SAN FRANCISCO HEALTH PLAN

CO-58 Palliative Care

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	5/29/2024	Policy Update
DocuSigned by: Steve O'Brien 60DFB20814944C4...	CMO	6/4/2024	

SAN FRANCISCO HEALTH PLAN

SFHP POLICY AND PROCEDURE

Palliative Care

Policy and Procedure number:	CO-58
Department :	Clinical Operations
Accountable Lead:	Clinical Operations Analyst
Lines of Business Affected:	☒Medi-Cal ☐Healthy Workers HMO ☐Healthy SF ☐City Option ☐ All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) offers palliative care as a benefit to members who qualify for and choose palliative care. SFHP ensures all members who elect and meet criteria are provided the scope of services as defined by Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014).

PROCEDURE

I. Eligibility Criteria

Palliative care does not require the beneficiary to have a life expectancy of six (6) months or less and may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if he/she meets the hospice eligibility criteria (outlined in CO-32 Hospice Care). A member 21 years of age and older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years-of-age may be eligible for palliative care and hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302. Additionally, members who are eligible for EPSDT may receive other services. Accordingly, SFHP must provide EPSDT eligible members with any other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services, whether or not such services are covered benefits. Services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and promote physical, and mental health and efficiency.

Members of any age are eligible to receive palliative care services in Section III below if they meet all of the criteria outlined in Section I.A. below, and at least one of the four requirements outlined in Section I.B.

Members under the age of 21 years who do not qualify for services based on the above criteria may become eligible for palliative care services according to the broader criteria outlined in Section I.C. below, consistent with the provision of EPSDT services.

Members who do not meet the criteria in this policy are eligible for Medi-Cal benefits, including services with a palliative purpose, as medically necessary.

A. General Eligibility Criteria:
   1. The member must not be a Medicare-Medi-Cal dual eligible.
   2. The member 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.
   3. The member has an advanced illness (defined in section B below) with appropriate documentation of continued decline in health status, and is not eligible for, or declines hospice enrollment.
   4. The member's death within a year would not be unexpected based on clinical status.
   5. The member has either received appropriate patient-desired medical therapy or is a beneficiary of patient-desired medical therapy that is no longer effective. The patient is not in reversible acute decompensation.
   6. The member 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 member 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)[i] heart failure classification III or higher; and
      b. The member 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 member has a Forced Expiratory Volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or

b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
   a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b. The member has a Karnofsky Performance Scale (KPS) score less than or equal to 70[ii] 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 member has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
   b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19[iii].

C. Pediatric Palliative Care Eligibility Criteria
Must meet (a) and (b) listed below. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
   a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
   b. There is documentation of a life-threatening diagnosis. This can include but is 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 infections or difficult-to-control symptoms)

If a member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to

access both palliative care and curative care until the condition improves, stabilizes, or results in death.

II. Identification/Referral/Authorization Process

a. The primary care provider, SFHP and medical group staff may refer members directly to palliative care services. For home-based palliative care, members and/or the member's relatives may also refer directly.
b. SFHP informs staff, network providers and other relevant programs/non-network providers of the importance of timely recognition of a member's eligibility for palliative care services and their election of palliative care services.
c. Prior authorization requirements:
    i. Home-based palliative care outlined in SB 1004 and provided by Hospice by the Bay is covered and managed by SFHP for members assigned to all delegated groups. Prior authorization is required.
    ii. All other outpatient palliative care services, including SB1004 services provided on an outpatient basis, are covered and managed by the delegated group the member is assigned to. For members SFHP manages for all other outpatient palliative care as well, prior authorization is required for out-of-medical-group requests.

III. Palliative Care Benefits

The following seven (7) services are provided at minimum when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions.

a. Advance Care Planning: Advance care planning for members enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified health care professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms. Please refer to the section on Advanced Care Planning in the Medi-Cal Provider Manual for further details.
b. 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

c. Plan of Care: A plan of care should be developed with the engagement of the member and/or his or her representative(s) in its design. If a member 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 member'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 (e.g. CCS Program).

d. 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 members and their families and are able to assist in identifying sources of pain and discomfort of the member. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. The palliative care team should 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, licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP), and a social worker. Chaplain Services: It is recommended that members have access to chaplain services as part of the palliative care team, but not required and not reimbursable by SFHP.

e. Care Coordination: A member of the palliative care team should provide coordination of care, ensure continuous assessment of the member's needs, and implement the plan of care.

f. 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 the member's pain and other symptoms. The member's plan of care must include all services authorized for pain and symptom management.

g. Mental Health and Medical Social Services: Counseling and social services must be available to the member 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 San Francisco Behavioral Health Services (SFBHS) and does not change SFHP's

responsibilities for referring to, and coordinating with, SFBHS as delineated in DHCS APL 18-020.

