	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1527	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Palliative and Hospice Care	
<b>Original Date:</b> 10/17/2017	<b>Date Published:</b> 04/15/2025
<b>Approved by:</b> Utilization Management Work Group (UMWG)	

**Purpose:**

To describe the Central California Alliance for Health (the Alliance) Palliative Care Benefit and procedures for Hospice Care.

**Policy:**

The Alliance will authorize Medi-Cal members to receive palliative care in accordance with SB 1004, APL 18-020, and California Children’s Services (CCS) Numbered Letters (NLs). The Alliance will authorize Medi-Cal members to receive hospice care services as specified in Title 22 CCR section 51349 and all applicable DHCS APLs.


**Definitions:**

Advance Care Planning: Advance care planning for beneficiaries enrolled in Medi-Cal palliative care under SB 1004 includes discussions between a physician or other qualified healthcare professional and a patient, family member, or surrogate in counseling and discussing advance directives, including Physicians Order for Life Sustaining Treatment (POLST) forms.

California Children’s Services: CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).

Hospice Care: Hospice care is a Medi-Cal benefit that serves terminally ill beneficiaries consisting of interventions that focus primarily on pain and symptom management rather than cure or prolongation of life. Hospice care does not affect a member’s eligibility for enrollment. 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. A beneficiary with a serious illness who is receiving palliative care may choose to transition to hospice care if he/she meets the hospice eligibility criteria. A beneficiary may not be concurrently enrolled in hospice care and palliative care.

Palliative Care: 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 Managed Care Program 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. Palliative care may be provided concurrently with curative care and does not require the beneficiary to have a life expectancy of six months or less.

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Pediatric Palliative Care (PPC): A beneficiary under age 21 years may be eligible for palliative care concurrently with curative care through other existing programs such as Section 1915(c) Home and Community Based Services waiver known as Partners for Children (PFC) or Section 2302 of the Patient Protection and Affordable Care Act (ACA). Community-based pediatric palliative or hospice care services are covered for any child that meets medical necessity/has a qualifying diagnosis. Information regarding the concurrent care policy is available in APL 13-014, California Children's Services Numbered Letter 12-1119, and Managed Care Policy Letter 11-004. Palliative care for children with life-threatening or terminal conditions is defined as an active approach to comprehensive comfort-oriented care for children, youths, and families. The purpose of PPC is to enhance quality of life, minimize suffering, and provide emotional support through interdisciplinary services and interventions. Palliative care can be provided as part of hospice care for Medi-Cal beneficiaries at the end of life, or as a set of supportive services for beneficiaries with life-threatening conditions who have a life expectancy that is longer than six-months.

Terminally Ill: An individual who has a medical prognosis that their life expectancy is six months or less, if the illness runs its normal course.<sup>i</sup>

Whole Child Model (WCM): The purpose of the WCM program is to incorporate services covered by the CCS Program into Medi-Cal managed care for Medi-Cal-eligible CCS Program members. Managed care plans (MCPs) operating in WCM counties will integrate Medi-Cal managed care and CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

## **Procedures:**


- I. Palliative Care
  - A. Members Eligible for Palliative Care
    1. General Eligibility Criteria: The following apply to members eligible to receive palliative care:
      - i. Likely to or have started to use the hospital or emergency department as a means to manage late stage disease;
      - ii. In a late stage of illness, as defined below and not eligible for or decline hospice enrollment;
      - iii. Death within a year would not be unexpected based on clinical status;

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- iv. Have either received appropriate patient-desired medical therapy, or for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation; and,
- v. The member and, if applicable, the family/patient-designated support person, agrees to:
  - a. Attempt in-home, residential-based or outpatient disease management instead of first going to the emergency department; and
  - b. Participate in Advance Care Planning discussions.

2. Disease-Specific Eligibility Criteria

- i. 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 New York Heart Association (NYHA) heart failure classification III or higher, and
  - b. The member has an Ejection Fraction <30% for systolic failure or significant co-morbidities.
- ii. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
  - a. The member has a Forced Expiratory Volume (FEV)<sub>1</sub> 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.
- iii. 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 OR has failure of two lines of standard chemotherapy.
- iv. 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, spontaneous 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.
- v. Other conditions that meet general eligibility criteria listed in Section A. above will be considered eligible on a case-by-case basis.


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- vi. Additional provisions for eligibility: 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, results in death, or until the member elects hospice care. The Alliance will assess members receiving care in the palliative care program every 3 months through the prior authorization process for changes in his/her condition or palliative care needs. Members determined to be eligible for hospice/palliative services prior to 21 years of age may continue to receive services after 21 years of age if the member is still eligible. Palliative care that is no longer medically necessary or reasonable may be discontinued.
- vii. Grievances and disputes will be addressed per Policies 105-1002 – Member Grievance System and 105-1003 – Provider Dispute Resolution Mechanism as consistent with current grievance and dispute requirements.

