Hospice Transition to Managed Care Benefit Package Questions and Answers

Rates/Payment

Question	***Answer***
NYS DOH website has published hospice rates from 2009. Are these rates still in effect, or are there updated rates for 2013?	The 2011 - 2012 hospice rates were issued and were sent out with the policy document. Revised rates will be posted to the DOH website at a later date.
DOH indicated that the rates on the NYSDOH website for Hospice would be updated and plans would receive the new rates by 9/1/13. Have the rates been released? If so how can plans get a copy so we may execute provider contracts?	The updated rates were shared with the policy document.
When will SDOH provide the provider specific Medicaid FFS rates?	Hospice rates are county based, not provider specific.
Will MCO's be required to pay the "enhanced" rates currently in place under Mediciad for HIV/AIDS hospice patients?	Claims for hospice for persons with HIV/AIDS are submitted under a different series of rate codes. These rate codes are rarely used.
Are there mandated billing codes the provider should use? Or is it left to the plan's discretion?	Codes will be decided by the plan.
Will the MCO reimburse for Physician visits outside of the per diem?	The administrative role of the hospice physician is included in the 3945 rate. Hospice attending and consulting physician services must be billed separately to the plan outside of the per diem. Prior to October 1, 2013, hospice physician services for plan enrollees would continue to be paid by the plan, since physician services are included in the plan benefit package.

If a hospice patient is hospitalized, does the plan cover the hospitalization separately or is this service paid through the hospice?	General Inpatient Care (GIP) service is provided in hospitals or nursing homes that contract with hospice programs, but it does not include nursing home based hospice RHC services. Instead, the hospice provider is requried under the contract with the hospital or nursing home to pay a portion of the rate for rate code 3947 to the hospital or nursing home. The hospital or nursing home does not bill Medicaid for a DRG or a nursing home per diem. In the event the hospital or nursing home is not in the health plan's network, as long as the plan has a contract with the hospice provider and the hospital or nursing home the plan should cover the hospice service.
Will nursing homes bill MCOs directly for nursing home room and board?	With nursing home based hospice, the hospice provider will bill for each day of service. The hospice provider will also bill for the room and board provided to patients residing in the nursing home, and pass this amount to the nursing home. A nursing home is not allowed to bill its per diem rate during the period of the hospice services. This daily payment will be made to a hospice for Medicaid-eligibile patients who have elected the hospice benefit and reside in a nursing facility.
When a member receives hospice in a SNF or acute care facility, is it correct that MCOs pay the Hospice provider, and the hospice provider reimburses the facility?	Yes, the hospice provider will bill for room and board provided to patients residing in the nursing home and pass this amount to the nursing home.
How is bereavement coded?	Bereavement services are contained within the bundle of hospice services and are included under the per diem code.
How are bereavement services for the family covered if the bereavement takes place after the member is deceased and becomes non-eligible in our systems?	The hospice does not bill for bereavement services. The hospice agency is required to provide this service to family for up to 1 year after the patient has died.
Will DOH provide guidance to plans that regulations require provide payment to hospices for the direct professional care of patients provided by hospice-based physicians, in addiition to the per diem rates?	Current Medicare rates do not include a factor for these services and provides separate reimbursement. State Medicaid programs are required to mirror this policy.

Services

Question	*Answer*
Will plans be required to provide bereavement services for families?	Bereavement counseling services are included in the hospice benefit.
If hospices must obtain prior approval from plans for a change of level of care, for example, an inpatient admission, will plans be required to provide such authorization 24/7?	In a case of Hospice, providers will not be required to get prior approval for change in level of care. Hospice providers will need document a change in condition that warrants the change to the level of care.
What is the proposed outcome expected from formalized occupational and speech therapy in a hospice setting?	Hospices are required to provide physical, occupational, and speech therapy as needed for the palliation and management of the terminal illness. An occupational therapist can improve the patient's ability to accomplish the activities of daily living. The speech language therapist assists those with difficulties in swallowing food, speaking or communicating. The expectation for the outcome of therapies is for less dependence on others and improved quality of life.
If the member is GIP (inpatient) level clinically and that care is in a contracted bed in an out of network hospital is that OK?	In the event the hospital or nursing home is not in the health plan's network, as long as the plan has a contract with the hospice provider and the hospice provider has a contract with the hospital or nursing home the plan should cover the hospice service. However, we strongly encourage alignment with the plan's network in the event the patient needs services unrelated to the hospice diagnosis.
How will the case management be broken down as both Hospice and MCO provide case management?	There must be a cooperative effort between the plan and provider to avoid duplication of services.
Will Hospice cover all Personal Care Services?	Hospice is responsible for all Personal Care Services related to the hospice diagnosis.
Will HIV Positive Hospice patients still receive HIV antiretroviral medications? Or are they suspended?	Hospice focuses on easing symptoms rather than treating disease. HIV antiretroviral medicaitons would not be appropriate unless there is a palliative effect.