IV. Palliative Care Provider Network

a. SFHP ensures it has a qualified network of providers to offer palliative care services.
b. SFHP may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings.
c. SFHP contracts with and utilizes only qualified providers for palliative care based on the setting and needs of a member.
d. SFHP ensures that its providers comply with existing Medi-Cal contracts and/or APLs.
e. SFHP uses providers with current palliative care training and/or certification to conduct palliative care consultations or assessments, if possible.

MONITORING

A. SFHP utilizes a variety of methods to monitor and track service utilization to identify patterns of over- /underutilization. The Utilization Management Committee (UMC) is responsible for the monitoring of utilization data to identify potential services being over- or underutilized. If a service is identified, the UMC will conduct further discussions and analysis to identify opportunities for improvement.

B. SFHP's Clinical Operations Department monitors turnaround times of internal processing of benefit/service requests for compliance with standards.

C. SFHP's Clinical Operations Department performs inter-rater reliability audits at least annually for both physician and nurse reviewers.

D. The Utilization Management Committee (UMC) reviews Appeals, IMRs, and State Fair Hearings resulting in authorization decision made by SFHP or one of its delegated medical groups. The UMC recommends corrective action and/or identifies where the Clinical Operations Department can revise the authorization process, if necessary, to improve the member experience, to address any barriers, and ensure the utilization management criteria are consistent with current industry and evidence-based practices. The Quality Improvement and Health Equity Committee (QIHEC) reviews an Appeals Report (overturned and upheld appeals) every quarter regarding the activity of pharmacy and medical authorizations.

E. SFHP's Member Services and Health Services Programs Departments evaluate member grievances and appeals, as well as, SFHP's member and provider satisfaction survey responses to identify patterns.

F. The SFHP Chief Medical Officer (CMO), Medical Director, or physician designee identifies potential quality issues (PQI), including provider preventable conditions (PPCs), and follows the PQI process defined in QI-18 and the PPC process defined in QI-19.

G. Dashboards and other reports regarding SFHP's CO Department's monitoring activities are reviewed by the Utilization Management Committee (UMC) and presented to QIHEC at least annually for evaluation and corrective actions as needed.

H. Medical groups delegated to perform utilization management are audited annually as outlined in DO-02 Oversight of Delegated Functions.

DEFINITIONS

Palliative Care: Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.

POLST (Physician Orders for Life-Sustaining Treatment): A form that gives seriously-ill patients more control over their end-of-life care, including medical treatment, extraordinary measures (such as ventilator or feeding tube) and CPR[iv].

AFFECTED DEPARTMENTS/PARTIES

Compliance and Regulatory Affairs
Health Services -- Care Management
Health Services -- Clinical Operations
Health Services – Health Services Programs
Operations -- Claims
Operations -- Member Services
Operations -- Provider Network Operations

RELATED POLICIES AND PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

CO-22: Authorization Requests
CO-32: Hospice Care
DO-02: Oversight of Delegated Functions
Oversight of Delegated QI Functions DTP
GA-01: Clinical Member Grievances
GA-03: Member Appeals
QI-18: Potential Quality Issues

REVISION HISTORY

Original Date of Issue:	January 1, 2018
Revision Date(s):	March 1, 2018, March 21, 2019; May 20, 2021, May 18 2023, May 23, 2024

REFERENCES

1. DHCS All Plan Letter (APL) 19-010: Requirements for Coverage of EPDST Services for Medi-Cal Members Under the Age of 21
2. DHCS All Plan Letter (APL) 18-020: Palliative Care (Supersedes APL 17-015)
3. DHCS All Plan Letter (APL) 13-014: Hospice Services and Medi-Cal Managed Care
4. DHCS All Plan Letter (APL) 13-021: Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
5. DHCS MMCD Policy Letter 11-004: Implementation of Section 2302 oF ACA, Entitled “Concurrent Care for Children”
6. Medi-Cal Provider Manual
7. Section 1905(a) of the Social Security Act (SSA)

[i] Classes of Heart Failure | American Heart Association
[ii] Performance Scales: Karnofsky and ECOG Scores
[iii] MELD Score (Model For End-Stage Liver Disease)
[iv] Physician Orders for Life-Sustaining Treatment Form