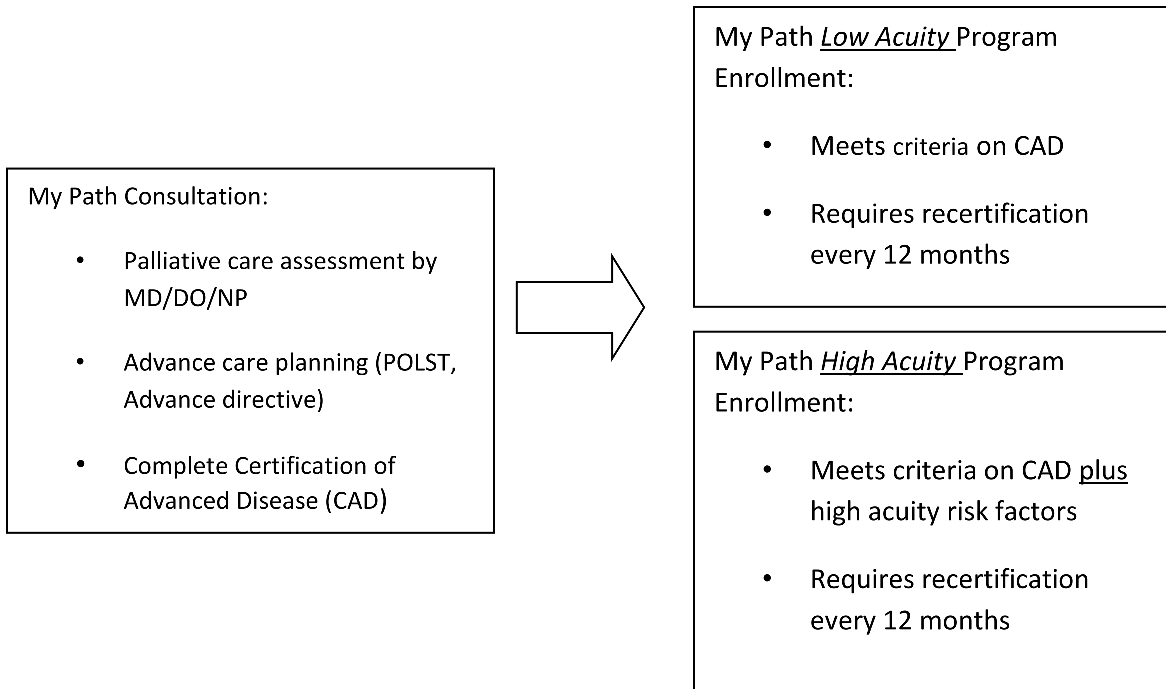
IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	My Path (A Palliative Care Approach)	**Guideline #**	UM_OTH 09
		Original Effective Date	11/8/2017
Section	Other	**Revision Date**	05/9/2018

COVERAGE POLICY

Inland Empire Health Plan (IEHP), in accordance with Senate Bill (SB) 1004, is dedicated to creating a community/home-based palliative care program for its Medi-Cal and non-delegated Medicare Members without regard to age.

The My Path Program consists of a consultation visit that will include an assessment of eligibility for program enrollment when criteria are met as documented on the Certification of Advanced Disease (CAD) (Appendix A). The consultation visit does not require prior authorization. Program enrollment requires prior authorization.



A. The Certification for Advanced Disease (CAD) will assess if the Member meets all the General Criteria (section B) and at least one of the Disease-Specific Criteria (section C) for enrollment in the program. Providers will recommend Program Acuity Tier based on the criteria outlined (section D). The CAD must be submitted with the authorization request for My Path program enrollment.

B. General Criteria (all needed) [2-9]**:**

1. Patient who is likely to or has started to use the hospital and/or emergency room as a means to manage their advanced stage disease; and
2. Patient is in the advanced stage of illness with continued decline in health, and is not eligible or declines hospice; and
3. Patient may be receiving appropriate patient-desired medical therapy, OR for whom patient-desired medical therapy is no longer curative, OR is intolerant/ declines further medical therapy, OR decompensates due to severe non-compliance; and
4. Patient's death within two (2) years would not be unexpected based on clinical status; and
5. Patient and, if applicable, family/patient-designated support person agree to both of the following:
   a. Willing to attempt, as medically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; AND
   b. May be willing to participate in Advance Care Planning discussions.

C. Disease-Specific Criteria (at least one) [2-9]**:**

1. Congestive Heart Failure (CHF)
   a. Any patient who is hospitalized due to CHF as the primary diagnosis, **OR**
   b. NYHY III classification or higher (definition of NYHA III: Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain) **AND** one of the following:
      i. Ejection Fraction < 30 for systolic failure
      ii. Significant co-morbidities: e.g. renal disease, diabetes, dementia, or poor biomarkers including rising BNP, pro-BNP, hsCRP, BUN/Creatinine (patient is in their best compensated state), and CAD.

