MyPath PROGRAM GUIDELINES

(A Palliative Care Approach)

A BETTER QUALITY OF LIFE

IEHP

Inland Empire Health Plan

Overview

Palliative care, as defined by the Centers for Medicare and Medicaid Services (CMS), is patient- and family-centered care aimed at improving quality of life by anticipating, preventing and managing suffering. It addresses physical, intellectual, emotional, social, and spiritual needs while supporting patient autonomy, informed decision making and choice. Clinicians often describe palliative care as a comprehensive approach to medicine appropriate for any age and any stage of serious illness — not only end of life care.

In alignment with Senate Bill (SB) 1004, Inland Empire Health Plan (IEHP) offers "MyPath," a palliative care program for Medi-Cal and IEHP DualChoice (HMO D-SNP) members who are eligible for Medicare Parts A and B and full benefit Medi-Cal. While the program follows SB 1004 clinical criteria, its mission reflects the broader CMS definition of palliative care.

MyPath Program Services

Palliative care must include, at a minimum, the following services when medically necessary and reasonable to the palliation or management of a qualifying serious illness:

1. **Advance Care Planning (ACP)** – Documents discussions between a physician or other qualified healthcare professional and a member, family member or legally recognized . decision-maker. Counseling should address advance directives. For appropriate members, Physician Orders for Life-Sustaining Treatment (POLST) forms should include family conflict resolution over issues surrounding the member's decisions. Family members who may wish to supersede the member's goals of care should be identified, supported and reconciled.

2. **Palliative Care Assessment and Consultation** – Collects routine medical data and personal information not regularly included in a medical history. Topics may include, but are not limited to:
   - Treatment plan, including palliative care and chronic disease management
   - Pain and symptom management
   - Medication tolerance and side effects
   - Emotional, social and spiritual concerns
   - Patient goals
   - Advance directive and/or POLST forms
   - Identification of the legal decision maker

3. **Individualized Written Plan of Care** – Engages the member and/or his or her representative(s) in its development. If the member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative consultation or ACP discussion. 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. The plan of care must not include services already provided through another Medi-Cal-funded program.

4. **Pain and Symptom Management** – Provides prescription medications, physical therapy and other medically necessary services to address the member's pain and other symptoms.

For additional resources, visit Palliative Care in Medi-Cal (SB 1004) Resource Center hosted by the California Health Care Foundation (CHCF).

5. **Mental Health and Medical Social Services** – Offers counseling and social services to assist in minimizing the member's stress and psychological problems that arise from a serious illness. Services include, but are not limited to, psychotherapy, bereavement counseling, medical social services, and discharge planning. Particular attention and education are given to the primary caregiver to prevent both unnecessary hospitalizations of the member and unnecessary health harms to the caregiver due to the role of caregiving. Medical social services should not duplicate specialty mental health services provided by the county. The Palliative Care Team works with the member, county and IEHP to coordinate care as needed.

6. **Care Coordination** – Ensures continuous assessment of the member's needs and implementation of the plan of care. The Palliative Care Team regularly communicates plan of care with the member's Primary Care Physician (PCP). This communication occurs at a minimum of weekly intervals. The Palliative Care Team is willing to address the member's immediate needs (e.g., pain and symptom management, DME needs) if the PCP is unavailable, to avoid a delay in care.

7. **Palliative Care Team** – Coordinates care to meet the physical, medical, psychosocial, emotional, and spiritual needs of members and their families. Palliative Care Team members must provide all authorized palliative care. The Team consists of:
   a. Doctor of medicine or osteopathy
   b. Registered nurse, licensed vocational nurse, and/or Nurse Practitioner
   c. Social worker
   d. Chaplain

8. **24/7 Telephonic Palliative Care** – This is the delivery of supportive emotional, medical, and social care management for serious illnesses via regular telephone calls for those members who qualify.

As specified in SB 1004, members who meet the eligibility criteria may access both palliative care and traditional chronic disease management services that are medically necessary. The Palliative Care Team and a plan of care ensure coordination between care services, particularly including the member's PCP. For those whose illness is sufficiently far advanced, the option of electing hospice care remains.

MyPath Program Workflow

The MyPath program workflow consists of a consultation visit that includes an assessment of eligibility for program enrollment when criteria are met as documented on the Certification of Advanced Disease (CAD). The consultation visit does not require prior authorization. Program enrollment requires prior authorization. Consultation visits must occur according to IEHP timeliness access standards.

Consultation visits must occur according to IEHP timeliness access standards.

