



State of California—Health and Human Services Agency
Department of Health Care Services



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Governor

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MMCD All Plan Letter 07014
Supersedes APL 05003

TO: All Medi-Cal Managed Care Health Plans

SUBJECT: Hospice Services and Medi-Cal Managed Care

PURPOSE

The purpose of this All-Plan Letter (APL) is to summarize contractual, regulatory and statutory requirements applicable to Medi-Cal managed care plans with respect to their responsibilities to provide hospice care services for its members. This APL updates and supersedes APL 05003.

BACKGROUND

Hospice care services as specified in Title 22 California Code of Regulations (CCR) Section 51349 are covered under health plan contracts and do not affect members' eligibility for enrollment in plans. Health and Safety Code §1368.2 requires hospice care services provided in California by licensed health care service plans shall at a minimum be equivalent to the hospice benefits provided under the Medicare program, as defined in Section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

DISCUSSION

I. General

Under existing contract requirements, all Medi-Cal managed care plans (plans) are required to provide hospice care services. Members who qualify for and elect hospice care services remain enrolled in plans while receiving such services. To avoid problems caused by late referrals, a plan's written policies and procedures should clarify how Members may access hospice care services in a timely manner, preferably within 24 hours of the request. The only requirement for initiation of outpatient hospice care services is a physician's certification that a member has a terminal illness and a Member's "election" of such services.

II. Certification of Terminal Illness

Terminally ill as defined in Title 22 CCR §51180.2 means that an individual's medical prognosis as certified by a physician, results in a life expectancy of six months or less. Health and Safety Code §1746(7)(i) expands that definition for all licensed health care service plans to include "a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course." 42 Code of Federal Regulations (CFR) §418.22(b) requires that the physician certification contain the qualifying clause: "if the terminal illness runs its normal course." Pursuant to contractual requirements, plans may not deny hospice care services to members certified as terminally ill.

III. Member "Election" of Hospice Care Services and Revocation Rights

A. Election of Hospice Care Services

Plan procedures shall facilitate member "election" of hospice care services. Pursuant to Title 22 CCR §51349(d), the member's "election" of hospice care services shall include the following on an appropriate hospice election form:

1. The identification of the hospice;
2. The patient's or representative's acknowledgement that:
 - a. He or she has full understanding that the hospice care services to be given as it relates to the individual's terminal illness will be palliative rather than curative in nature. Palliative care as defined in Health and Safety Code §1339.31(b) means interventions that focus primarily on reduction or abatement of pain and other disease-related symptoms, rather than interventions aimed at investigation and/or interventions for the purpose of cure or prolongation of life;
 - b. Certain specified Medi-Cal benefits are waived by the election;
3. The effective date of the election; and
4. The signature of the individual or representative.

Effective January 1, 2002, and as stated in Social Security Act §1812(d)(1), the election period shall consist of two periods of 90 days each and an unlimited number of subsequent periods of 60 days each during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care services that are provided by, or pursuant to arrangements made by, a particular hospice program, rather receive certain other benefits.

Title 22 CCR, Section 51250(c) states that, "a hospice shall not discontinue or diminish care provided to a Medi-Cal beneficiary based on expiration of the beneficiary's final election period."

B. Hospice Services

Upon member election of hospice care services, the plan will ensure provision of and payment for services (listed below) provided by a hospice provider as defined in either Title 22 §51180, §51349, or in §1861(dd)(1) of the Social Security Act or by other providers under arrangements made by a hospice provider. Plans may require that the member use a plan-contracted hospice provider. Pursuant to Title 22 §51180, §51349, and §1861 (dd)(1) of the Social Security Act, hospice care services include, but are not limited to, the following:

1. Nursing services;
2. Physical, occupational, or speech-language pathology;
3. Medical social services under the direction of a physician;
4. Home health aide and homemaker services;
5. Medical supplies and appliances;
6. Drugs and biologicals;
7. Physician services (see below);
8. Counseling services related to the adjustment of the member's approaching death; Counseling, including bereavement, grief, dietary and spiritual counseling;
9. Continuous nursing services may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill member at home. 42 CFR §418.204 defines a crisis as the period in which the member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms. Section 230.3 of the Medicare Hospice Manual and CMS Transmittal A-03-016 states that the care provided requires a minimum of eight hours of primarily nursing care within a 24-hour period commencing at midnight and terminating on the following midnight. The eight hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required;
10. Respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time;
11. Short-term inpatient care for pain control or chronic symptom management which cannot be managed in the home setting; and

12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

Physician services include (1) general supervisory services of the hospice medical director and (2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice interdisciplinary team (42 CFR §418.304 and Title 22 CCR §51544). Physician services not described above shall be billed to the plan separately and includes services of the members attending physician or a consulting physician(s), if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Physician visits by a hospice employed physician, medical director, or consultant are billable separately if not directly related to hospice services.

