NEW YORK STATE DEPARTMENT OF HEALTH

OFFICE OF HEALTH INSURANCE PROGRAMS

Guidelines for the Provision of Hospice Services in Mainstream Medicaid Managed Care

Overview

Effective October 1, 2013, the provision of Hospice services to enrollees in mainstream Medicaid managed care organizations (MCOs) will become the responsibility of the MCO. The following guidelines identify the scope of benefits, the roles and responsibilities of MCOs and Hospice providers, network responsibilities, and claims coding.

I. Scope of the Hospice Benefit

a) Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. Care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care. Hospice provides four levels of care: 1) routine home care, 2) respite care, 3) continuous care, and 4) general inpatient care. The program is available to persons with a medical prognosis of one (1) year or less to live if the terminal illness runs its normal course.

b) Hospice services are provided following an interdisciplinary model, and include palliative and supportive care provided to an enrollee to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement.

c) Hospice's all-inclusive per diem reimbursement rate includes all services, durable medical equipment and medicine related to the hospice diagnosis.

d) For children under age 21 who are receiving Hospice services, medically necessary curative services are covered, in addition to palliative care.

e) 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.

II. Transitional Care

a) As of October 1, 2013, Medicaid managed care organizations will begin covering the Hospice benefit.

b) Individuals in receipt of Hospice services prior to October 1, 2013, regardless of enrollment status, will continue to be covered under the fee for service (FFS) Medicaid program (per diem reimbursement) for the duration of their approved Hospice services.

c) Managed care plans will be responsible for Hospice services for enrollees new to Hospice on and after October 1, 2013. In addition, MCOs are responsible for monitoring the quality of care.

d) Hospice service providers are licensed to provide an array of services in order to maintain the quality of life for patients during the provision of end of life care. The transition of the benefit to managed care should not preclude the hospice providers from administering the full range of services under Article 40 of the Public Health Law as long as it is within their scope to provide and appropriate for the patient.

IV. Fee for Service

a) 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.

b) 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.

V. MCO Responsibilities

a) MCOs will reimburse Hospice providers at the Medicaid fee for service per diem rate, or higher, consistent with Article 40 of the Public Health Law, for the period October 1, 2013 through March 31, 2015, after which, MCOs may negotiate a different rate.

b) MCOs must designate a Hospice liaison and provide direct contact information for the liaison. The MCO Hospice liaison will work with the provider and assist in navigating the process of obtaining authorization for Hospice services, billing, and other issues that may arise through this transition. The MCO Hospice liaison will serve as link to within the MCO to assure timely access to hospice services for eligible members.

VI. Hospice Provider Responsibilities

a) For Hospice cases open prior to October 1, 2013, the provider will continue to submit claims under fee for service Medicaid at the per diem rate until the end of care.

b) For Hospice cases open on or after October 1, 2013, the Hospice provider must:

   i. Verify managed care eligibility prior to performing the admission or assessment;

   ii. Notify the MCO if the enrollee presents a physician order for services, and work with the MCO to arrange those services from an in network provider. If the plan does not have an in-network Hospice provider, the plan must allow the member to go out-of-network.

   iii. The Hospice provider must obtain authorization from the MCO for Hospice services and provide these services.

   iv. 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. The Hospice provider also has appeal rights on his or her own behalf pursuant to the provider contract and Article 49 of the Public Health Law.

VII. Accessing Benefits and Authorization of Services

a) 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).

b) When the need for Hospice services presents and/or an urgent referral is made by a provider 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. The MCO may not deny Hospice services provided under these circumstances for lack of medical necessity or prior authorization, while the MCO determination is pending.

VIII. Hospice Network Requirement

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.

IX. Suggested Claims Coding

The hospice HCPCS codes are listed below. Plans are expected to provide providers with specific coding guidance for all hospice services. The FFS billing rate code for hospice services are also listed below. The FFS rates for each provider and rate code, as well as a detailed description of the FFS billing guidelines (i.e., proper use of the hospice rate codes) is found in the next section of this document.

