INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER BULLETIN

BT200607 MARCH 9, 2006

To: **IHCP-Enrolled Hospice Providers**

Subject: **Final Medicare Hospice Rules Effective January 23, 2006 and Medicaid Hospice Authorization Changes**

Overview

This bulletin summarizes the Final Medicare Hospice Rules that became effective January 23, 2006. These rules codify many of the changes noted in the Balanced Budget Act of 1997.

> *Indiana Health Coverage Programs (IHCP)-enrolled hospice providers must be Medicare-certified hospice providers before enrolling in the IHCP.*

By State statute, the IHCP hospice benefit must mirror the covered services and reimbursement methodology of the Medicare hospice program. This bulletin provides information about the final rules; any policy implications; the procedure changes for hospice providers and the Office of Medicaid Policy and Planning (OMPP) contractors; and the sections and page numbers of the *IHCP Hospice Provider Manual* that are modified and superseded by these rule changes. This bulletin should be used as an addendum to the *IHCP Hospice Provider Manual* dated March 2004.

This bulletin also addresses hospice program issues regarding the new hospice rates effective October 1, 2005, hospice program trends, and new documentation requirements for submitting a hospice authorization request when other personal care service programs such as Home- and Community-Based Services (HCBS) waiver and CHOICE are also serving the member.

The complete text of *42 CFR Part 418* may be accessed at http://www.in.gov/isdh/regsvcs/acc/lawrules/.

Final Medicare Hospice Rules at 42 CFR Part 418

Subpart B-Eligibility, Election and Duration of Benefit Periods

Section 418.21 Duration of Hospice Coverage—Election Periods

In Sec. 418.21, paragraph (a) is revised to read as follows:

Sec. 418.21 Duration of hospice care coverage--Election periods.

(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods:

(1) An initial 90-day period;

(2) A subsequent 90-day period; or

(3) An unlimited number of subsequent 60-day periods.

Language Impacted in the *IHCP Hospice Provider Manual*

The preceding rule does not impact the Medicaid hospice rule or the *IHCP Hospice Provider Manual.*

Section 418.22 Certification of Terminal Illness

In Sec. 418.22, paragraphs (a) and (b) are revised to read as follows:

(a) Timing of certification—

(1) General rule. The hospice must obtain written certification of terminal illness for each of the periods listed in Sec. 418.21, even if a single election continues in effect for an unlimited number of periods, as provided in Sec. 418.24(c).

(2) Basic requirement. Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification before it submits a claim for payment.

(3) Exception. If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

(b) Content of certification. Certification will be based on the physician's or [hospice] medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements:

(1) The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

(2) Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification as set forth in paragraph (d)(2) of this section. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.

Language Impacted in the *IHCP Hospice Provider Manual*

Sections 3 and 5 of the *IHCP Hospice Provider Manual* address Medicaid hospice authorization procedures for the physician certification form and the hospice plan of care. Unlike the federal Medicare program, the IHCP hospice rules at *405 IAC 5-34* requires hospice authorization paperwork be submitted to the HCE Prior Authorization Unit within ten business days of the start date of each hospice benefit period. The IHCP is consistent with the final rules in that medical documentation must support the physician's certification of the six-month prognosis of the terminal illness so there is no impact on the current language.

Section 418.25 Admission to Hospice Care

New Sec. 418.25 is added to read as follows:

Sec. 418.25 Admission to hospice care.

(a) The hospice admits a patient only on the recommendation of the [hospice] medical director in consultation with, or with input from, the patient's attending physician (if any).

(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

(1) Diagnosis of the terminal condition of the patient.

(2) Other health conditions, whether related or unrelated to the terminal condition.

(3) Current clinically relevant information supporting all diagnoses.

Language Impacted in the *IHCP Hospice Provider Manual*

Section 4 of the *IHCP Hospice Provider Manual* will be amended to include the preceding new section.

Section 418.26 Discharge from Hospice Care

New Sec. 418.26 are added to read as follows:

Discharge From Hospice Care (Sec. 418.26)

(a) Reasons for discharge. A hospice may discharge a patient if--

(1) The patient moves out of the hospice's service area or transfers to another hospice;

(2) The hospice determines that the patient is no longer terminally ill; or

(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:

(i) Advise the patient that a discharge for cause is being considered;

(ii) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;

(iii) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and

(iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

(b) Discharge order. Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

(c) Effect of discharge. An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice--

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under Sec. 418.24(d); and

(3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

(d) Discharge planning.

(1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

(2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

Language Impacted in the *IHCP Hospice Provider Manual*

The preceding section is in addition to Section 4 of the *IHCP Hospice Provider Manual* and the article on Hospice Discharge printed in the September and October 2005 IHCP Provider Monthly Newsletters (*NL200509* and *NL200510*). The IHCP will mirror this new section in the next revision of the *IHCP Hospice Provider Manual*.

