



Transition of Hospice Services into Medicaid Managed Care

September 11, 2013



Effective October 1, 2013

Hospice services provided to enrollees in mainstream Medicaid managed care will become the responsibility of the managed care organization (MCO).



Scope of Hospice Services

- Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families.
- Patient and his or her family receive physical, psychological, social and spiritual support and care.
- Hospice is available to persons with a medical prognosis of one year or less to live if the terminal illness runs its normal course.



Scope of Benefit, continued

- Hospice services follow an interdisciplinary model, including palliative and supportive care provided to an enrollee to meet the special needs experienced during the final stages of illness and during dying and bereavement.
- Hospice services address physical, psychological, spiritual, social and economic stress.
- For children under age 21 receiving Hospice services, medically necessary curative services are covered, in addition to palliative care.



Scope of Benefit, continued

- Hospice services are provided consistent with licensure requirements, and State and Federal regulations.
- All services must be provided by qualified employees and volunteers of the hospice, or by qualified staff through contractual arrangements to the extent permitted by state and federal requirements.
- All services must be provided pursuant to a written plan of care which reflects the changing needs of the enrollee and the enrollee's family.



Scope of Benefit, continued

- Medicaid reimburses for hospice care as follows:
 - For routine home care using an all-inclusive daily reimbursement rate;
 - Continuous home care during periods of crisis;
 - General inpatient care for pain or symptom management;
 - Inpatient respite to relieve caregivers; and
 - Room and board for individuals receiving hospice care in a skilled nursing facility or hospice residence.



Scope of Benefit, continued

Services may be provided in the home, nursing home, assisted living facility, free standing hospice, hospital or hospice residence. Services must be provided according to a written plan of care and are focused on easing symptoms rather than curing the disease. The individual and family receive medical, psychological and social services, and bereavement and pastoral care related to the individual's terminal diagnosis.

Hospice includes the following services as the needs of the patient dictate:

- Nursing;
- Physical Therapy;
- Speech and Language Pathology;
- Home Health Aide and Homemaker;
- Pastoral Care;
- Social Work;
- Psychological;
- Respiratory Therapy.
- Physician;
- Occupational Therapy;
- Medical Supplies and Equipment;
- Bereavement;
- Pharmaceutical/Laboratory;
- Nutrition;
- Audiology;



Transition to Managed Care

- Individuals in receipt of Hospice services prior to October 1, 2013, regardless of Medicaid managed care enrollment status as of that date, will continue to be covered under the fee for service (FFS) Medicaid program for the duration of their approved Hospice services.
- MCOs will be responsible for Hospice services for enrollees new to Hospice on and after October 1.
- MCOs will also be responsible for monitoring quality of care.



Transition from FFS to Managed Care

- For Hospice cases open prior to October 1, 2013 the provider will continue to submit claims under fee for service Medicaid.
- Hospice care initiated for plan members on or after October 1, 2013 will be covered by the MCO.



FFS Billing for Plan Enrollees Beginning October 1, 2013

- DOH will place all persons with FFS hospice claiming prior to October 1, 2013 on an eMedNY “system list” of FFS-eligible hospice patients.
- Plan enrollees who appear on this list will remain eligible for FFS billing for hospice services for the duration of their life.
- Beginning October 1, 2013, FFS hospice billing for persons enrolled in plans and not on the list will result in a claim denial.
- Due to claim lag, some persons with FFS hospice services prior to October 1, 2013 will not appear on the initial draft of the eMedNY system list.
- A mechanism will be provided to allow the list to be updated so that hospice providers will be able to bill FFS for persons not on the initial draft of the eMedNY system list.



Suggested Claims Coding

- Plans must provide Hospice practitioners with coding guidance for Hospice services.
- The Hospice HCPCS and fee for service codes are listed in the Guidelines for the Provision of Hospice Services in Mainstream Medicaid Managed Care.
- The FFS rates for each provider and rate code as well as a description of the FFS billing guidelines will be issued to the plans prior to implementation.