Enrollment/Eligibility

Question	*Answer*
Will the duration of hospice services under FHPlus change from being available for six (6) months to one (1) year, consistent with Medicaid policy?	No, this change in policy applies only to Medicaid managed care.
If a patient is initially in receipt of hospice services prior to 10/1/2013, is discharged after 10/1/2013, then is readmitted, will the member still receive hospice services under FFS Medicaid?	The readmission will be treated as new to service and will not be billable to FFS Medicaid.
Will the MCOs require a notice of non coverage if the provider discharges the patient prior to death?	If hospice services are no longer appropriate, the provider must inform the plan to allow for adjustment of the patient's care plan to ensure safety.
The estimated number of current hospice patients in receipt of Medicaid seems low. Has DOH revised its estimated number of Medicaid recipients currently receiving hospice services?	The statewide total number of Medicaid managed care patients in receipt of hospice services on October 1, 2013 is over 300.
If a member requires hospice services and it is after hours, can these services be provided at the time and reimbursed later? How will plans know if the patient remains Medicaid eligible ?	The hospice provider is responsible for verifying eligibility before providing services. The MCO may not deny Hospice services provided during non-business hours for lack of medical necessity or prior authorization while the MCO determination is pending.
Must the PCP sign off on the determination that the member is eligible for hospice services due to terminal diagnosis?	The initial referral is the physician order for hospice services.
If a patient is dually eligible, having both Medicare and Medicaid coverage, does the plan still provide authorization of services, or does the hospice approve based upon Medicare guidelines?	This policy applies only to Medicaid managed care. If a patient has Medicare coverage, Medicaid managed care enrollment is not allowed.

Contracting

Question	*Answer*
Do hospice providers need a contract in place as of 10/1/2013 with the MCO or can they contract on a case by case basis?	In counties where multiple hospice agencies operate, each MCO must contract with at least two of the hospice providers. In counties where there is only one provider, the MCO must contract with that agency. If no contracted provider is available, the MCO must allow the enrollee to access hospice services out of network.
Will the hospice benefit be carved in to the HIV SNP benefit package on October 1, 2013 as well?	Yes, this transition includes the HIV SNPs.
Can a plan contract with a hospice provider for palliative care?	Hospice care is one type of palliative care for people who are teminally ill, if the disease runs its normal course.
Are all hospice providers approved Medicaid providers?	Hospice providers who provide services to Medicaid consumers must be enrolled Medicaid providers.

Miscellaneous

Question	*Answer*
What is the benefit of including hospice services in the Medicaid managed care benefit package?	This is a recommendation of the Medicaid Redesign Team to provide care management for all.
If a member's condition improves significantly, is it within the plan's rights to move the patient into another type of care?	The member may discontinue hospice by choice or if there is improvement in prognosis.
Can DOH provide a list of the MCOs by county?	The plans are listed by county on the NYS DOH website at this address: http://www.health.ny.gov/health_care/managed_care/pdf/cnty_dir.pdf
What are the standards for authorization and re-authorization of hospice services?	The first two authorization periods are for 90 days each. All subsequent authorization periods are for 60 days. There is no limit on the number of additional authorization periods allowed.
Where can I get a copy of this presentation?	The power point is posted on the MRT website under Supplemental Information, Proposal # 1458.

Are plans required to monitor quality of care for its members receiving hospice via fee for service Medicaid?	The plans are responsible for monitoring quality of care for members receiving hospice services, regardless of payment method.
Must hospice providers register the members receiving Hospice care with the state? If so, how will the list be distributed?	DOH asked to be notified of members receiving Hospice services under fee for service Medicaid prior to the transition of the benefit. This was a one time request during the transition phase to allow billing for these members to continue uninterrupted.
Are there recommendations how plans should handle advance directives, such as documentation requirements or education?	Managed Care/Family Health Plus/HIV Special Needs Model Contract states in Section 13.7 that the Contractor shall, in compliance with the requirements of 42 CFR § 438.6(i)(1) and 42 CFR Part 489 Subpart I, maintain written policies and procedures regarding advance directives and inform each Enrollee in writing at the time of enrollment of an individual's rights under State law to formulate advance directives and of the Contractor's policies regarding the implementation of such rights.