PPC Waiver

1. What is the difference between the Pediatric Palliative Care (PPC) waiver and the Partners for Children (PFC) program?
The PPC waiver was a federal Home and Community Based Services 1915(c) waiver which authorized the Department of Health Care Services (DHCS) to develop a home-based Medi-Cal pediatric palliative care program called Partners for Children (PFC). Throughout this document, we use the term “PPC waiver” in reference to both the PPC waiver and its service program, Partners for Children (PFC).

2. What services were offered under the pediatric palliative care (PPC) waiver?
The PPC waiver program provided comprehensive access to pediatric palliative care in a home/community-based setting. Referrals to the program were managed by a CCS Nurse Liaison in each participating county.
   ● Care Coordination – RN or social worker supported family in coordination of medical and palliative care services at home, clinic, school, and other settings. The care coordinator, also sometimes referred to as the nurse case manager, often accompanied family to clinic visits and visited patient if hospitalized to ensure smooth coordination of care between all teams.
   ● Expressive Therapies – creative art, music, massage, and child-life therapy
   ● Family Training – including education and training on palliative care issues, care needs, treatments, and use of equipment
   ● Respite Care – in-home and out of home
   ● Family Counseling – including anticipatory grief and bereavement for caregivers, as needed
   ● Pain and Symptom Management
   ● 24/7 nurse line

Please refer to “Developing Benefit and Payment Options” section of this resource guide for more details.

3. What were the criteria for eligibility for the Partners for Children waiver program?
To be eligible for the PPC waiver program, children had to live in a participating county, be CCS and full-scope Medi-Cal eligible, be under 21 years old, and meet Level of Care determination, which required that the referring provider assert that in the absence of waiver services the child’s condition and stage of progression put them at risk of being hospitalized for at least 30 non-consecutive days in the coming year.

4. Are MCPs required to cover the same services that were available under the PPC Waiver?
No. The services covered under SB 1004 are not the same as the services that were available under the PPC waiver. Most notably, the provision of expressive therapies and respite care is not mandated by DHCS, but DHCS encourages and allows Managed Care Plans to authorize additional palliative care services, including expressive therapies and respite care, at their own discretion and cost.

Under SB 1004, there are seven palliative care services that Medi-Cal requires when determined to be medically necessary for eligible patients.
   ● Advance Care Planning
   ● Palliative Care Assessment and Consultation
     ○ Including family training
   ● Plan of Care
   ● Palliative Care Team
DHCS recommends that the palliative care team include, but not be limited to, a doctor of medicine or osteopathy, a registered nurse, a licensed vocational nurse or nurse practitioner, and a social worker. They also recommend that a chaplain be included in the team, but do not reimburse for chaplain services. Other pediatric palliative care team members may include a massage therapist, expressive art and music therapists, child-life specialists, complementary medicine therapies, and personal home health aides at the discretion of the MCPs and provider agencies.

- Care Coordination
  - Available through MCPs and through PPC provider.
  - For fee-for-service Medi-Cal, care coordination is only available to the extent that the PPC provider coordinates the services they are providing, but it is not a separately billable service
  - 24/7 nurse advice lines are available through most MCPs.
  - The primary goal of care coordination under SB 1004 is for continuous assessment of needs and ensuring implementation of the plan of care. This is in sharp contrast to care coordination under the PPC waiver program, where the care coordinator was responsible for organizing a multifaceted array of services and assumed a large part of the burden of responsibility, otherwise placed on the parents, in condensing, organizing, and making accessible to providers critical information that was related to the patient’s care and necessary for effective medical management of the life-limited or life-threatening illness.

- Pain and Symptom Management
- Mental Health and Medical Social Services
  - Including anticipatory grief, bereavement, counseling and family counseling

Please refer to “Developing Benefit and Payment Options" section of this resource guide for more details.

