PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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I. RELATED POLICIES:

A. Health Services Policy MCUP3020 – Hospice Services

II. IMPACTED DEPTS:

A. Claims
B. Health Services

III. DEFINITIONS:

A. Hospice Care: A medical multidisciplinary care designed to meet the unique needs of terminally ill individuals. Hospice care is used to alleviate pain and suffering and treat symptoms rather than cure illness. Items and services are directed toward the physical, psychological, social, and spiritual needs of the patient and family unit. Medical and nursing services are designed to maximize the patient's comfort, alertness, and independence so that the patient can reside in the home as long as possible.

B. Terminal Illness: A condition caused by injury, disease, or illness from which, to a reasonable degree of certainty, there can be no restoration of health, and which, absent artificial life-prolonging procedures, will inevitably lead to natural death.

IV. PURPOSE:

To provide, for the provider, general guidelines and requirements relating to hospice services.

V. POLICY / PROCEDURE:

A. Per APL 25-008, Hospice services, as specified in Title 22 California Code of Regulations (CCR) section 51349, are covered under Partnership Healthplan of California's (Partnership) contract and does not affect a Member's eligibility for enrollment in Partnership. Health and Safety Code (H&S) section 1368.22 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 Title 42 United States Code (USC) section 1395x(dd).

Under existing Contract requirements and state law, Partnership is required to provide hospice services upon Member election to start and receive such care services. Hospice coverage is provided in benefit periods: Two 90-day periods, beginning on the date of hospice election; followed by unlimited 60-day

periods. A benefit period starts the day the Member receives hospice care and ends when the 90-day or 60-day period ends. Members who qualify for and elect to receive hospice care services remain enrolled in Partnership while receiving such services. To avoid problems caused by late referrals, Partnership policies and procedures should clarify and detail how Members may access hospice care services in a timely manner, preferably within 24 hours of the request from in-Network hospice Providers. Consistent with contractual requirements for covered Medi-Cal benefits, Partnership may restrict coverage to in-Network Providers, unless Medically Necessary services are not available in-Network.

Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness.

For out-of-Network hospice Providers, Partnership should seek an agreement, such as a single case agreement or a letter of agreement, to cover hospice care services. Agreements with the out-of-Network hospice Provider require the Provider to submit necessary documentation for Partnership to ensure that hospice services are provided in accordance with coverage policy, including Medical Necessity. While Prior Authorization for hospice services is restricted, based on the level of care, Partnership is required to review documentation to avoid Fraud, Waste, and Abuse. To avoid possible delays in hospice care services while Partnership processes requests from out-of-Network hospice Providers, Partnership policies and procedures should clarify and detail how Members may access hospice care services in a timely manner after Partnership confirms qualifications and/or agreement with the out-of-Network hospice Provider, or transfer to an in-Network hospice Provider. For out-of-Network hospice Providers, Partnership must ensure the hospice Provider has Medicare certification, is licensed by the California Department of Public Health (CDPH) and has a National Provider Identifier (NPI) prior to payments of claims.

Requirements for the initiation of outpatient hospice services include a certification by the attending physician and/or the hospice medical director that a Member has a terminal illness with a life expectancy of six months or less, and the Member's election of hospice services in lieu of curative care for the terminal illness. Election of hospice care occurs when the Member or Authorized Representative voluntarily files an election statement with the hospice Provider. The hospice Provider is responsible for the coordination of hospice services and must submit the appropriate Department of Health Care Services' (DHCS) election form (Medi-Cal Hospice Program Election Notice) to Partnership within five (5) calendar days of certification and election of hospice care. In instances where the hospice Provider does not timely submit the election form to Partnership, Partnership is not obligated to cover and pay for the days of hospice care from the hospice admission date to the date the election form is submitted to and accepted by Partnership. These non-covered days are the hospice Provider's liability, and the hospice Provider cannot bill the Member for them. DHCS and Partnership may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of its claims processing and Utilization Management functions regarding a Member's certification and election, including supporting documentation.

Title 22 CCR section 51349 requires that Medi-Cal implement the certification procedures for hospice in accordance with those specified in Medicare (Title 42 Code of Federal Regulations (CFR) Part 418, Subpart B). A hospice Provider must obtain written certification of terminal illness for each hospice benefit period. For the initial 90-day benefit period, the hospice Provider must obtain written certification statements from the medical director of the hospice, the physician designee (as defined in 42 CFR 418.3), or the physician member of the hospice interdisciplinary group; as well as the Member's attending physician (generally the Member's Primary Care Physician and/or referring physician), if the Member has an attending physician. For subsequent benefit periods, the certification must be done by the

medical director of the hospice, the physician designee, or the physician member of the hospice interdisciplinary group. "Terminally ill" means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course. Federal law requires that the physician certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. Partnership must not deny hospice care to Members certified as terminally ill. The Centers for Medicare & Medicaid Services (CMS) provided guidance for reference by hospice Providers and Partnership in determining terminal status. The guidelines are not wholly restrictive and/or inclusive for Partnership Members to receive hospice care services. The guidelines are a tool and are not exclusive to determining eligibility for hospice care and do not replace a physician's professional judgement, as some Members may not meet these guidelines, yet still have a life expectancy of six months or less.