Plans should be aware that the Medi-Cal program payment for hospice care services is based upon the level of care provided so that hospice providers may group the above services into the following categories:

1. Routine home care;
2. Continuous home care requiring a minimum of eight hours of care per 24-hour period;
3. Respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time; and
4. General inpatient care for pain and symptom control or chronic symptom management which cannot be managed in the patient's residence.

C. Revocation of Hospice Care Services

An individual's voluntary election may be revoked or modified at any time during an election period. To revoke the election of hospice care, the individual or individual'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. At any time after revocation, an individual may execute a new election for any remaining election period. An individual or representative may change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit (42 CFR §418.28 and §418.30).

D. Special Considerations in Hospice Election

1. In the event that a member wishes to elect a hospice that is not contracted with the plan, DHCS encourages plans to consider the case of each member individually when such a choice is made.

The plan has the option of immediately initiating a contract (one time or ongoing) with the hospice provider or referring the patient to a plan contractor for hospice care.

On occasion, enrollees receiving hospice at the time they become plan members may not be able to change their hospice provider even if requested due to limitations on the number of times there may be a change in the designation of a hospice provider during an election period; or the plan may determine that such a change would be disruptive to the enrollee's care or would not for some other reason be in the patient's best interest. In such instances, the plan should consider a one time or ongoing contract with the established hospice provider until the new election period, or until the end of hospice services.

2. Hospice care services may be initiated or continued in a home or clinical setting. Plans remain responsible for the provision of and payment for all medically necessary services not related to the terminal illness, including those of the member's primary care physician.
3. Members who move their legal residence out of the service area must disenroll from the plan. Consequently, upon enrollment in a new plan, a "change in designated hospice" must be initiated (42 CFR §418.30). This may be done only once per election period.
4. Hospice care providers shall provide transferring members with a transfer summary including essential information relative to the patient's diagnosis, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, which shall be signed by the physician (Health and Safety Code §1262.5).

IV. Transition to Hospice Services

A. General

Plans should instruct staff, network providers, and other programs and non-network providers of the importance of timely recognition of a member's eligibility

for hospice care services and their election of hospice care services. Once a member has elected hospice care services, plan network providers and case management staff shall work closely with hospice care providers to facilitate the transfer of member services from those directed towards cure and/or prolongation of life to those directed towards palliation. Ongoing care coordination shall be 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 (42 CFR §438.208).

B. Hospice Care Services for Children Served by California Children Services (CCS) for the Terminal Condition

End of life care for children with a life threatening condition may be substantially different than that for adults. Hospice care options for children do not fit the traditional adult hospice model. Children can and often do live longer with a life threatening condition because of aggressive treatment and their natural resilience. Rather than receiving hospice care services, children and families may benefit from receiving palliative care services earlier in the course of a child's illness.

For additional information on this subject, please see the attached CCS Numbered Letter (N.L.): 04-0207 regarding palliative/hospice options for CCS eligible children. This N.L. can be found on CCS's website at: <http://www.dhs.ca.gov/PCFH/cms/onlinearchive/pdf/ccs/numberedletters/2007/ccsnl040207.pdf>.

Plans should contact CCS directly at (916) 327-1400 with questions regarding palliative/hospice services for eligible children and shall work with CCS to facilitate continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible. Transition to hospice care, if elected, for children with terminal diseases requires close consultation and coordination between the plan, the local CCS program (when applicable), and/or other caregivers to facilitate the transfer. Hospice counseling services (including grief, bereavement and spiritual) may be necessary during this transition.