5. What cost analysis data is available to demonstrate the fiscal impact of PPC waiver services?
An analysis of the data from the Partners for Children waiver pilot program2,3 showed a significant decrease in health care spending for children participating on the waiver program due primarily to a reduction in admissions, hospitalizations, and lengths of stay, resulting in a net savings of $3,331 per month per enrollee. The program demonstrated:
  - A nearly 50% reduction in the average number of inpatient days per month, from 4.2 to 2.3.
  - A significant drop in average hospital length of stay from 16.7 days to 6.5 days (more than a 60% reduction).
  - A strong trend in reducing 30-day readmission rates, from 45% of admissions to 37%.

6. What were the qualifying criteria for hospice and home health agencies to provide PPC under the PPC waiver program?
Agencies were required to be a Medi-Cal Provider and complete provider training offered by DHCS prior to providing services under the PPC waiver. In addition, participating agencies were required to provide:
  - Phone consultation on a 24-hour basis, 7 days a week by a Registered Nurse (RN), with pediatric palliative care experience preferred;
  - Interpreter services for the participant and family;
  - Continuum of PPC waiver services

Provider agency direct care staff qualifications varied based on the service, but all positions required pediatric care experience. Clinical staff were required to have a minimum of three years clinical pediatric experience, one year clinical end of life care experience, and provide proof of completion of the End of Life Nursing Education Consortium (ELNEC) or equivalent training within the previous five years or within one year of beginning to provide services.
California Children’s Services (CCS) and Managed Care Plans (MCPs)

7. What is the role of the California Children’s Services (CCS) program within the Department of Health Care Services (DHCS)?

The CCS program is administered as a partnership between county health departments and DHCS. Through this program, from birth through 20 years old, children who meet the clinical and financial eligibility requirements can receive diagnostic and treatment services, medical case management, and physical and occupational therapy services related to their special health needs. Typically, county staff performs all case management activities for eligible children residing within their county, including determination of program eligibility, evaluation of needs for specific services, referral to appropriate provider(s), and authorization for medically necessary care. The Medi-Cal program, administered by DHCS, reimburses care related to their CCS-eligible conditions either directly or through the Medi-Cal managed care system, with some exceptions. For example:

- If the child is enrolled with a Whole Child Model Medi-Cal managed care plan (MCP), CCS is integrated. The county CCS staff still determine eligibility, but the MCP administers authorization, care coordination, case management, and claims payment.
- If the child is enrolled with a non-Whole Child Model Medi-Cal MCP, CCS is carved out, not integrated. CCS determines eligibility and has case management, referral, and authorization responsibility, and the Medi-Cal program reimburses care. The MCP is generally responsible for reimbursing and authorizing medical care that is not related to the child’s CCS-eligible condition. However, MCPs are responsible for the provision of home-based PPC services, whether the care is related to the CCS condition or not.
- If the child has a CCS-eligible condition, has full scope Medi-Cal, and is not enrolled with a Medi-Cal MCP, they are considered “Medi-Cal fee-for-service (FFS).” CCS determines eligibility and administers all the case management and referral and authorization components of the program, and the state Medi-Cal program reimburses the care.
- If the child is not eligible for Medi-Cal but otherwise meets the financial and clinical criteria, they are considered “CCS-Only.” CCS determines eligibility and administers case management, authorization, and referrals. Care is funded by both the state and the county.

8. What is the distinction in the roles that CCS and MCP play with respect to Pediatric Palliative Care?

CCS is responsible for PPC services for CCS-eligible patients when those services are part of the Special Care Center (SCC) treatment plan. MCPs are responsible for PPC services for all of their enrolled members, including those who are CCS-eligible, regardless of whether the PPC services are related to their CCS condition. With the exception of Whole Child Model counties, the MCP has responsibility for ensuring access to PPC services that are requested/identified outside of the SCC treatment plan. DHCS will be issuing a clarification to NL 16-1812 to further distinguish responsibilities between CCS and the MCP with respect to the SCC. In the meantime, please refer to the flow chart in this guide on “Navigating PPC Post-Waiver” for a visual representation of the role of the MCP and CCS in PPC.