### 3. Pediatric Palliative Care Eligibility Criteria:

The Alliance covers and ensures the provision of palliative care, as required by W&I Code section 14132.75 and APL 18-020, and as required for Members less than 21 years of age under the EPSDT benefit and standard of Medical Necessity. The Alliance will continue to cover all Medically Necessary Covered Services for Members receiving palliative care. For Members less than 21 years of age, The Alliance covers palliative care concurrently with hospice care and other Medically Necessary covered services for Members under 21 years of age, if hospice care is elected by the Member.<sup>ii</sup> Members under 21 years of age may also be eligible for palliative care and hospice services concurrently with curative care, provided:

- a. The family and member agree to the provision of pediatric care services; and
- b. There is documentation of a life-threatening diagnosis. This can include, but is not limited to:
  - 1. Conditions of 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

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sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

If the 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. Members will be identified for these services by primary and specialty care providers and referred via a prior authorization process.


#### B. Palliative Care Services:

Palliative care includes, at a minimum, the following services when medically necessary or 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 discussions between a physician or other qualified healthcare professional and a patient, family member, or surrogate in counseling and discussing advance directives, including Physicians Order for Life Sustaining Treatment (POLST) forms.
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:
  - a. Treatment plans, including palliative care and curative care
  - b. Pain and symptom management
  - c. Medication side effects
  - d. Emotional and social challenges
  - e. Spiritual concerns
  - f. Patient goals
  - g. Advance directives, including POLST forms
  - h. Legally recognized decision maker

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3. Plan of Care: A plan of care should be developed with the engagement the beneficiary and/or his or 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.
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 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 Alliance recommends that the palliative care team include, but is not limited to, a doctor of medicine or osteopathy (Primary Care Provider if MD or DO), a registered nurse and/or nurse practitioner (Primary Care Provider if NP), a social worker, and a chaplain.
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 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 must include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of mental health and medical social services shall not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs).
8. Medically necessary Pediatric Palliative Care (PPC) services may also include the following:
  - i. Advance Care Planning

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- Discussions between client, family and physician or other member of PPC team.
- Discussions may address advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

ii. Palliative care assessment and consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in earlier or 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. 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

iii. Plan of care


iv. Child and family counseling and medical social services

v. Care coordination

vi. Pain and symptom management


C. Palliative Care Providers: The Alliance will maintain a network of qualified palliative care providers who will offer care in the appropriate setting and based on member needs. Qualified palliative care providers will meet provider credentialing guidelines as described in Alliance Policy 300-4040 – Professional Provider Credentialing Guidelines and will meet access requirements as described in Alliance Policy 300-5050 – Geographic Accessibility Standards. Palliative care may be provided in a variety of settings, including but not limited to: inpatient, outpatient, or community-based settings.

1. Providers must meet Alliance credentialing requirements as applicable to their position.
2. The Alliance will assist providers in identifying members eligible for palliative care through the concurrent review process in the hospital, through referrals to the Case Management program. Prior Authorization is not needed for hospice or palliative care.

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3. Names of members identified for palliative care services by the Alliance will be shared with the members' primary care providers.
4. Physician leaders of palliative care teams are specialist providers that conduct palliative care consultations and assessments with the following credentials:
  - i. Previous Board Certification by the Board of Hospice and Palliative Care Medicine with an expiration date on or after December 31, 2008 or,
  - ii. Current Board Certification from the Board of Hospice and Palliative Medicine as recognized by the Board of Medical Specialties, or
  - iii. Current eligibility for certification by the Board of Hospice and Palliative Care Medicine or
  - iv. Be currently Board of Hospice and Palliative Medicine eligible based upon completing an accredited fellowship in the specialty or,
  - v. On a case by case basis the Medical Director or the Peer Review and Credentialing Committee (PRCC) may approve for a board certified or board eligible specialist with at least 3 years of experience as a provider of palliative care.
5. The following provider types and settings will be considered for palliative care:
  - i. hospitals
  - ii. long-term care facilities
  - iii. clinics
  - iv. hospice agencies
  - v. home health agencies
  - vi. other types of community-based providers that include licensed clinical staff
  - vii. Community-Based Adult Services (CBAS) facilities that coordinate advance care planning or palliative care referrals.
6. Palliative care provided in a beneficiary's home must comply with Alliance Policy 404-1719 –Home Health Care. A current roster of approved palliative care providers will be maintained in the Alliance Provider Portal.