HCPCS Code	HCPCS Description
Q5001	Hospice in patient home
Q5002	Hospice in assisted living
Q5003	Hospice in LT/non-skilled NF
Q5004	Hospice in SNF
Q5005	Hospice, inpatient hospital
Q5006	Hospice in hospice facility
Q5007	Hospice in LTCH
Q5008	Hospice in inpatient psych
Q5009	Hospice care, NOS
Q5010	Hospice home care in hospice

Rate Cd	Rate Cd Desc
2862	MEDICARE
2863	NON-MEDICARE
3756	AIDS, NON-MEDICARE
3764	PEDIATRIC, NON-MEDICARE
3765	PEDIATRIC, MEDICARE
3767	AIDS, NON-MEDICARE
3771	VENTILATOR DEPENDENT, NON-MEDICARE
3775	VENTILATOR DEPENDENT MCARE PT D (HB)(FS)
3776	VENTILATOR DEPENDENT MCARE PT B&D (HB)(FS)
3810	NON-MEDICARE
3812	MEDICARE
3836	NURSING FACILITY CASH ASSESSMENT RATE
3838	NURSING FACIL MCARE PART D COVERAGE (FS) (HB)
3839	NURSING FACIL MCARE PARTS B & D COVERAGE (FS) (HB)
3845	NEURO BEHAVIORAL MCARE PT B&D (HB)(FS)
3849	AIDS MCARE PT B&D (HB)(FS)
3945	HOSPICE ROUTINE HOME CARE
3946	HOSPICE INPATIENT RESPITE
3947	HOSPICE GENERAL INPATIENT
3948	HOSPICE CONTINUOUS HOME CARE-MIN 8 HOURS
3949	HOSPICE CONTINUOUS HOME CARE-MIN 9 HOURS
3950	HOSPICE CONTINUOUS HOME CARE-MIN 10 HOURS
3951	HOSPICE CONTINUOUS HOME CARE-MIN 11 HOURS
3952	HOSPICE CONTINUOUS HOME CARE-MIN 12 HOURS
3953	HOSPICE CONTINUOUS HOME CARE-MIN 13 HOURS
3954	HOSPICE CONTINUOUS HOME CARE-MIN 14 HOURS
3955	HOSPICE CONTINUOUS HOME CARE-MIN 15 HOURS
3956	HOSPICE CONTINUOUS HOME CARE-MIN 16 HOURS
3957	HOSPICE CONTINUOUS HOME CARE-MIN 17 HOURS
3958	HOSPICE CONTINUOUS HOME CARE-MIN 18 HOURS
3959	HOSPICE CONTINUOUS HOME CARE-MIN 19 HOURS
3960	HOSPICE CONTINUOUS HOME CARE-MIN 20 HOURS
3961	HOSPICE CONTINUOUS HOME CARE-MIN 21 HOURS
3962	HOSPICE CONTINUOUS HME CARE-MIN 22 HOURS
3963	HOSPICE CONTINUOUS HOME CARE-MIN 33 HOURS
3964	HOSPICE CONTINUOUS HOME CARE-MIN 24 HOURS
3969	HOSPICE ROUTINE HOME CARE-AIDS PTS
3988	HOSPICE GENERAL INPATIENT-AIDS PATIENTS
3990	HOSPICE-STAND ALONE INPATIENT FACILITY

X. Hospice Billing During the Transition to Managed Care

The current FFS hospice rate codes are shown above and the rate amounts, by county, are shown in the accompanying Excel file. Do not use the 2009 rates found on the web at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hospice/.

Hospice payment is not provider-specific, but rather varies by county (as shown in the accompanying Excel file). The correct rate to utilize is the rate that applies to the county of the hospice provider's operating certificate, which is not necessarily the county in which the service is provided. **All of these rates are exclusive of a $9.92 per diem add-on for recruitment, training and retention (with the exception of rate codes 3965 and 3966 to which this add-on does not apply). When mirroring FFS payment, plans must add $9.92 to each of the FFS rates that have been provided. Another 3% add-on for recruitment and retention is already included in each of the FFS rates, so no further adjustment is required to compensate for that add-on.**

a) Routine Home Care (RHC) - Rate code 3945 is the per-diem rate code for hospice RHC provided in the home, nursing home, or hospice residence. This is the rate code most frequently used for hospice services.