PPC Providers

9. What home health and hospice agencies participated in the PPC waiver and what counties did they serve?

Until its expiration on December 31, 2018, the following counties were actively participating in the PPC waiver program: Alameda, Los Angeles, Marin, Monterey, Orange, San Francisco, Santa Clara, Santa Cruz, and Sonoma. Coastal Kids Home Care served Santa Clara, Santa Cruz, and Monterey counties; Hospice by the Bay (By the Bay
Kids) served Alameda, Marin, San Francisco, and Sonoma counties; Providence TrinityKids Care served Los Angeles and Orange counties; and Libertana Home Health served Los Angeles County. Previously, Fresno, San Diego, and Ventura counties had participated in the PPC waiver program but were not active at the time of its expiration. Participating providers in these counties included Libertana Home Health (Ventura) and Hinds Hospice (Fresno).

10. Do MCPs have established credentialing criteria for PPC providers in order to be contracted in their network?
   Each MCP will likely share the same credentialing criteria but they may differ in the standards they set specific to palliative care services. For example, some MCPs require any provider of palliative care, pediatric or adult, to be Joint Commission-certified. While this may be important to ensure quality of care, there are many counties throughout the state without a Joint Commission-certified agency, and many counties where the volume of patients, specifically pediatric patients, is not high enough to meet the Joint Commission criteria for certification. Providers in these counties should not be excluded from contracting with plans to provide palliative care. Typically, MCPs will have exceptions to ensure access to care and supporting policies for monitoring quality of care. PPC providers should ensure that the staff has training in the clinical and psychosocial care of pediatrics, including information on how pediatric palliative care differs from adult palliative care. DHCS recommends that MCPs contract with providers with current pediatric palliative care training.

11. Where can MCPs find a list of qualified pediatric palliative care providers by county and setting (i.e. hospitals, clinics, hospices, home health agencies)?
   CCCC is not aware of a list of qualified pediatric palliative care providers in California. Hospice agencies providing palliative care (under the SB 294 pilot program) are required to register with the state, but home health agencies providing palliative care are not required to register. The Center to Advance Palliative Care (CAPC) has created a national provider directory (getpalliativecare.org) in which any agency or health system providing palliative care can self-register, but that registry is not verified or comprehensive. CCCC has made an effort to identify and share PPC Medi-Cal provider contact information with MCPs whenever possible, and this effort is ongoing.

Authorization and Eligibility

12. What are the age criteria for pediatric palliative care?
   Patients are eligible for pediatric palliative care from birth up until their 21st birthday.

13. Are services authorized fee-for-service or as a bundled per patient per month service rate?
   Billing arrangements are made between each provider and MCP. Some plans may choose to allocate a per-patient-per-month rate to the provider and allow the provider to care for the patients as necessary. Other plans may choose to pay for PPC services as fee-for-service based on the exact care provided to the patient. The payment guideline in the “Developing Benefit and Payment Options” section of this resource guide is a great tool for navigating these conversations on both the plan and provider side.
14. **Is there guidance on how long authorization for PPC is valid and how often to review?**
   Authorization for pediatric palliative care services under the PPC waiver program was granted for up to six months, depending on the county. MCPs establish their own policies but it is recommended that an authorization period of six months to one year would not overburden providers or plans with frequent re-authorizations requests. While the condition of children receiving home-based palliative care may progress or stabilize, the children’s eligibility and need for PPC services typically remains constant throughout the course of their condition.

15. **Who is responsible for determining eligibility for home-based palliative care services for pediatric members?**
   The referring provider should ensure that the patient meets eligibility criteria for pediatric palliative care before referring the patient (see APL 18-020 and the “Guideline for Consideration of Referral to Home-based Palliative Care” section of this resource guide for eligibility criteria). Once a referral has been made to the MCP, the plan is responsible for determining which services are approved for that patient on the basis of medical necessity. The referring provider can help this process by providing as much detailed information about the child’s condition as possible in their referral to the MCP.

16. **Who is responsible for authorizing and paying for home-based palliative care services for pediatric members?**
   The flowchart in the “Developing Benefit and Payment Options” section of this resource guide is a great tool to determine whether the MCP, CCS, or Medi-Cal is responsible for authorizing palliative care services for pediatric members. Conversation is ongoing with DHCS to achieve clarity regarding delineation of responsibility between MCPs and CCS.

