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EDMUND G. BROWN JR.
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DATE: OCTOBER 28, 2013

ALL PLAN LETTER 13-014
SUPERSEDES ALL PLAN LETTER 07-014

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 highlight certain contractual, regulatory, and statutory requirements applicable to Medi-Cal managed care health plans (MCPs) with respect to their responsibilities to provide hospice services to MCP members. This APL supersedes 07-014.

BACKGROUND:

Hospice services, as specified in Title 22, California Code of Regulations (CCR), Section 51349, are covered under MCP contracts and do not affect a member's eligibility for enrollment in a MCP. Health and Safety (H&S) Code, Section 1368.2 requires hospice care provided in California by licensed health care service plans to be at least equivalent to the hospice benefits provided under the Medicare program, as defined in the Social Security Act (SSA), Section 1861(dd) (42 United States Code 1395x).

REQUIREMENTS:

I. General

Under existing contract requirements, MCPs are required to provide hospice services. Members who qualify for and elect hospice care services remain enrolled in a MCP while receiving such services. To avoid problems caused by late referrals, MCP-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 the initiation of outpatient hospice services is a physician's certification that a member has a terminal illness and the member's "election" of such services.

II. Certification of Terminal Illness

Title 22, CCR, Section 51349 requires that Medi-Cal implement the certification procedure for hospice as it is set forth in Medicare, Title 42, Code of Federal Regulations (CFR), Part 418, Subpart B. A hospice must obtain written certification of terminal illness for each hospice benefit period. "Terminally ill," as defined in Title 42, CFR, Section 418.3, means that an individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. Section 418.22(b) requires that the physician certification contain the qualifying clause: "the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course." Pursuant to contractual requirements, MCPs may not deny hospice care to beneficiaries certified as terminally ill.

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

A. Election of Hospice Care Services

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

- 1) The identification of the hospice.
- 2) The patient's or representative's acknowledgement that:
 - 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 H&S Code, Section 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.
 - Certain specified Medi-Cal benefits are waived by the election.
- 3) The effective date of the election.
- 4) The signature of the individual or representative.

As stated in Section 1812(d)(1) of the SSA and Title 42, CFR, Section 418.21, an individual may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.

B. Hospice Services

Upon member election of hospice services, MCPs will ensure provision of, and payment for, hospice care services (listed below) provided by a hospice provider (as defined in Title 22, CCR, Sections 51180 and 51349, or Section 1861(dd)(1) of the SSA). MCPs may require that the member use a MCP-contracted hospice. Pursuant to Title 22, CCR, Sections 51180 and 51349, and Section 1861 (dd)(1) of the SSA, 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 biological.
- 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. Title 42, CFR, Section 418.204 defines a crisis as the period in which a 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 Centers for Medicare & Medicaid Services (CMS) Transmittal A-03-016 states that care provided requires a minimum of eight hours of nursing care, a minimum of 51 percent of time must be by a licensed nurse, within a 24-hour period commencing at midnight and terminating on the following midnight. Nursing care includes either homemaker or home health aide services. The eight hours of care does not need to be continuous within the 24-hour period, but an aggregate of eight hours of primarily nursing care is required.
- 10) Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing or hospice facility.
- 11) Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility.
- 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 of the hospice interdisciplinary team (Title 42, CFR, Section 418.304 and Title 22, CCR, Section 51544). Physician services not described above shall be billed to the MCP separately and include services of the member's attending physician or 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 to the MCP.

MCPs should be aware that the Medi-Cal program payment for hospice services is based upon the level of care provided so that hospice providers may group the above services into the following at an amount outlined in the fee-for-service (FFS) Manual. The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare. These rates are authorized by Section 1814(i)(1)(C)(ii) of the SSA, which also provides for an annual increase in payment rates for hospice care services. MCPs must update their rates annually to coincide with changes to the Medicare rates.

MCPs may pay more, but not less than, the Medicare rate for hospice services (Section 1902(a)(13)(B) of the SSA). The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register:

- 1) Routine home care, Healthcare Common Procedure Coding System (HCPCS) code Z7100.
- 2) Continuous home care requiring a minimum of eight hours of care per 24-hour period, HCPCS code Z7102.
- 3) Respite care provided on an intermittent, non-routine, and occasional basis for up to five consecutive days at a time, HCPCS code Z7104.
- 4) General Inpatient care for pain and symptom control, HCPCS code Z7106.
- 5) Physician services, HCPCS Z7108.

C. Revocation of Hospice

A member's voluntary election may be revoked or modified at any time during an election period. To revoke the election of hospice care, the member or member'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, a member may execute a new election, thus restarting the 90/90/unlimited 60-day certification periods of care. An individual or representative may change the designation of a hospice provider once each benefit period. This change is not a revocation of the hospice benefit (Title 42, CFR, Sections 418.28 and 418.30).

If a member revokes the hospice benefit, or is discharged by the hospice for cause and later elects hospice and is readmitted to the same or different hospice provider, then the 90/90/unlimited 60-day election periods are initiated as if hospice is starting anew. A member's change from one designated hospice to another is not considered a revocation of the hospice election.

D. Special Considerations in Hospice Election

- 1) In the event that a member wishes to elect a hospice that is not contracted with the MCP, The Department of Health Care Services (DHCS) encourages MCPs to consider the case of each member individually when such a choice is made. The MCP has the option of immediately initiating a contract (one-time or ongoing) with the hospice provider or referring the patient to a MCP contractor for hospice care. On occasion, members receiving hospice at the time they become MCP members may not be able to change their hospice provider, 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. In addition, the MCP may determine that such a change would be disruptive to the member's care or would not for some other reason be in the patient's best interest. In such instances, the MCP should consider a one-time or ongoing contract with the established hospice provider until the new benefit period, or until the end of hospice services.
- 2) Hospice care services may be initiated or continued in a home or clinical setting. MCPs remain responsible for the provision of, and payment for, all Medi-Cal covered 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 MCP.
- 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 requirements, rehabilitation potential, known allergies, and treatment plan, which shall be signed by the physician (H&S Code, Section 1262.5). Consequently, upon enrollment in a new MCP, a "change in designated hospice" must be initiated (Title 42 CFR, Section 418.30). This may be done

only once per election period.

IV. Transition to Hospice Services

A. General

MCPs 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, MCP 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 (Title 42, CFR, Section 438.208).

B. Services for Children Served by California Children Services (CCS) for Life Limiting Condition

End of life care for children with a life threatening condition may be substantially different than it is 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.

Children and families may benefit from receiving palliative care services earlier in the course of a child's illness. In addition to hospice care services, a waiver program is available to children and families who may benefit from receiving palliative care services earlier in the course of a child's illness.

For additional information on this subject, please see CCS Numbered Letter (NL): 04-0207 regarding palliative/hospice options for CCS eligible children. This NL can be found on CCS's website at:

<http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl040207.pdf>

Policy guidelines and procedural direction on authorization of medically necessary services related to the child's CCS life-limiting condition for children who have elected hospice care can be found at:

<http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf>

MCPs 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. Hospice care, if elected, for children with terminal diseases, requires close consultation and coordination between the MCP, the local CCS program (when applicable), and/or other caregivers. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition.

C. Concurrent Hospice Palliative and Curative Care for Children

Under Section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, Medicaid children who have elected to receive hospice services may continue receiving coverage of any payment for other services to treat their terminal illness. Additional information on concurrent care for children can be found at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-004.pdf>

Medi-Cal's Pediatric Palliative Care Benefit (the Benefit) is designed to assess and demonstrate the advantage of providing community-based palliative care concurrent with life-prolonging therapies. The Benefit contains two primary components:

- 1) The first component is Partners for Children, a federal waiver, which suspends hospice eligibility requirements for children with certain life-limiting medical conditions and adds additional pediatric specific services not available under the state plan. This waiver was piloted in 13 California counties. DHCS has received CMS approval to extend this waiver until March 31, 2017. Additional information on the waiver, Partners for Children, can be found at:

<http://www.dhcs.ca.gov/services/ppc/Pages/ProgramOverview.aspx>.

- 2) The second component is palliative care. CCS NL 04-0207 defines the principles of palliative care, identifies palliative care services currently available under the state plan, and provides guidelines for timely authorization and payment for these services. This NL can be found at:
<http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl040207.pdf>

D. Provision of Hospice Services by Hospice Interdisciplinary Group

Due to the highly specialized services provided by hospices, federal law mandates that the hospice 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 the interdisciplinary group prior to providing care. The plan of care 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 (Title 42, CFR, Section 418.56.)

MCPs shall assure coordination of care between MCP 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, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:

- 1) Certification of physician orders for general inpatient care.
- 2) Justification for this level of care.

MCPs may not require prior authorization for routine home care, continuous home care and respite care or hospice physician services. Hospices shall notify the MCP of general inpatient care placement that occurs after normal business hours on the next business day. A MCP may require documentation following the provision of general inpatient and continuous care for reasons of justification. If the documentation does not support these levels of care, or if the documentation included is inadequate, reimbursement may 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 (LTC)

Pursuant to the contract, hospice services are covered services and are not categorized as LTC services regardless of the member's expected or actual length of stay in a nursing facility (NF) while also receiving hospice care. MCPs shall not require authorization for room and board as described in Title 42, CFR, 418.112 and Section 1902(a)(13)(B) of the SSA.

Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a skilled nursing facility (SNF) or intermediate care facility. Payment from the MCP will be provided to the hospice for hospice care (at the appropriate level of care).

In accordance with the Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Rev. 156, 06-01-12) 20.3 - Election by Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries (Rev. 1, 10-01-03) HO-204.2, payment for room and board shall be made directly to the hospice. The hospice shall then reimburse the NF for the room and board at the rate negotiated between the hospice and SNF. Payment for the room and board component must be equal to at least 95 percent of the reimbursement the NF/SNF would have been reimbursed by Medi-Cal or the MCP, less the member's share of cost, if applicable. 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 MCP if the patient had not been enrolled in a hospice.

LTC residents who elect the Medi-Cal hospice benefit are not disenrolled from the MCP. Hospices will bill the MCPs using the following revenue codes:

- 1) Revenue code 658-Facility Code Type 25.
- 2) Revenue code 658-Facility Code Type 26.

C. Dually Eligible Medicare/Medi-Cal

For beneficiaries with both Medicare and Medi-Cal coverage (dual-eligibles), the hospice bills Medicare for the hospice services. The room and board charge is billed to Medi-Cal only. Following payment from Medicare, the hospice then bills the MCP for the co-payment amount; however, the total reimbursed amount

cannot exceed the Medicare rate (Title 22, CCR, Section 51544). For Medicare beneficiaries entitled to only Medicare Part B, benefits will be billed directly to the MCP. No Medicare denial will be required.

MCPs cannot require authorization for the hospice to bill the MCP for the room and board covered by Medi-Cal while the patient is receiving hospice services under Medicare.

The hospice shall notify the MCP when a member elects the Medicare hospice benefit. The MCP 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 and board payment continues to be determined by the nursing home and the MCP. The nursing home continues to remain responsible to collect the LTC share of cost, if applicable.

For beneficiaries enrolled in the Coordinated Care Initiate Demonstration Project (www.calduals.org), referred to as Cal MediConnect, DHCS will implement specific billing, claims, and payment procedures if hospice becomes part of Cal MediConnect. Currently, the benefit is covered by Medicare.

D. Hospice Rates

The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare. These rates are authorized by Section 1814(i)(1)(C)(ii) of the SSA, which also provides for an annual increase in payment rates for hospice care services. MCPs must update their rates annually to coincide with changes to the Medicare rates.

MCPs may pay more, but not less than, the Medicare rate for hospice services (Section 1902(a)(13)(B) of the SSA). The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register.

Inpatient rates (general or respite) shall be paid for the date of admission and all subsequent inpatient days except the day on which a patient is discharged. For the day of discharge, the appropriate home care rate shall be paid unless the patient dies as an inpatient. If the patient dies while an inpatient, the inpatient rate (general or respite) shall be paid for the discharge day.

E. Physician Services

Hospice providers must use HCPCS code Z7108 when billing for physician services for pain and symptom management related to a patient's terminal condition and provided by a physician employed by, or under arrangements made by, the hospice. MCPs are required to reimburse code Z7108 which is limited to one visit-per-day, per-patient.

Consulting/special physician services code Z7108 may be billed only for physician services to manage symptoms that cannot be remedied by the patient's attending physician because of one of the following:

- 1) Immediate need.
- 2) The attending physician does not have the required special skills.

F. Utilization Review

MCPs may not restrict access to hospice care services any more than the FFS program may restrict the same services (Title 42 CFR, §438.210(a)). The FFS program does not require prior authorization of hospice services except for inpatient admissions; therefore, MCPs shall adjust their utilization review standards, if necessary, to meet those of the FFS program.

Per Chapter 9 of the Medicare Claims Processing Manual, Medicare Hospice Benefit Section 40.1.5 - Short-Term Inpatient Care, general inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting. General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit.

For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care, general inpatient care is appropriate. Other examples of appropriate general inpatient care include a patient in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring, or a patient whose family is unwilling to permit needed care to be furnished in the home.

G. Services not Covered by Hospice Provider

- 1) Private pay room and board or residential care.
- 2) Acute in-patient hospitalization unrelated to the terminal illness.
- 3) Level A or Level B NF for unrelated issues.
- 4) Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
- 5) Other necessary services for conditions unrelated to the terminal illness.

If you have any comments or questions regarding this letter, please contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar, Assistant Deputy Director
Health Care Delivery Systems