Policy:	PA.2003
Title:	**PACE Palliative Care**
Department:	CalOptima Health Pace
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 03/06/2025*
Effective Date:	01/01/2025
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the scope and services of the Palliative Care Program for CalOptima Health Program of All-Inclusive Care for the Elderly ("PACE") Participants.

II. POLICY

A. CalOptima Health PACE shall provide Palliative Care services to Participants as outlined in this policy, Senate Bill (SB) 1004 and Department of Health Care Services (DHCS) contractual requirements and the Centers of Medicare and Medicaid Services (CMS).

B. CalOptima Health PACE shall ensure that the Participant or Authorized Representative receive information, in writing, and fully understand, Palliative Care, comfort care, or end of life care services as described in Title 42 Code of Federal Regulations (CFR) §460.112, before implementation by CalOptima Health PACE.

1. CalOptima Health PACE shall identify all services that are impacted and provide a detailed explanation of how the services will be impacted if the Participant or Authorized Representative elects to initiate Palliative Care, comfort care, or end-of-life care, including but not limited to the following types of services:

a. Physician services, including specialist services;

b. Hospital services;

c. Long-term care services;

d. Nursing services;

e. Social services;

f. Dietary services;

g. Transportation;

h. Home care;

i. Therapy, including physical, occupation, and speech therapy;

j. Behavioral health;

k. Diagnostic testing, including imaging and laboratory services;

l. Medications;

m. Preventative healthcare services; and

n. PACE center attendance.

C. CalOptima Health PACE shall provide Medically Necessary Palliative Care services to Participants who satisfy the minimum eligibility requirements described in Section III of this Policy.

D. If the Participant continues to meet the minimum eligibility requirements, the Participant can continue to receive both Palliative Care and Curative Care until their condition improves, stabilizes, or results in death.

E. Palliative Care services shall include the following coordination of care.

1. Advanced Care Planning, which includes documentation of discussions between the Provider and the Participant or Authorized Representative. Discussion and planning shall address the Participant's Advance Directives, such as their Physician Orders for Life-Sustaining Treatment (POLST).

2. Palliative Care assessment and consultation (can be done at the same time of the Advanced Care Planning stage). The discussion should include all of the information regarding the CalOptima Health PACE Palliative Care program, and may include but is not limited to:

a. Treatment plan for Palliative Care.

b. Pain and medication effects.

c. Emotional and social challenges.

d. Spiritual concerns.

e. Participant goals.

f. Advanced Directives; POLST

g. Legally recognized decision maker.

3. The Interdisciplinary Team (IDT) must develop and update the Participant's Plan of Care to reflect the Palliative Care services. The IDT shall provide all authorized services within the timeframes noted in CalOptima Health Policy PA.1007: Delivery of PACE Services as outlined in Title 42 C.F.R. §460.98.

4. Care coordination to ensure continued oversight of provided services and continued need for Palliative Care.

5. Pain management as authorized by the IDT, which may include prescription drugs and physical therapy to help manage Participant's pain needs.

6. Mental health services to support Participants with their psychosocial needs that may arise from serious illness and the dying process. This could include psychotherapy, bereavement counseling, and discharge planning.

F. CalOptima Health PACE shall assess Palliative Care needs as deemed necessary or during the Participant's assessment cycle. CalOptima Health may discontinue Palliative Care services that are no longer Medically Necessary or reasonable, or at the request of the Participant or Authorized Representative.

III. PROCEDURE

A. Minimum Eligibility Criteria

1. CalOptima Health PACE Participants are eligible to receive Palliative Care services if they meet all the of criteria outlined in Section III.A.2., and at least one of the four requirements in Section III.A.3 of this Policy.

2. General Eligibility Criteria

a. The Participant is likely to or has started to use the hospital or emergency department to manage their advanced disease (unanticipated decompensation and not including elective procedures).

b. The Participant has an advanced illness as outlined in Section III.A.3. of this Policy with appropriate documentation of continued deterioration in health status and is not eligible for or declines hospice enrollment.

c. The Participant's death within a year would not be unexpected based on clinical status.

d. The Participant has either received appropriate patient-desired medical therapy or is a Participant for whom patient-desired medical therapy is no longer effective. The Participant is not in reversible acute decompensation; and

e. The member and, if applicable, the family/member-designated support person, agrees to:

i. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and

ii. Participate in Advance Care Planning discussions.

3. Disease-Specific Eligibility Criteria

a. Congestive Heart Failure (CHF) with both:

i. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and

ii. An ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

b. Lung Disease

i. Chronic Obstructive Pulmonary Disease (COPD)

a) Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24)-hour oxygen requirement of less than three (3) liters per minute; or

b) Twenty-four (24)-hour oxygen requirement of greater than or equal to three (3) liters per minute.

ii. Other lung disease such as but not exclusive to Interstitial Lung Disease or Pulmonary Hypertension

a) Recurrent lung infections, increased dyspnea on exertion, FVC in 1 second <1 liter, oxygen saturation of <88% at room air at rest, hypercapnia PCO2>49 mmHG, weight loss >10% over preceding 6 months, or resting HR >100/min.