17. **Are pediatric members required to meet the general eligibility criteria outlined in Section 1.A of APL 18-020 (Palliative Care) or just the pediatric-specific criteria outlined in Section 1.C?**
   Pediatric members do not need to meet the general eligibility criteria outlined in Section 1.A of APL 18-020 or the disease-specific criteria in Section 1.B of the APL. Pediatric members must only meet the pediatric-specific eligibility criteria outlined in Section 1.C of the APL 18-020. Please see the “Member Referral and PPC Eligibility Guidelines” section of this guide for consideration of referral to pediatric home-based palliative care.

**Training and Other**

18. **What training and resources are available on pediatric palliative care for utilization management, care coordination, and other clinical MCP staff?**
   Several national organizations have published thorough pediatric palliative care resources. The Center to Advance Palliative Care (CAPC), the National Hospice and Palliative Care Organization (NHPCO), the End-of-Life Nursing Education Consortium (ELNEC), and the American Association for Hospice and Palliative Medicine (AAHPM) are among the organizations that have published information on what to consider when defining PPC functions on a care team and information about how care is delivered. Please see the resources section at the bottom of this guide for more sources of information.

19. **If an MCP chooses to cover expressive therapies and/or respite care, what guidance is available on how to bill for those services?**
   If an MCP chooses to cover expressive therapies and respite care, the MCP should provide a framework to bill for these services. Each provider should work with that plan to determine the best way to be reimbursed for the services. Codes that existed under the PPC waiver for expressive therapies (e.g., G0176) may still be active in the HCPCS. Please refer to “Developing Benefit and Payment Options” section of this resource guide for more details.
EPSDT

20. What is EPSDT?
EPSDT stands for “Early and Periodic, Screening, Diagnosis, and Treatment.” This benefit is mandated by the federal government to be provided by state Medicaid, or Medi-Cal in California, for eligible children and youth through age 20. EPSDT requires that states provide medically necessary health care services to correct or ameliorate health conditions, even when the service may not be covered in the state’s Medicaid benefit.

21. How does EPSDT apply to pediatric palliative care?
The EPSDT benefit includes shift nursing in the home, which is the most frequent use of this benefit by agencies providing pediatric palliative care. According to the All Plan Letter on EPSDT, 18-007, the benefit also includes case management services meant to assist patients and families in gaining access to necessary medical, social, educational, and other services. These case management services are often available through the MCP, but if appropriate case management services are not already available, the MCP must arrange and pay for them. EPSDT also mandates that the MCP covers non-emergency medical and non-medical transport when necessary for patients to receive medically necessary covered services and when ordered by a qualified clinician. EPSDT may cover art and music therapy for children receiving PPC as part of the Behavioral Health Treatment (BHT) requirement. Please refer to APL 18-006 for eligibility requirements.

22. Does EPSDT cover expressive therapies and respite care?
Art and music therapies may be covered under EPSDT, per APL 18-006. Respite care, child life services, and massage therapy are not covered by EPSDT or Medi-Cal. Coverage of those services is at the discretion of the MCPs and is not available to fee-for-service Medi-Cal beneficiaries. Even though most expressive therapies and respite care are not paid for by the state or covered under the EPSDT benefit, some plans and providers are finding other ways to pay for the services. Health plans may choose to provide the home health or hospice agencies with a per-patient-per-month reimbursement for each pediatric patient receiving palliative care, which could allow the provider to allocate funds to expressive therapies or respite care. Alternatively, some agencies may receive philanthropic funds that allow them to continue providing expressive therapies and/or respite care. Please refer to the guideline for referral to pediatric home-based palliative care on page 9 for more information.

23. Who can answer questions about EPSDT Private Duty Nursing (PDN)?
DHCS has created an email inbox specifically for questions about EPSDT PDN and Pediatric Day Health Care. They can be contacted at epsdt@dhcs.ca.gov.