MEDS Reporting

Inpatient Hospice

NURSING FACILITY

Category of Service = 12 (Institutional Long Term Care) **AND**

Provider Specialty Code =

- **660 INSTITUTIONAL LTC**
- 663 NURSING HOME CARE
- 790 RESPITE

AND Type of Bill and UB-04 Revenue Codes

- SNF UB-04 Bill Type Code: 21 OR
- SNF UB-04 Bill Type Code: 27 **AND**

UB-04 Revenue Codes:

- 0190-0199 SNF **OR**

UB-04 Revenue Codes:

- 0655 HOSPICE SERVICE, INPATIENT RESPITE CARE
- 0658 HOSPICE SERVICE, HOSPICE ROOM & BOARD - NURSING FACILITY



MEDS Reporting

Outpatient Hospice

OTHER MEDICAL

Category of Service **NOT** 15 (Non-Institutional Long Term Care) **AND**
Provider Specialty Codes =

- 661 Social and Environmental Supports
- **669 Hospice Care**
- 999 Other

See pages 11 and 55 of the MEDS/MMCOR Category of Service Guidelines available on the MEDS and MMCOR HCS web pages.



MMCOR Reporting

- Inpatient and outpatient hospice should be mapped to the **Other Medical** category of service.

Contacts (518-474-5050)

- MEDS Robert Biggane (rpb01@health.state.ny.us)
- MMCOR Rachel Barbash (rab16@health.state.ny.us)



Accessing Benefits and Authorization of Services

- All authorizations for Hospice services must be expedited by the MCOs.
- MCOs will make a service authorization determination of the full array of Hospice services as fast as the enrollee's condition requires and no more than 3 business days from request as per the MMC/FHP/HIV SNP Model Contract Appendix F.1(3)(b)(i).
- When the need for Hospice services presents and/or an urgent referral is made during non-business hours, and the MCO cannot be reached to request authorization, the Hospice provider will request authorization with all necessary information by the next business day.



Accessing Benefits and Authorization of Services

- The MCO may not deny Hospice services provided during non-business hours when the MCO could not be reached, for lack of medical necessity or prior authorization, while the MCO determination is pending.
- If there is not a network Hospice provider, MCO must allow benefit from an out-of-network provider.



Network Requirements

- In counties with multiple Hospice agencies in operation, each MCO must contract with at least 2 providers.
- In counties where there is only 1 provider, the MCO must contract with that agency.



Hospice Provider Responsibilities

For managed care enrollees entering Hospice care on or after October 1, the provider must:

- Verify managed care eligibility prior to assessment or admission.
- If there is a physician order, work with the MCO for services from a network provider.
- Obtain initial authorization from the MCO and provide services according to the approved care plan for the duration of the authorization.



Provider Responsibilities, continued

- If the Hospice provider and the MCO disagree in determination of the hospice plan of care, the Hospice provider may file an appeal.
- The enrollee will also have the right to a State fair hearing and may be eligible for an external appeal.
- Provider has appeal rights on his or her own behalf pursuant to the provider contract and Article 49 of the Public Health Law



MCO Responsibilities

- MCOs will reimburse Hospice providers at the Medicaid fee for service rate for the first year of the transition: 10/1/2013 – 9/30/2014.
- After the first year, MCOs may negotiate a different rate.
- Hospice's all-inclusive per diem reimbursement rate includes all services, durable medical equipment and medicine related to the hospice diagnosis.
- This transition policy applies to Medicaid managed care only and does not affect current Hospice rates agreed upon between the MCO and FHP or CHP providers.



MCO Responsibilities

- MCOs must designate a Hospice liaison and provide direct contact information for the liaison.
- The Hospice liaison will serve as a link within the MCO, and assist the provider in obtaining authorization for Hospice services, billing, and other issues that may arise during the transition.
- This policy is consistent with the transition of other benefits and/or populations into Medicaid managed care.



MCO Responsibilities

- MCOs must provide education to its members regarding the availability of this benefit.
- The MCO must also provide assistance with navigating provider and member inquiries regarding the Hospice benefit and access to services.
- This policy is consistent with the transition of other benefits and/or populations into Medicaid managed care.



Questions?