Only general inpatient care is subject to Prior Authorization regardless of whether the services are to be rendered by an in-Network or out-of-Network Provider. The below documents must be submitted to Partnership for Prior Authorization of general inpatient care:

a. A written prescription signed by the Member's attending physician;
b. Justification for the general inpatient care level of care;
c. A copy of the certification of the Member's terminal condition;
d. A copy of the written initial plan of care; and
e. A copy of the Member's signed election form.

Partnership must not require Prior Authorization for routine home care, continuous home care and respite care, or hospice physician services. Hospices must notify Partnership of general inpatient care placements that occur after normal business hours on the next business day. Partnership may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care. If the documentation does not support the continuous home care or respite home care levels of care, or if the documentation included is inadequate, reimbursement may be reduced to the rate for routine home care. The hospice Provider may submit an appeal for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care. Payment and/or hospice care services coverage may be denied if it is determined, based on documentation, that the hospice care services are not medically necessary or the Member is not terminally ill, with liability placed on the hospice Provider.

Upon Member election of hospice services, Partnership must ensure provision of, and payment for, hospice care services (listed below) provided by a hospice Provider. Partnership may require that the Member use an in-Network hospice Provider, unless Medically Necessary services are not available in-Network. Hospice care services include, but are not limited to, the following:

a. Nursing services
b. Physical, occupational, or speech-language pathology
c. Medical social services under the direction of a physician
d. Home health aide and homemaker services
e. Medical supplies and appliances
f. Drugs and biologicals
g. Physician services*
h. Counseling services related to the adjustment of the Member's approaching death; counseling, including bereavement, grief, dietary, and spiritual counseling

i. 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. A period of crisis is defined as a period in which a Member requires continuous care for as much as 24 hours to achieve palliation or management of acute medical symptoms. The Medicare Benefit Policy Manual (Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Rev. 11056, 10-21-21)) section 40.2.1 - Continuous Home Care states 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

j. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing, or hospice facility

k. Short-term respite care for pain control or symptom management in a hospital, skilled nursing, or hospice facility

l. 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. Physician services not described above must be billed to Partnership separately and include services of the Member's attending physician or consulting physician(s) if they are 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 Partnership. Note that palliative items or services in the context of Medi-Cal hospice benefits are defined separately from the services referenced in Medi-Cal Palliative Care, as defined in APL 18-020.

A Member's voluntary election may be revoked or modified at any time during a benefit period. To revoke the election of hospice care, the Member or Authorized Representative must file a signed statement with the hospice Provider revoking the individual election for the remainder of that benefit period, including the effective date of the revocation. The hospice Provider must submit the Partnership Member's signed hospice revocation statement to Partnership within five calendar days. The revocation effective date may not be retroactive. At any time after revocation, or a discharge by the hospice for cause, a Member may execute a new election, if they meet hospice coverage eligibility requirements. If the Member is still eligible, and makes a hospice election, and is readmitted to the same or different hospice Provider, the 90/90/unlimited 60-day benefit periods of care restart. If the Member re-elects hospice care, the hospice Provider must submit a new hospice election form to Partnership. A Member or Authorized Representative may change the designation of a hospice Provider once in each benefit period from the original hospice Provider with which the election was made. This change of the designated hospice Provider is not a revocation of the hospice benefit.

In the event that a Member wishes to elect a hospice that is out-of-Network, DHCS encourages Partnership to consider the individual cases of each Member. Partnership has the option of immediately initiating a contract (i.e., Network Agreement, LOA, or single case agreement) with the hospice Provider or referring the Member to an In-Network Provider for hospice care services. On occasion, Member's receiving hospice at the time they become Partnership Members may not be able to change their hospice Provider, if requested, due to the limitation of one designation change during a benefit period. A

Member has the right to request Continuity of Care if they were receiving hospice care services at the time of their enrollment with Partnership. In addition, Partnership may determine that such a change would be disruptive to the Member's care or would not for some other reason be in the Member's best interest. In such instances, Partnership should consider entering into an agreement with the established hospice Provider until the new benefit period, or until the end of hospice care services.

Hospice care services may be initiated or continued in a home or clinical setting. Partnership remains responsible for the provision or payment of all Medi-Cal covered services not related to the terminal illness, including those of the Member's Primary Care Physician.

Members who move their legal residence out of the service area must disenroll in Partnership.

Hospice providers must provide transferring Members with a transfer summary including essential information relative to the Member's diagnosis, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan, which must be signed by the physician. Consequently, upon enrollment in a new Managed Care Plan (MCP), a "change in designated hospice" must be initiated. This may be done only once per benefit period.

B. REIMBURSEMENT:

Partnership payments for hospice services are based upon the level of care provided so that hospice Providers may group the above services into the following revenue codes as outlined in the Medi-Cal Provider Manual. The hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare. These rates are authorized by federal law, which also provides for an annual increase in payment rates for hospice care services. Partnership must update their rates annually to coincide with changes to the Medicare rates. (Title 42 USC section 1395f(i)(1)(C)(ii)).