MyPath CONSULTATION:

- Palliative care assessment by MD/DO/NP
- Advance care planning (POLST, advance directive)
- Complete Certification of Advanced Disease (CAD)

Necessary documentation captures:
California POLST Registry (CPR)
Palliative Care Quality Network (PCQN)

MyPath LOW ACUITY PROGRAM ENROLLMENT:

- Meets criteria on CAD
- Requires recertification every 12 months

MyPath HIGH ACUITY PROGRAM ENROLLMENT:

- Meets criteria on CAD plus high acuity risk factors
- Requires recertification every 12 months

MyPath Program Details

Eligibility Requirements

MyPath is a Medi-Cal benefit. All Medi-Cal beneficiaries are eligible. Also, IEHP provides the benefit for IEHP DualChoice (HMO D-SNP) members (only Direct).

During a program consultation visit, a physician will assess the patient, looking to see if he or she meets program criteria listed on the provider website. On the top right menu at iehp.org, click "Providers" and search "Utilization Management Clinical Criteria." Download the "Table of Contents (PDF)" and "Clinical Care UM Guidelines" for review codes and more.

Certification Process

Members must meet criteria to be eligible for this ongoing in-home program. They will need to be recertified every 12 months.

Program Length

There is no time limit. The program targets members with a prognosis of two years or fewer.

Referral Process

Submit a referral request to IEHP for a MyPath Palliative Care consultation.

Certification of Advanced Disease

Below is one SAMPLE page from the Certification of Advanced Disease (CAD) form.
To access the full form, visit the IEHP website at https://www.iehp.org/en/providers/special-programs?target=mypath

Inland Empire Health Plan

APPENDIX A

Certification of Advanced Disease:

Name: _____

DOB: _____

Member ID: _____

Name of Palliative Care Program: _____

A. General criteria: Check each of the following that apply (**All** needed for eligibility).

- ☐ 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.
- ☐ Patient is in the advanced stage of illness with continued decline in health, and is not eligible or declines hospice.
- ☐ 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.
- ☐ Patient's death within two (2) years would not be unexpected based on clinical status.
- ☐ Patients 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.

B. In addition, one of the following diagnoses must be selected, and associated severity criteria met:

1. **Congestive Heart Failure (CHF)**
   - ☐ Any patient who is hospitalized due to CHF as the primary diagnosis

     OR

   - ☐ NYHA 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:

   - ☐ Ejection Fraction < 30 for systolic failure
   - ☐ Significant comorbidities: 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.

My Path
Appendix A

Palliative Performance Scale

%	Ambulation 1	Activity & Evidence of Disease 2	Self-Care 3	Intake 4	Conscious Level 5
100	Full	Normal Activity, No Evidence of Disease	Full	Normal	Full
90	Full	Normal Activity, Some Evidence of Disease	Full	Normal	Full
80	Full	Normal Activity with Effort, Evidence of Disease	Full	Normal or Reduced	Full
70	Reduced	Unable for Most Activities, Significant Disease	Full	Normal or Reduced	Full
60	Reduced	Unable for Most Activities, Significant Disease	Occasional Assitance	Normal or Reduced	Full
50	Mainly Chair	Minimal Activity, Extensive Disease	Considerable Assitance	Normal or Reduced	Full ± Confusion
40	Mainly Bed	As Above	Mainly Assisted	Normal or Reduced	Full or Drowsy± Confusion
30	Bed Bound	As Above	Total Care	Reduced	Full or Drowsy± Confusion
20	Moribund	As Above	Total Care	Sips	Full or Drowsy± Confusion
10	Moribund	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	0	0	0	0

Functional Assessment Staging Scale

Score	DESCRIPTION
1	No difficulty either subjectively or objectively.
2	- Complains of forgetting location of objects. - Subjective work difficulties.
3	- Decreased job functioning evident to co-workers. - Difficulty in traveling to new locations. - Decreased organization capacity.
4	Decreased ability to perform complex tasks such as: • Planning dinner for guests • Handling personal finances (e.g., forgetting to pay bills) • Difficulty shopping, etc.
5	- Requires assistance in choosing proper clothing to wear for the day, season,or occasion. - Repeatedly, observed wearing the same clothing, unless supervised.
6	- Improperly putting on clothes without assistance or cueing (e.g. shoes on wrong feet, day clothes vs. overnight clothes, difficulty buttoning). - Unable to bathe properly (e.g., difficulty adjusting bath water temperature). - Unable to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or does not properly dispose of toilet tissue). - Urinary incontinence (intermittent or constant). - Fecal incontinence (intermittent or constant).
7	- Limited ability to speak ± 6 intelligible words in an average day or interview. - Speech ability is limited to the use of a single intelligible word in a normal interaction; demonstrates repetitive actions. - Ambulatory ability is lost (cannot walk without personal assistance). - Cannot sit up without assistance. - Individual falls over if no lateral arm rests on chair. - Loss of ability to smile. - Loss of ability to hold up head independently.

Tier Description

	LOW ACUITY	HIGH ACUITY
CRITERIA	Meets MyPath program criteria **Participation requires recertification/authorization every 12 months**	Meets MyPath program criteria AND **ANY** of the following: • ACG score = CCM level and PHU > 50%[1] • More than two inpatient admissions in the past three months[2] • More than three ER visits in the past three months • Palliative Performance Scale (PPSv2) 50% or less • Presence of co-morbid uncontrolled significant mental health disorder (e.g., Bipolar, Schizophrenia) and marked with poor functionality (GAF <=50) • Homeless • Active alcohol and/or drug abuse **Participation requires recertification/authorization every 12 months**
SERVICES	• Initial visit by MD/DO/NP • Follow-up visit by NP/RN as needed • Minimum two visits per month by licensed nurse (or every 14 days) • Social worker and spiritual counselor visit once a month as needed • Minimum of two outbound calls per week • Access to 24-hour nursing on call and triage services to include escalation to provider home visit	• Initial visit by MD/DO/NP • Follow-up visit by MD/DO/NP as needed • **Minimum one visit per week by licensed nurse** • Social worker and spiritual counselor visit once a month as needed • **Visits by HHA two times per week or as needed** • Access to 24-hour nursing on call and triage services to include escalation to provider home visit • **For specialty mental health needs, assist with referral and coordination of care with county mental health services**

[1]CCM = Complex Case Management High Risk ACG Population Health Score

[2]PHU = Probability of High Utilizer ACG Risk Score

Program Evaluation

The MyPath program is evaluated on patient outcomes, utilization, program engagement, and cost.

Patient Outcomes

1. Improved quality-of-life scores, better clinical outcomes, and a noticeable reduction in pain and symptoms
2. High rates of completion of advance care planning documentation (POLST, advance directives)

Utilization Analysis

1. Decrease Inpatient Admissions and Emergency Department and urgent care (UC) visits.
2. Increase primary care provider (PCP) visits

Program Engagement

1. Low percentage of members enrolled in the program who then disenrolled because they refused service
2. High percentage of members who authorized MyPath consultation and received services within 15 days
3. Positive provider and member experience

Cost

1. Overall decrease in total cost of care for members when comparing pre-program and post-program enrollment

References:

1. Coalition for Compassionate Care of California, California Advanced Illness Collaborative, Community-Based Palliative Care Consensus Standards for California https://coalitionccc.org/CCCC/CCCC/Our-Work/Palliative-Care-Update.aspx.

2. Department of Health Care Services, Draft All Plan Letter, Palliative Care and Medi-Cal Managed Care, released 12/7/2018.

3. Hoefer, D, Transitions Guidelines Chronic Illness Management, Transitions Program - Sharp HealthCare, 2020.

4. Vitas Healthcare, Hospice Eligibility Reference Guidelines for End-Stage Renal Disease (ESRD), https://www.vitas.com/partners/hospice-eligibility-reference-guide/renal-disease.

5. AAHIVM Fundamentals of HIV Medicine, 2025 edition: https://aahivm.org/fundamentals-of-hiv-medicine/.

6. A Clinical Guide to Supportive and Palliative Care for HIV/AIDS Chapter 23. Medical Care in Advanced AIDS. https://www.thebodypro.com/article/clinical-guide-supportive-palliative-care-hiv-aids-chapter-23-med.

7. Arbor Hospice, HIV Disease, https://www.thebodypro.com/article/clinical-guide-supportive-palliative-care-hiv-aids-chapter-23-med.

Evaluation of Potential Interested Partners for Palliative Services

Proposals are requested that address the following questions:

1. **Detail of infrastructure to support the provision of palliative care services for IEHP members. This should include:**
   a. Number and type of provider make-up of organization including palliative physician support, physician extender support, nursing support, mental health providers and chaplain support
      i. Clinical staff trained in palliative care: minimum training is the Cal State San MarcosInstitute for Palliative Care Training Curriculum, or equivalent, which must be completed by staff members no later than three months after beginning Home-Based Palliative Program. Medical Director must be board certified in Hospice & Palliative Medicine
   b. Geographical coverage area
   c. Estimation of member capacity for palliative care services

2. **Joint Commission Accreditation Status**

3. **Organization's experience serving the Medi-Cal population**
   a. Capacity to bill IEHP

4. **Two letters of support from major expected referral sources (hospitals, health centers, at least one oncologist, at least one other specialist from this group: gastroenterology hepatology, pulmonology, cardiology)**

5. **If the palliative organization is not an IEHP-contracted agency for hospice services, the palliative provider must refer members to an IEHP-contracted hospice agency for patients who require hospice level of care.**