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7. Pediatric Palliative Care (PPC) services related to a child's CCS-eligible medical condition may be provided in a variety of settings, including hospitals, clinics, or in the client's home. Palliative care services may be authorized by CCS if they are part of a plan of care of a CCS SCC. The services may be provided by the following providers:


- i. CCS paneled physicians with palliative care expertise
- ii. Hospice agencies
- iii. Home health agencies, which may provide the following services when requested by SCC or CCS paneled specialty physician affiliated with a children's hospital:
  - a. Skilled nursing visits
  - b. Home health aide visits
  - c. Physical therapy visits
  - d. Occupational therapy visits
  - e. Social worker visits
  - f. Speech therapy visits
  - g. Respiratory therapy visits
  - h. Registered dietitian visits
  - i. Respite care

D. Palliative Care Assessment and Consultation components- Palliative care provision includes collection of 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:


1. Treatment plans, including palliative care and curative care
2. Pain and symptom management
3. Medication side effects
4. Emotional and social challenges
5. Spiritual concerns
6. Patient goals
7. Advance directives, including POLST forms

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- E. Provider Education: The Alliance will inform and educate providers regarding the availability of palliative care through Alliance-utilized provider education methods including CME events, Fax Blasts, and Provider Manual information.
- F. Disputes- The Alliance will address disputes related to the provision of palliative care consistent with current grievance and appeals requirements as described in Policies 105-1002 – Member Grievances and 105-1003 – Provider Dispute Resolution Mechanism.
- G. Data collection: The Alliance will monitor and collect palliative care enrollment and utilization data and will report to DHCS on a quarterly basis and as requested. Reports will include the following:
1. A list of members enrolled in palliative care will be collected and updated monthly..
  2. A listing of all approved Alliance palliative care providers will be maintained in the Alliance Provider Portal
  3. Utilization reports including all claims for authorized members (inpatient, emergency department, palliative care services and other outpatient services will be updated quarterly).
- H. Referrals
1. Providers that identify candidates for palliative care may refer to the Alliance Palliative Care Program. No Prior Authorization is required for Hospice or Palliative Care.
  - 2.
  2. Members meeting eligibility criteria as described in A1 and A2 above will be approved for 3 months of palliative care services.
  3. Requests can be submitted every 3 months and will be re-evaluated as described above.
  4. The Palliative Care Assessment should include all services described in section B above.
  5. There will be no limits on Evaluation and Management, counseling, or care coordination.
  6. Advance care planning will be approved as currently allowed by Medi-Cal.
- II. Hospice Care
- A. Members Eligible for Hospice Care
1. Members that are certified as terminally ill are eligible for hospice care services. A hospice must contain a written physician certification of terminal illness for each hospice benefit period.

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2. The physician certification must contain the following qualifying clause: "the individuals prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course."
  3. The Alliance does not deny hospice care to any member certified as terminally ill.
- B. Member Election of Hospice Care Services
1. Members must elect to participate in hospice care services.
  2. The Member's "election" of hospice care services must include the following fields, on an appropriate hospice election form:
    - i. The identification of the hospice;
    - ii. The member's or representative's acknowledgement that:
      - i. The member or representative has full understanding that the hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature; and,
      - ii. Certain specified Medi-Cal benefits are waived by the election;
    - iii. The effective date of the election; and,
    - iv. The signature of the individual or representative.
  3. Members may elect to receive hospice care during one or more of the following periods:
    - i. An initial 90-day period;
    - ii. A subsequent 90-day period; or,
    - iii. An unlimited number of subsequent 60-day periods.
  4. Hospice providers must notify the Alliance of general inpatient care placement that occurs after normal business hours on the following business day.
- C. Revocation of Hospice
1. A member's voluntary election may be revoked or modified at any time during an election period. To revoke the election, the member or member's representative must file a signed statement with the hospice revoking the individual election for the remainder of the election period. The effective date may not be retroactive.
  2. At any time after revocation, the member may execute a new election, and may choose to change the designation of a hospice provider once each benefit period.
- D. If a member revokes the hospice benefit or is discharged and later elects hospice and is readmitted to the same or different provider, then a new election period is initiated as if the hospice care services are starting anew. A members change from one designated hospice to another is not considered a revocation of the hospice election.
1. Upon member election of hospice services, the Alliance ensures provision and payment for hospice care services, provided by a hospice provider.