b) General Inpatient Care (GIP) - Rate code 3947 is the per-diem rate code for hospice GIP. This service is provided in hospitals or nursing homes that contract with hospice programs, but it does not include nursing-home-based hospice RHC services (see below). A hospice provider billing 3947 must have a contract to provide GIP with the hospital or nursing home facility. The hospital or nursing home does not bill Medicaid for a DRG or a nursing home per diem. Instead, the hospice provider is required 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. There is no billing for rate code 3945 when 3947 has been billed. 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.

c) Inpatient Respite - Rate code 3946 is for per-diem inpatient respite. An inpatient respite care day is a day on which the individual who is receiving in-home hospice care receives RHC on a short-term basis, as respite for the patient's other care giver(s), in a hospital or nursing home that has a contract with the hospice provider. The hospice provider is responsible for paying the inpatient facility under the terms of that contract. There is not separate rate code from 3946 that is billed to obtain

any sort of pass-through reimbursement for the inpatient facility. Utilization of this service is extremely minimal.

d) Continuous Home Care - Rate codes 3948 through 3964 are for hospice continuous home care and are based on duration (hours of service provided during the day). This service consists of a minimum of 50% nursing care. Continuous home care is only furnished during brief periods of crisis, and only as necessary to maintain the terminally ill patient at home or in a hospice stand-alone residence (see below) in lieu of hospitalization or hospice inpatient care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms. This service has relatively low utilization.

e) Routine Home Care with Escort - Rate code 3970 is for per-diem hospice services that require an "escort for security" to the premises (due to the low quality of the neighborhood). This rate code is used as an alternative to 3945. Use of this rate code is minimal.

f) Free-Standing Hospice Facilities - Rate code 3990 is not shown in the rate file. It applies to the room and board component of the rate for stand-alone hospice residences, of which there are 11 in the state. The per-diem room and board rate for each of those facilities is a percentage of the average nursing home rate for the county in which it is located. The hospice provider also bills for rate code 3945 to cover the hospice routine home care component of the rate (or one of the rate codes in the 3948 to 3964 range).

g) Hospice for Persons with AIDS - The entire set of rate codes described above (except 3990) is paralleled in another series of "with AIDS" rate codes (see rate file). Use of those rate codes is minimal or non-existent.

h) Nursing-Home-Based RHC - When RHC hospice care is provided in a nursing home the hospice provider will bill 3945 for each day of service. In addition to 3945, they will also bill for the room and board provided to patients residing in the nursing home and pass this amount to the nursing home (which 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-eligible patients who have elected the hospice benefit and reside in a nursing facility. This payment takes into account the room and board furnished by the nursing facility and is an amount equal to 95% of the facility rate that would have been paid by the State to the nursing home if the patient had not elected to receive hospice care. The hospice provider cannot bill for this additional amount on a day in which the patient who has elected hospice

care is receiving either general inpatient or inpatient respite care. Again, the patients must have been eligible under Medicaid for nursing facility services if he/she had not elected to receive hospice care. To be eligible to receive Medicaid room and board payment, a hospice must have a written agreement with a nursing facility under which the hospice takes full responsibility for the professional management of the patient's hospice care, and the nursing facility agrees to provide room and board to the patient, collect any patient payment contributions, and maintain an accounting of the patient's financial contribution. Typically rate code 3810 - non Eligible for Medicare Parts B&D is used for this reimbursement for non-duals. The rate codes used for this pass through (3812- Eligible Part B, 3839 Eligible for B&D, 3838 Eligible for D and Rate Code, and 3810 – non Eligible for B&D) are not shown in the attached rate file. Payment varies by nursing home. Usage of this service by non-duals is believed to be minimal.

i) Physician Payment – The administrative role of the hospice physician is included in 3945 rate. Billing for hospice attending and consulting physician services is to be billed separately to the plan outside of the per diem. In fact, hospice patients already enrolled in a plan should be having their hospice physician services paid by the plan already (pre-Oct 1) since physician services are not carved out of the plan benefit.

j) Drugs - All medications related to the "hospice diagnosis" are included in the hospice home care rate, including pain and symptom management medication. Drugs for unrelated conditions are covered separately and not the responsibility of the hospice provider. The same policy that applies to drugs applies to durable medical equipment (DME).