C. Provision of Hospice Services by Hospice Group

Due to the highly specialized services provided by hospices, federal law mandates that the hospice provider designate an interdisciplinary group(s) to plan, provide and/or supervise the care and services offered by the hospice provider. A written plan of care must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to

providing care. The plan is then reviewed and updated at intervals specified in the plan of care by the attending physician, the medical director or physician designee and interdisciplinary group of the hospice (42 CFR §418.58 and §418.68).

Plans shall assure coordination of care between plan and hospice care providers and allow for the hospice interdisciplinary team to professionally manage the care of the patient as outlined in the law.

V. Reimbursement Issues

A. Hospice Services

Of the four levels of hospice care as described in Title 22 CCR §51349, only general inpatient care is subject to prior authorization. Documents to be submitted for prior authorization include:

- Written prescription signed by the patient's attending physician;
- Patient's Hospice Election form;
- Certification of terminal illness by a physician; and
- A Hospice General Inpatient Information Sheet (DHS 6194).

Prior authorization is not a Med-Cal requirement for routine home care, continuous home care or respite care. However, when the hospice is billing for continuous home care and respite home care, medical justification must be entered on the claim in a remarks area. If medical justification is not included or is inadequate, reimbursement will be reduced to the rate for routine home care. An appeal may be submitted for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care.

B. Long Term Care

Pursuant to the contract, hospice care services are covered services and are not categorized as long term care services regardless of the member's expected or actual length of stay in a nursing facility while also receiving hospice care. Section 1905(o)(1)(A) of the Social Security Act allows for the provision of hospice care while an individual is a resident of a skilled nursing facility or intermediate care facility. Payment from the plan will be provided to the hospice provider for hospice care (at the appropriate level of care). Payment for the room and board component must be equal to at least 95 percent of the reimbursement the Nursing Facility/Skilled Nursing Facility (NF/SNF) would

have been reimbursed by Medi-Cal or the health plan. The hospice shall, in turn, reimburse the nursing facility for the room and board while retaining the hospice care portion. Payments by a hospice provider to a nursing home for room and board shall not exceed what would have been received directly from Medi-Cal or the plan if the patient had not been enrolled in a hospice.

C. Dually Eligible Medicare/Medi-Cal

For members with both Medicare and Medi-Cal coverage (dual eligibles), the hospice bills Medicare for the hospice services. Following payment from Medicare, the hospice bills the plan for the co-payment amount; the total reimbursed amount must not exceed the Medicare rate (Title 22 CCR §51544).

No prior authorization is necessary for the hospice to bill the plan for the room and board covered by Medi-Cal while the patient is receiving hospice care services under Medicare.

The hospice provider shall notify the plan when a plan member residing in a nursing home paid by Medi-Cal elects the Medicare Hospice Benefit. The plan will then pay the room and board payment to the hospice provider according to the rate outlined above, and the hospice shall be responsible for paying the nursing home. Eligibility for the Medi-Cal nursing home room & board payment continues to be determined by the nursing home and the plan.

D. Hospice Rates

The Medicaid hospice rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by §1814(i)(1)(C)(ii) of the Social Security Act, which also provides for an annual increase in payment rates for hospice care services. Plans must update their rates annually to coincide with changes to the Medicare rates.

Plans may pay more, but not less than, the Medicare rate for hospice services (§1902(a)(13)(B) of the Social Security Act). Hospice physician services are not increased under this provision. The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register.

E. Utilization Review

Plans may not restrict access to hospice care services any more than the fee-for-service program may restrict the same services furnished to beneficiaries (42 CFR §438.210(a)). The Fee-for-Service program does not require prior

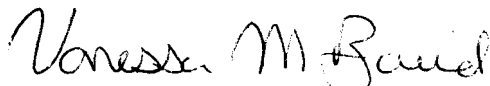
authorization of hospice services except for inpatient admissions; therefore plans shall adjust their utilization review standards, if necessary, to meet those of the fee-for-service program.

F. Services not Covered by Hospice Provider

- Room and board;
- Acute in-patient hospitalization;
- Level A or Level B nursing facility beyond the respite care limits; and
- Physician and/or consulting physician services are not considered Hospice, and the physician is not an employee of the hospice or providing services under an arrangement with the Hospice.

If you have any comments or questions regarding this letter, please contact your contract manager.

Sincerely,



Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division