2. Chronic Pulmonary Disease (e.g. COPD, Cystic Fibrosis, Pulmonary Fibrosis):
   a. Severe airflow obstruction: FEV1<35% predicted **AND** 24-hour oxygen requirement, **OR**
   b. 24-hour oxygen requirement of greater than or equal to three liters/minute

3. Advanced Cancer:
   a. Any Stage III or IV cancer, or locally advanced or metastatic cancer, leukemia or lymphoma **AND** one of the following:
      i. Palliative Performance Scale (PPS) score < or equal to 70% (PPS 70%= Cares for self; unable to carry on normal activity or do active work) (Appendix B)
      ii. Failing two lines of standard of care therapy (chemotherapy or radiation therapy).
      iii. Patient is not a candidate for or declines further disease-directed therapy

4. Liver Disease:
   Irreversible Liver Damage as evidenced by one of the following:
   a. Ascites; and/or
   b. Subacute (spontaneous) bacterial peritonitis; and/or
   c. Hepatic encephalopathy; and/or
   d. Hepatorenal syndrome; and/or
   e. Recurrent esophageal bleed; and/or
   f. Model for End Stage Liver Disease (MELD) score of greater than 19 (To calculate MELD Score: (https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator/)

5. End Stage Renal Disease:
   a. GFR < 15 **AND one of the following:**
      i. Patient refusing dialysis, has poor compliance, OR
      ii. Declining status with multiple other advanced co-morbidities, such as CHF, ESLD, COPD.

6. Dementia:
   Any one of the following:
   a. Functional Assessment Staging Scale (FASS) score of 5 with high risk of using the hospital to manage their disease with documentation of reason for high risk status (Appendix C) **OR**
   b. FASS 6 to 7 **OR**
   c. Any patient with diagnosis of dementia who has been institutionalized or required hospitalization primarily due to their dementia, plus completed an appropriate metabolic workup (CMP, Thyroid Function Tests, B12) and neuro-imaging (or documented refusal).

7. Neurodegenerative Disease (e.g. Parkinson's, ALS, Multiple Sclerosis):
   a. Impaired breathing capacity requiring oxygen **OR**
   b. Rapid disease progression as evidenced by decline in ambulation status from independent to wheelchair/bed bound, or decline in speech to unintelligible, or decline in oral intake to pureed foods, or decline in ADLs to requiring mod/max assistance **AND one of the following:**
   c. Nutritional impairment associated with weight loss **OR**
   d. Life threatening complication event in past 12 months such as aspiration pneumonia, sepsis, and stage 3 or 4 pressure ulcers.

8. AIDS:
   a. Palliative Performance Scale (PPS) ≤ 50% **AND**
   b. CD4 cell count < 25 or viral load > 100,000 WITH either non-compliance, refusal, intolerance, failure, or resistance to antiretroviral therapy **AND** presence of ANY of the following:
      i. Opportunistic infections (e.g. multidrug-resistant M. tuberculosis, MAC, CMV, Cryptosporidium, Toxoplasmosis, Progressive Multifocal Leukoencephalopathy), and/or
      ii. AIDS related malignancy (e.g. Non-Hodgkin's or CNS lymphoma, visceral Kaposi's sarcoma), and/or
      iii. HIV-associated dementia, and/or
      iv. HIV wasting syndrome (>10% unintentional weight loss over 12 months, 33% loss of lean body mass or BMI <20), and/or

v. Declining status with presence of multiple co-morbidities (e.g. advanced liver disease, CHF, ESRD)

9. Documentation of other advanced illness (psychiatric or substance abuse related diagnoses are excluded as *primary* qualifying diagnoses for program).

D. Providers will recommend program acuity tier (Low vs. High) based on the following criteria:

1. Low- meets criteria in C and D
2. High – meets criteria in C and D, and requires clinical justification – clinical justification criteria includes (at least one):
   a. ACG score = CCM level and PHU > 50%
   b. More than 2 inpatient admissions in the past 3 months
   c. More than 3 ER visits in the past 3 months
   d. Palliative Performance Scale (PPSv2) 60% or less
   e. Presence of co-morbid uncontrolled significant mental health disorder (e.g. Bipolar, Schizophrenia) and marked with poor functionality (Global Assessment of Functioning scale (GAF) <= 50)
   f. Homeless or poor social support
   g. Co-morbid active alcohol and/or drug abuse
   h. Clinical justification.