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2. The Alliance does not require prior authorization for hospice services. Non-contracted hospice providers are reimbursed at Medi-Cal rates.
    - i. The Alliance may require documentation following the provision of general inpatient and continuous care for reasons of justification. If the documentation does not support these levels of care, or if the documentation is inadequate, reimbursement rates may be reduced to a lower level of care.
    - ii. An appeal may be submitted for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care.
  3. Hospice care services may be provided in a home or clinical setting.
  4. Hospice care does not affect a member's eligibility for enrollment. The Alliance remains responsible for the provision of all Medi-Cal covered services not related to the terminal illness, including those of the member's PCP.
- E. Transition to Hospice Services
1. Once a member has elected hospice care services, the member's providers and Alliance staff work closely with hospice care providers to facilitate the transfer of services from those directed towards cure and prolongation of life to those directed toward palliation.
  2. Ongoing care coordination are provided to ensure that services necessary to diagnose, treat, and follow-up on conditions not related to the terminal illness continue to be provided or are initiated as necessary.
  3. Services for Children with Life-Limiting Conditions
    - i. For CCS eligible members, the Alliance will coordinate palliative and hospice care services with the CCS program and the member's caregivers to facilitate continuity of medical care, including maintaining established patient provider relationships, to the greatest extent possible.
    - ii. Children who have elected to receive hospice services may continue receiving coverage for other services to treat their terminal illness.

#### **References:**

##### Alliance Policies:

- 200 -9002 – Member Grievance System
- 600-1017 – Provider Inquiry and Dispute Resolution
- 300-4040 – Professional Provider Credentialing Guidelines
- 300-5050 – Geographic Accessibility Standards
- 404-1719 – Home Health Care
- 404-1201 – Authorization Request Process

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Impacted Departments:

Community Care Coordination  
Provider Services

Regulatory:

Title 28, CCR, Section 1300.68.2  
SB 294 (Chapter 515, Statutes 2017) and codified in Health and Safety Code (HSC) section 1747.3  
CCS Numbered Letter 06-1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care  
CCS Numbered Letter 12-1119 Palliative Care Options for CCS Eligible Children - Revised

Legislative:

Assembly Bill (AB) 847 – Medi-Cal Pediatric Palliative Care Services

Contractual (Previous Contract):

DHCS Medi-Cal Contract Exhibit A, Attachment 10, Provision 8.C  
DHCS Medi-Cal Contract Exhibit A, Attachment 18, Provision 10.L.1  
DHCS Medi-Cal Contract Exhibit E, Attachment 3, Provision 5

Contractual (2024 Contract):

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5  
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7.C  
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7.D

DHCS All PlanLetter:

DHCS APL 13-014 Hospice Services and Medi-Cal Managed Care  
DHCS APL 18-020 Palliative Care  
DHCS APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services  
DHCS APL 24-010 - Subacute Care Facilities - LTC Benefit Standardization and Transition  
Managed Care Policy Letter 11-004


NCQA:

Supersedes:

DHCS APL 17-015 (Superseded by APL 18-020)  
DHCS APL 17-018 (Superseded by APL 22-006)

Other References:

NYHA classifications are available at:  
[http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure\\_UCM\\_306328\\_Article.jsp#.V-MZu9LH--o](http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart-Failure_UCM_306328_Article.jsp#.V-MZu9LH--o)  
Performance Scales: Karnofsky and ECOG Scores,"  
[Performance Scales: Karnofsky & ECOG Scores Practice tools \(esmo.org\)](https://www.esmo.org/practice-tools/performance-scales/karnofsky-and-ecog-scores)  
MELD score calculator is available at:  
<https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator>  
Medi-Cal Provider Manual "Evaluation and Management (E&M)." Available at:

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<https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval.pdf>

Attachments:

**Lines of Business This Policy Applies To**

- ☐ DSNP  
☒ Medi-Cal  
☐ Alliance Care IHSS

**LOB Effective Dates**

(01/01/2026 – present)  
(01/01/1996 – present)  
(07/01/2005 – present)

**Revision History:**

Reviewed Date	Revised Date	Changes Made By	Approved By
09/06/2022	09/06/2022	Paige Harris Regulatory Reporting Supervisor	UMWG
03/27/2023	04/11/2023	Paige Harris Regulatory Reporting Supervisor	UMWG
10/23/2023	10/23/2023	Danah Hernandez Regulatory Reporting Supervisor	UMWG
03/26/2024	03/26/2024	Danah Hernandez, Regulatory Reporting Supervisor	UMWG
11/5/2024	11/12/2024	Tisa Llamas, RN Prior Authorizations Supervisor	UMWG
12/06/2024	12/06/2024	Linda Walker, UM Concurrent Review Supervisor (RN)	UMWG
02/04/2024	02/04/2025	Tisa Llamas RN/Lorna Metzger RN, UM Prior Authorizations Supervisor	UMWG

<sup>i</sup> Title 42, CFR section 418.3

<sup>ii</sup> 2024 Medi-Cal Contract Exhibit A, Attachment 3, Provision 5.3.7.C