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

California Department of Health Services
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MMCD All Plan Letter 05003

TO: [X] County Organized Health Systems Plans (COHS)
[X] Geographic Managed Care (GMC) Plans
[X] Prepaid Health Plans (PHP)
[X] Primary Care Case Management (PCCM) Plans
[X] Two-Plan Model Plans

FROM: Luis R. Rico, Acting Chief
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SUBJECT: Hospice Services and Medi-Cal Managed Care

PURPOSE

The purpose of this All-Plan letter is to summarize contractual, regulatory and statutory requirements applicable to Medi-Cal managed care plans with respect to their responsibilities to provide hospice services to members in light of new regulatory requirements.

BACKGROUND

Hospice services are covered under plan contracts and, as specified in Title 22, CCR, Section 51349, do not affect members' eligibility for enrollment in plans. Health and Safety Code §1368.2 requires hospice care 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 1812 of the Social Security Act [42 U.S.C. 1395d] (the Act).

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DISCUSSION

I. General

Under existing contract requirements, all Med-Cal managed care plans (plans) are required to provide hospice services. Members who qualify for and elect hospice services remain enrolled in plans while receiving hospice services. Plan written policies and procedures shall clarify how to access hospice services in a timely manner. The only requirement for initiation of outpatient hospice services is physician certification that a member has a terminal illness and member "election" of such services.

Of the four levels of hospice care as described in Title 22 CCR §51349, only general inpatient care is subject to prior authorization if all other requirements regarding prior authorization and associated clinical guidelines have been met. When prior authorization for any level of hospice care is to be required, plans shall respond within 24 hours.

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 §1368.2 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 CFR §418.22(b) requires that the physician certification contain the qualifying clause, "if the terminal illness runs its normal course."

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

A. Election of Hospice

Plan procedures shall facilitate member "election" of hospice. Pursuant to Title 22, CCR §51349(d), the member's "election" of hospice 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 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 intervention 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, the election period shall consist of two periods of 90 days each and an unlimited number of subsequent periods of 60 days each (§1812 of the Act).

B. Hospice Services

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

1. Nursing services;
2. Physical, occupational, or speech-therapy;
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. Dietary/nutrition counseling;
9. Counseling, including bereavement, grief and spiritual counseling;
10. 42 CFR §418.204 provides for continuous home nursing care for as much as 24 hours a day during a period of crisis, and only as necessary to maintain the patient at home. Section 230.3 of the Medicare Hospice Manual and CMS Transmittal A-03-016 allows for the provision of continuous home care for a minimum of 8 hours of care (aggregate) during a 24-hour day, which begins and ends at midnight;
11. Respite care provided on an intermittent, non-routine and occasional basis for up to five days at a time;
12. Short-term inpatient care for pain control or chronic symptom management which cannot be managed in the home setting; and
13. Any other item or service for which payment may otherwise be made under the Medi-Cal program.

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). Visits made

to a hospice patient by the hospice Medical Director, hospice physician, or consultant, shall be billed to the plan separately by the hospice.

Transition to hospice, if elected, for children or adults with terminal diseases requires close consultation between the plan, the local CCS program (when applicable), and/or other caregivers to facilitate the transfer to palliative care. Hospice counseling services (including grief, bereavement and spiritual) may be necessary during this transition.

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

> (1) Routine home care; (2) continuous home care at 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 days at a time; and (4) general inpatient care for pain control or chronic symptom management which cannot be managed in the patient's residence.

If a plan chooses to negotiate reimbursement of hospice services either individually or differently bundled, the resulting services must still comply with the federal standard, articulated at 42 CFR §438.210(a)(2), that requires the amount, duration and scope of a particular service or bundle of services provided by the plan to be no less the amount, duration and scope of service that would be provided under the FFS methodology.

C. Revocation of Hospice

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 representative must file a signed statement with the plan and 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, DHS 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 if requested, due to limitations during an election period. In such instances, the plan should consider a one time or ongoing contract with the established hospice provider until the enrollee can be transitioned to a contracting hospice provider during a new election period.

2. Hospice 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 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 and network providers, and other programs and non-network providers of the importance of timely recognition of a member's eligibility for hospice and their election of hospice. Once a member has elected hospice, 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 Services for Children Served by California Children Services (CCS) for the Terminal Condition

Care provided by California Children's Services (CCS) is normally carved out of plan contracts. CCS services are designed to be curative in nature and to prolong life, while hospice services are palliative in nature. As a

consequence, CCS does not offer the range of services provided through hospice for the terminally ill child. Members and their families shall be clearly advised of the differences between CCS and hospice services and of the potential change in caregivers, should hospice be elected. As is the case for all plan members hospice services for CCS recipients are the responsibility of the plan and all hospice policies are applicable.

C. Provision of Hospice Services By Hospice Group

Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group(s) to provide or supervise the care and services offered by the hospice. 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 that coordination of care and joint case management occurs between plan and hospice care providers.

V. Reimbursement Issues

A. Long Term Care

Pursuant to the contract, hospice 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 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 for hospice care (at the appropriate level of care) at a minimum of 95% of the room and board reimbursement the NF/SNF would have normally 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 portion. Payments by a hospice 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.

B. Medicare

For members with both Medicare and Medi-Cal coverage (dual eligibles), the hospice bills Medicare first. 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).

C. Calculation of 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 Act, which also provides for an annual increase in payment rates for hospice care services. 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

D. Rate Negotiations by Plans

Federal rate methodology, (provided in A and B of Section V. Reimbursement Issues, of this letter), should be considered when reimbursement rates between plans and hospices are negotiated.

E. Utilization Review

Plans may not restrict access to hospice services any more than they may restrict the same services furnished to beneficiaries under the fee-for-service program (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 accordingly.

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