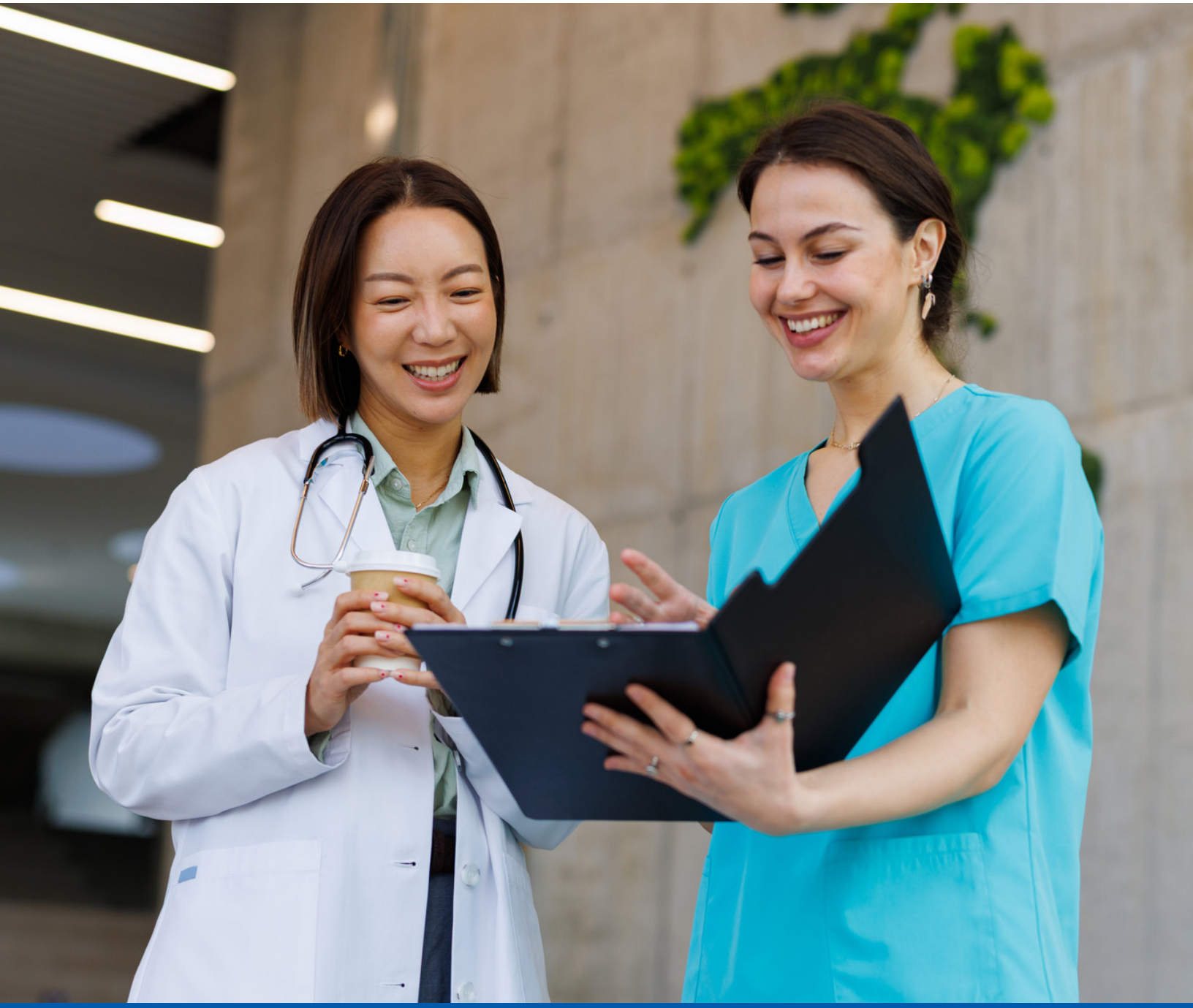
6. **Potential ability to collect and submit data using the Palliative Care Quality Network system (PCQN) which is provided to contracted providers by IEHP. A provider is required to enter into a Data Sharing Agreement in order to submit data through the PCQN system.**

7. **Access points for provision of palliative services (e.g., home-based, SNF, LTAC, CBAS, inpatient, etc.)**

8. Organizational approach to meet IEHP's Core Program Elements as listed above and include details of how a palliative care provider will collaborate with member's PCP in overall treatment plan.

9. Organizational support to provide program-specific metrics and share with IEHP on a quarterly basis.

10. Contract proposal (e.g., fee for service with detail of service codes, case rate, shared risk model, etc.)



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IEHP PROVIDER RELATIONS

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