COVERAGE LIMITATIONS AND EXCLUSIONS

A. My Path is a plan benefit for Medi-Cal (Direct and delegated) and non-delegated Medicare Members (Dual Choice Members whose Medicare is assigned to IEHP Direct).
B. The provision of My Path shall not result in the elimination or reduction of any covered benefits or services 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 My Path [2].
C. A Member with a serious illness who is receiving palliative care may choose to transition to hospice care if they meet hospice eligibility criteria. A Member may not be concurrently enrolled in hospice care and palliative care.
D. My Path program enrollment requires re-certification every 12 months.
E. Examples of Members eligible for My Path are:
   1. A patient with lymphoma who is receiving palliative chemotherapy, has a PPS 50%, and is willing to attempt in-home or outpatient disease management instead of using the emergency room, when appropriate.
   2. A delegated Medi-Cal Member with end-stage liver disease complicated by recurrent upper GI bleeding from esophageal varices, who is hospice appropriate but declines participation, and is willing to attempt in-home or outpatient disease management instead of using the emergency room, when appropriate.
F. Examples of Members not eligible for My Path are:
   1. A patient with end-stage renal disease on hemodialysis who is compliant with dialysis and has stable co-morbid conditions.
   2. A delegated Medicare Member (e.g. a Dual Choice Member whose Medicare is not assigned to IEHP Direct).

ADDITIONAL INFORMATION

None

CLINICAL/REGULATORY RESOURCE

A. The Centers for Medicare and Medicaid Services (CMS) defines palliative care as: "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 facilitating patient autonomy, access to information, and choice [1]."

   As described in Department of Health Care Services, All Plan Letter 17-015, *Palliative Care and Medi-Cal Managed Care*, released 10/19/17, palliative care must include, at a minimum, the following services, without regard to age, when medically necessary and reasonable for the palliation or management of a qualifying serious illness [2]:

   1. **Advanced Care Planning (ACP):** To include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling should address, but is not limited to, advance directives and, for appropriate Members, POLST forms and should include family conflict resolution over issues surrounding the patient's decisions. Family members who may wish to supersede the patient's goals of care should be identified, supported, and reconciled.
   2. **Palliative Care Assessment and Consultation:** Aimed at collecting routine medical data and personal information not regularly included in a medical history. Topics may include, but are not limited to:
      a. Treatment plan, including palliative care and chronic disease management
      b. Pain and symptom management
      c. Medication side effects
      d. Emotional and social challenges
      e. Spiritual concerns
      f. Patient goals
      g. Advanced directive and/or POLST forms
      h. Legally recognized decision maker
   3. **Individualized Written Plan of Care:** Developed with the engagement of the Member and/or his or her representative(s) in its design. The Member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and chronic disease management.
   4. **Pain and Symptom Management:** To include prescription medications, physical therapy, and other medically necessary services to address Member's pain and other symptoms.
   5. **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. Services to include, but not limited to, psychotherapy, bereavement counseling, medical social services, and discharge planning. Particular attention and education will be given to the primary caregiver to both prevent unnecessary hospitalizations of the Member and unnecessary health harms to the caregiver from the role of care-giving. Provision of medical social services shall not duplicate specialty mental health services provided by the county and the palliative team shall work the Member, county, and IEHP in assisting with coordinating care as needed.
   6. **Care Coordination** provided by a member of the palliative team ensuring continuous assessment of the Member's needs, and implements the plan of care. The palliative team will regularly communicate plan of care with the Member's PCP. This communication should occur at a minimum of weekly intervals. The palliative team

must be willing to address Member's immediate needs (e.g. pain and symptom management, DME needs) in the event that the PCP is unavailable to avoid a delay in care.

7. **Palliative Care Team** who will work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of Members and their families. The team members must provide all authorized palliative care. The team is to consist of:
   a. Doctor of medicine or osteopathy
   b. Registered nurse, licensed vocational nurse, and/or nurse practitioner
   c. Social worker
   d. Chaplain

MCPs may authorize additional palliative care not described above, at the MCPs discretion and cost. An example of an additional service is telephonic palliative care support that is available 24 hours a day, 7 days a week [2].

B. As specified in SB 1004 [13], beneficiaries who meet the eligibility criteria may access both palliative and traditional chronic disease management services that are medically necessary. Essential to care coordination, the palliative care team and a plan of care will ensure coordination between care services, particularly including the beneficiary's PCP. For those whose illness is sufficiently far advanced, there will remain the option of electing hospice care.

DEFINITION OF TERMS

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 facilitating patient autonomy, access to information, and choice [1]."

REFERENCES

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