c. Advanced cancer with both:

i. Stage III or IV solid organ cancer, lymphoma or leukemia; and

ii. A Karnofsky Performance Scale (KPS) score less than or equal to seventy (70) or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

d. Liver disease with:

i. Evidence of irreversible liver damage, serum albumin less than 3.0 and International Normalized Ratio (INR) greater than 1.3, and

ii. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

iii. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

iv. To calculate MELD Score, visit the Health & Human Services Administration (HRSA) website: https://optn.transplant.hrsa.gov/data/allocation-calculators/meld-calculator/.

e. End Stage Renal Disease

i. Stage V Chronic Kidney Disease with Glomerular filtration rate (GFR) <15 ml/min; and

ii. Participant declines to start hemodialysis or decides to stop current hemodialysis.

f. Parkinson's Disease:

i. Stage IV of Parkinson's with severely disabling disease (nutritional impairment resulting in Body Mass Index (BMI) <18 or 10% weight loss and refusal of artificial

feeding methods, multiple falls, falls with fracture, infections, motor symptoms poorly responsive to medications, worsening dementia); or

ii. Stage V of Parkinson's with confinement to bed or wheelchair unless aided.

g. Dementia:

i. Stage 5, 6 or 7 on the Functional Assessment Staging Test (FAST) scale; and

ii. Patients have had one of the following secondary conditions within the past twelve (12) months:

a) Delirium;

b) Recurrent or intractable infections, such as pneumonia or other URI;

c) Pyelonephritis or other urinary tract infection;

d) Septicemia;

e) Decubitus ulcers, multiple stages 3-4; or

f) Inability to maintain sufficient fluid and calorie intake demonstrated by either of the following: 10% weight loss during the previous six months OR Serum albumin <2.5 gm/dl.

h. Cerebrovascular Disease

i. Diagnosis with one of the following: stroke, carotid stenosis, vertebral stenosis and intracranial stenosis, aneurysms, and vascular malformations; and

ii. Palliative Performance Scale (PPS) score of ≤ 60%.

B. Palliative Care Review and Consent Process

1. Participants who are identified to meet the eligibility criteria for Palliative Care Services will be identified by the CalOptima Health PACE IDT.

2. Participants who are identified to meet the eligibility criteria will have a Palliative Care consultation meeting with the CalOptima Health PACE Social Worker and Primary Care Provider to review the PACE Palliative Care Consent Form (Attachment A of this policy).

3. The Participant or Authorized Representative must make the decision to receive Palliative Care services. They also have the right to revoke or withdraw their consent to receive Palliative, comfort, or end-of-life care at any time and for any reason, either verbally or in writing.

4. If the Participant or Authorized Representative agrees to Palliative Care services, the Social Work Department and Primary Care Provider will review the consent form with them in detail and ensure the Participant understands the services that are rendered under the PACE Palliative Care program. If the Participant or Authorized Representative agrees, they will sign the consent form.

5. The IDT will review the Participant's care needs and add services into the care plan.

6. The Palliative Care Consent Form will be scanned and uploaded to the EMR.

7. The CalOptima Health PACE IDT is responsible for coordinating, authorizing and monitoring Palliative Care services.

IV. ATTACHMENT(S)

A. CalOptima Health PACE Palliative Care Consent Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for the PACE Program
B. CalOptima Health Policy PA.1007: Delivery of Services
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-014: Hospice Services and Medi-Cal Managed Care
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020: Palliative Care
E. Department of Health Care Services (DHCS) SB 1004 Medi-Cal Palliative Care Policy, November 2017 – Update
F. Senate Bill 1004 (SB 1004)
G. Title 42, Code of Federal Regulations (C.F.R.) §§460.96, 460.98, 460.112
H. Welfare and Institutions Code (WIC) § 14132.75

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	PA.2003	PACE Palliative Care	PACE

IX. GLOSSARY

Term	Definition
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the Participant is incapacitated.
Authorized Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Curative Care	Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Interdisciplinary Team (IDT)	A team composed of Participants qualified to fill, at minimum, the following Participant roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of Participants: 1. Primary Care Provider; Primary medical care must be furnished to a Participant by any of the following: a. A primary care physician. b. A community-based physician. c. A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. d. A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. 2. Registered Nurse; 3. Master's – level Social Worker; 4. Physical Therapist; 5. Occupational Therapist; 6. Recreational Therapist or Activity Coordinator; 7. Dietician; 8. PACE Center Manager; 9. Home Care Coordinator; 10. Personal Care Attendant or his or her representative; and Driver or his or her representative.
Medically Necessary	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.

Term	Definition
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.
Participant	An individual enrolled in the CalOptima Health PACE program.
Physician Orders for Life-Sustaining Treatment (POLST)	A tool for end-of-life planning. It ensures that a patient's treatment wishes are known and will be followed by health care professionals during a medical crisis, when the patient cannot speak for themselves.
Plan of Care	A comprehensive care plan developed by the interdisciplinary team for each participant to identify the care needed to meet the medical, physical, emotional, and social needs of the participant, as identified in the initial comprehensive assessment.
Primary Care Provider (PCP)	A provider responsible for supervising, coordinating, and providing initial and Primary Care to Participants; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Program of All-Inclusive Care for the Elderly ("PACE")	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.