Partnership may pay more, but not less than, the Medicare rate for hospice services. The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register:

a. Routine home care (service intensity add-on rate), Revenue Code 0552.
b. Routine home care (high rate), Revenue Code 0650.
c. Continuous home care, Revenue Code 0652.
d. Inpatient respite care, Revenue Code 0655.
e. General inpatient care (no respite)/hospice general care, Revenue Code 0656.
f. Physician services, Revenue Code 0657.
g. Routine home care (low rate), Revenue Code 0659

A hospice day billed at the routine home care level in the first 60 days of a hospice election is paid at the high routine home care rate. A hospice day billed at the routine home care level on day 61 or later of the hospice election is paid at the low routine home care rate. For a hospice Member that is discharged and readmitted to hospice services within 60 days of the discharge, the hospice days will continue to follow the Member at the routine home care rates outlined above (i.e. the first 60 days paid at the high routine home care rate and day 61 or later paid at the low routine home care rate). If the hospice Member is discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the Member's 60-day window, paid at the routine home care high rate upon the new admission. Routine home care days that occur during the last seven days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.

Partnership must pay inpatient rates (general or respite) for the date of admission and all subsequent inpatient days, except the day on which a member is discharged. For the day of discharge, Partnership must pay the appropriate home care rate (routine or continuous) unless the Member dies as an inpatient. If the Member dies while an inpatient, Partnership must pay the inpatient rate (general or respite) for the discharge day.

Pursuant to Partnership's contract, hospice services are Covered Services and are not categorized as Long-Term Care (LTC) services regardless of the Member's expected or actual length of stay in a nursing facility (NF) while also receiving hospice care. Partnership cannot require authorization for room and board for Members receiving hospice services and residing in a skilled nursing facility (SNF)/NF or intermediate care facility (ICF) as described in Title 42 USC section 1396a(a)(13)(B) and Title 42 CFR section 418.112.

A Member who is a resident of a SNF or ICF may elect hospice care. Payment from Partnership will be provided to the hospice for hospice care services (at the appropriate level of care).

The hospice Provider must reimburse the facility for the room and board at the rate negotiated between the hospice Provider and facility. 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 Partnership, less the Member's share of cost, if applicable. Payments by a hospice Provider to a nursing home for room and board must not exceed what would have been received directly from Medi-Cal or Partnership if the Member had not been enrolled in hospice.

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

a. Revenue Code 0658 – Facility Type Code 25.
b. Revenue Code 0658 – Facility Type Code 26.
c. Revenue Code 0658 – Facility Type Code 28.
d. Revenue Code 0658 – Facility Type Code 65.
e. Revenue Code 0658 – Facility Type Code 81.
f. Revenue Code 0658 – Facility Type Code 86.

C. COORDINATION OF BENEFITS:

For members with Medicare coverage prime, Partnership must ensure that Medicare remains the primary payor for the hospice care services. Partnership must cover cost sharing for contracted services.

For dually eligible SNF residents, in accordance with the Medicare Benefit Policy Manual (Chapter 9) section 20.3 - Election by Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries, payment for room and board must be made directly to the hospice Provider. The room and board charge billed to Partnership as the hospice benefit under Medicare does not cover room and board. Following payment from Medicare, the hospice Provider then bills Partnership for the Medicare co-payment amount; however, the total reimbursed amount cannot exceed the Medicare rate (Title 22 CCR section 51544). For Medicare Members entitled to only Medicare Part B, benefits will be billed directly to Partnership. No Medicare denial will be required.

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

Partnership cannot require a copy of an Explanation of Benefits, Remittance Advice, or denial letter from Medicare to accompany room and board claims.

The hospice Provider must submit the DHCS election form to both DHCS and Partnership for dual eligibles when a Member elects the Medicare hospice benefit. Partnership will then pay the room and board payment to the hospice Provider according to the rate outlined above, and the hospice must 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 Partnership. The nursing home continues to remain responsible for collecting the LTC share of cost, if applicable.

For members with other health coverage, Partnership is the payer of last resort and claims must be submitted to Partnership with a copy of the other health coverage EOB for consideration.

D. PHYSICIAN SERVICES:

Hospice Providers must use Revenue Code 0657 when billing for physician services for pain and symptom management related to a Member's terminal condition and provided by a physician employed by, or under arrangements made by, the hospice Provider. Partnership is required to reimburse Revenue Code 0657, which is limited to one visit-per-day, per-Member.

Consulting/special physician services Revenue Code 0657 may be billed only for physician services to manage symptoms that cannot be remedied by the Member's attending physician because of one of the following:

a. Immediate need: or
b. The attending physician does not have the required special skills.

E. SERVICES NOT COVERED BY HOSPICE PROVIDER:

a. Private pay room and board or residential care.
b. Acute in-patient hospitalization unrelated to the terminal illness.
c. Level A or Level B NF for unrelated issues.
d. 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.
e. Other necessary services for conditions unrelated to the terminal illness.

VI. REFERENCES:
C.

VII. DISTRIBUTION:
D. PARTNERSHIP4ME PowerDMS Policies & Procedures

VIII. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Claims Department

IX. REVISION DATES: