliative Care providers will contact members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
      b. No prior authorization is required for the engagement process before speaking with a member.
      c. No prior authorization is required prior to providing initial coordinated care (G9001). However, payment will require submission of a TAR. If the patient meets enrollment criteria specified in VI. B. above, the TAR for G9001 should be submitted with a TAR for ongoing case management and other services being requested (see VI. C.f. below). If the patient does not meet criteria, the TAR may be submitted for only the initial coordinated care service (G9001).
      d. The initial TAR for initial coordinated care (G9001) should include the Outpatient Pediatric Palliative Care Eligibility Assessment Form (Attachment A).
      e. The initial coordinated care covers a comprehensive assessment and support services for a period of 30 days. The applicable time period should be indicated on the TAR and on the claim submitted.
      f. A TAR for ongoing services (enrollment) based on the care plan developed in the initial coordinated care visit should be submitted during the initial coordinated care period (30 days). To ensure no gap in services, it is recommended that this TAR be submitted no later than 20 days after the initiation of the one month of initial coordinated care. The TAR for ongoing services should include

1) Dates of visits of the palliative care team members to the Partnership member (for G9001 services)
2) Advanced care discussion with goals of care document
3) A multidisciplinary comprehensive assessment, including assessment by a Registered Nurse and a Licensed Clinical Social Worker
4) Care Plan addressing medical, social, emotional and spiritual needs

g. Partnership intensive care management teams may identify and refer care managed members (who are potentially eligible for this benefit) to a contracted Partnership palliative care provider.

2. Pediatric Enrollment Process
   a. Submit a TAR for the member's enrollment into the Outpatient Pediatric Palliative Care program to Partnership in accordance with Partnership policy MCUP3041 TAR Review Process. With an enrollment TAR, the Provider must submit the information required for the engagement TAR (VI.B.1.e. and f.), as well as the Outpatient Pediatric Palliative Care Eligibility Assessment Form (Attachment A).
   b. For members in the hospital, enrollment will take place after discharge.
   c. Continued approval will require subsequent TAR submission, every 6 months, with the following information included:
      1) Detailed progress notes, documenting current disease status
      2) Dates of face to face and telemedicine visits
   d. TAR is required for these services (typically submitted as a package for a single patient):
      1) Minimum ongoing services required is **monthly care coordination** (T2022) which includes 4-12 hours of care coordination services per 30 day period. Included in this monthly care coordination is at least one monthly visit to the member in their home by one of the OPPC staff. Additional services that should be included on the TAR include:
         a) **Activity therapy** (G0176), 45 minutes or more per session, includes art, music, child life therapy and massage therapy. Maximum of three units per day, up to 60 hours per 90 days.
         b) **Initial case management** (G9001) as detailed above in section VI.C.1
      2) **Other specified case management** (G9012), provided by any OPPC staff, hourly for each hour of case management beyond 12 hours, which is covered by T2022. Maximum of 60 hours per 90 days.
      3) **Family home care training** by a Registered Nurse (S5110), 15 minutes per unit, maximum of 12 units per day, 100 hours per year.
      4) **Family Counseling** (90837) provided by psychologist or LCSW. One unit = 15 minutes; with a maximum of 22 units per rolling 12 month period (equal to 330 minutes per rolling 12 month period).
      5) **Pain and Symptom Management** (S9123), provided by a Registered Nurse, one hour per unit. Maximum of 100 hours per year.

3. Pediatric Re-Enrollment Criteria
   A new TAR is required every six (6) months for all members receiving Pediatric Palliative Care services. The TAR must include documentation and submission of the following items:
   a. Current clinical summary of member's condition and individualized care plan.
   b. Detailed progress notes completed by the palliative care physician, nurse practitioner or specialist documenting relevant specific clinical information showing continued eligibility for
   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.

4. OPPC Disenrollment Criteria
    a. Member is not eligible for Partnership for more than 30 days
    b. Member moves out of the service area
    c. Member, parent(s) or legal guardian declines participation after enrollment
    d. Member, parent(s) and legal guardian refuses to be contacted
    e. Member, parents(s) and legal guardian cannot be reached or is lost to follow-up for 30 days
    f. Member, parent or legal guardian exhibits inappropriate or threatening behavior towards staff
    g. Member, parent or legal guardian poses a safety or security risk to staff, other patients or clinic property
    h. Member is deceased
    i. Member begins hospice services
    j. Member's condition changes such that palliative care is no longer medically necessary or no longer reasonable. (Consultation with Partnership Palliative Care team may be necessary in some cases)

D. Outpatient Pediatric Palliative Care: Scope of Services
1. Outpatient Pediatric Palliative Care (OPPC) Services include the following:
    a. Care Coordination, including monthly in person or telephonic meetings with Partnership Care Coordination staff
    b. Advance care planning conversations
    c. Development of a treatment plan, including patient goals
    d. Control of pain, medication side effects, and other symptoms
    e. Addressing spiritual concerns
    f. Addressing social service needs
    g. Basic child and family counselling
    h. Expressive therapies
    i. Telephone advice line, available 24 hours per day, 7 days per week
    j. Close communication with Primary Care Provider
2. Outside optional auxiliary services that may be ordered by the palliative care team are not strictly part of the package of services specified above as part of OPPC. These are provided fee for service, according to usual Partnership processes.
    a. Skilled nursing visits
    b. Home health aide visits
    c. Physical therapy visits
    d. Occupational therapy visits
    e. Speech therapy visits
    f. Registered dietician visits
    g. Respiratory therapy visits
    h. Psychotherapy - More intensive counselling may be provided outside the OPPC services by licensed therapists through the Partnership mental health benefit
    i. Durable Medical Equipment

E. Providers of Services
1. General:
    a. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment C) and have a palliative care contract in place with Partnership.
    b. Partnership 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 Partnership policy MPCR13A Credentialing of Hospice and Palliative Care Medicine Specialist. Partnership 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 Partnership policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.

2. All approved Palliative Care service providers shall be listed in Partnership's Provider Directory.
3. Outpatient Pediatric Palliative Care: Provider organization must submit an application to become contracted Outpatient Palliative Care Providers (See Attachment C for application).
    a. Criteria for consideration includes the following:
        1) Completed application (Attachment C)
        2) Organization or all providers are contracted Medi-Cal providers
        3) Organization must have the capacity to bill Partnership for services provided
        4) Organizations that are already contracted with Partnership 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 Shiley 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 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) Provider organizations that include pediatric patients must have staff trained in the principles of pediatric palliative care.
        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
    b. Submission of an application does not guarantee that Partnership 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.
    c. Contracted sites must pass a Partnership facility and medical records 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 Partnership Policy MPQP1022 Site Review Requirements and Guidelines.

F. Respite Care
    1. Respite care services, out-of-home for use in a Congregate Living Health Facility, are covered for members under age 21 and require prior authorization and submission of a TAR. A maximum of 30 days per year is covered. Other approved facilities, such as skilled nursing facilities, should use policies and procedures for that location of services.
    2. Home-based respite therapy services are not covered by Partnership.

G. Transition of Care When Member Turns 21
    a. Pediatric members receiving palliative care who are turning 21 will be transitioned to the appropriate program or service, such as adult palliative care (see policy MCUP3137 – Palliative Care: Intensive Program [Adult]) or applicable state waiver program (see policy MCUP3106 – Waiver Programs).

Policy/Procedure Number: MCUP3140		Lead Department: Health Services
Policy/Procedure Title: Palliative Care: Pediatric Program for Members Under the Age of 21		☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/08/2019 **Effective Date:** 01/01/2019 per DHCS	**Next Review Date: 09/11/2025** **Last Review Date: 09/11/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VII. REFERENCES:

A. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
B. Centers for Medicare & Medicaid Services *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)
H. DHCS Numbered Letter (NL) 12-1119 Subject: Palliative Care Options for CCS Eligible Children-*Revised* (11/18/2019)
I. DHCS All Plan Letter (APL) 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll In Medi-Cal Managed Care from Medi-Cal Fee-for-Service, on or After January 1, 2023. (08/15/2023)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

05/13/20; 05/12/21; 06/08/22; 08/09/23; 09/11/24

PREVIOUSLY APPLIED TO:

N/A

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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

The materials provided are guidelines used by Partnership 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 Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.