New Procedure for Hospice Providers

The IHCP has the same documentation requirements for discharge with cause as noted in *42 CFR 418.26*. Before the State Medicaid agency will discharge an individual under this section, the hospice will need to complete the *Medicaid Hospice Discharge Form*, check the box *Other* under reason, specify the discharge for cause in the comment section of the Medicaid Hospice Discharge Form, and attach the medical documentation that supports the discharge for cause requested by the hospice medical director. If a patient has an attending physician involved in his or her care, the physician should be consulted before discharge and the physician's review and decision included in the discharge note. If the member does not have an attending physician, this must be reflected in the medical documentation supporting discharge with cause. In those cases, the hospice medical director serves as the patient's attending physician. Hospice providers are reminded that only the hospice medical director or the patient care coordinator may sign the Medicaid Hospice Discharge Form.

This new procedure applies for Medicaid-only members residing at home, Medicaid-only members residing in nursing facilities, and dually-eligible Medicare/Medicaid hospice members residing in nursing facilities. Hospice providers are reminded that federal regulations require dually-eligible Medicare/Medicaid hospice members residing in nursing facilities to elect, revoke, change hospice providers and be discharged from hospice care simultaneously under the Medicare and Medicaid hospice programs since State Medicaid Agencies pay for these nursing facility residents' room and board as required by the Omnibus Budget Reconciliation Act (OBRA '89) and state regulations at *405 IAC 1-16-4*. Hospice providers are required to submit the appropriate paperwork under each program. Dually-eligible Medicare/Medicaid hospice members residing at home are not required to elect, revoke, change hospice providers or be discharged from hospice care under both programs since Medicare pays for the hospice services and Medicaid has no room and board payment responsibilities.

Subpart F--Covered Services

In Sec. 418.202, the introductory text is republished, and a new paragraph (i) is added to read as follows:

Sec. 418.202 Covered Services

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

* * * * *

(i) Effective April 1, 1998, any other service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicare.

Language Impacted in the *IHCP Hospice Provider Manual*

There is no impact on the Medicaid hospice rule or the *IHCP Hospice Provider Manual.*

Subpart G--Payment for Hospice Care

Section 418.301 is amended by adding a new paragraph (c) to read as follows:

Section 418.301 Basic Rules

(c) The hospice may not charge a patient for services for which the patient is entitled to have payment made under Medicare or for services for which the patient would be entitled to payment, as described in Sec. 489.21 of this chapter.

Section 418.302 is amended by adding a new paragraph (g) to read as follows:

Section 418.302 Payment Procedures for Hospice Care.

(g) Payment for routine home care and continuous home care is made on the basis of the geographic location where the service is provided.

Language Impacted in the IHCP Hospice Provider Manual

There is no language change in Section 6 of the *IHCP Hospice Provider Manual* since the IHCP payment process mirrors this requirement under the Balanced Budget Act of 1997.

Section 418.304 [Amended]

In Sec. 418.304, the following changes are made:

a. In paragraph (b), the phrase ``physician's reasonable charge'' is removed and is replaced with ``physician fee schedule.''

b. In paragraph (c), the phrase ``subparts D or E, part 405 of this chapter'' is removed and the phrase ``subpart B, part 414 of this chapter'' is added in its place.

Language Impacted in the IHCP Hospice Provider Manual

Section 6 of the *IHCP Hospice Provider Manual* has not been impacted by this rule change.

Section 418.306 Determination of Payment Rates

In Sec. 418.306, the introductory text of paragraph (b) is republished, paragraph (b)(3) is revised, and new paragraphs (b)(4) and (b)(5) are added to read as follows:

Sec. 418.306 Determination of payment rates.

(b) Payment rates. The payment rates for routine home care and other services included in hospice care are as follows:

(3) For Federal fiscal years 1994 through 2002, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase minus--

(i) 2 percentage points in FY 1994;

(ii) 1.5 percentage points in FYs 1995 and 1996;

(iii) 0.5 percentage points in FY 1997; and

(iv) 1 percentage point in FY 1998 through FY 2002.

(4) For Federal fiscal year 2001, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase plus 5 percentage points. However, this payment rate is effective only for the period April 1, 2001 through September 30, 2001. For the period October 1, 2000 through March 31, 2001, the payment rate is based upon the rule under paragraph (b)(3)(iv) of this section. The payment rate in effect during the period April 1, 2001 through September 30, 2001 is considered the payment rate in effect during fiscal year 2001.

(5) The payment rate for hospice services furnished during fiscal years 2001 and 2002 is increased by an additional 0.5 percent and 0.75 percent, respectively. This additional amount is not included in updating the payment rate as described in paragraph (b)(3) of this section.

Language Impacted in the IHCP Hospice Provider Manual

This section does not impact Section 6 of the *IHCP Hospice Provider Manual*. The IHCP must establish rates based on the Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributed to the Medicare premium amounts. The rates are adjusted for regional differences in wages using indexes published by the Centers for Medicare & Medicaid Services (CMS). The IHCP notifies providers of the new Medicaid hospice rates annually through a formal publication notice.

The CMS Web site is located at http://www.cms.hhs.gov/.

Medicaid Hospice Rates Update

This section supplements information previously released in provider bulletin *BT200524* Annual Updates to Hospice Rates.

The IHCP would like to note the following unweighted amount for each hospice level of care (LOC) as noted on the *CMS Chicago Regional State Letter Number 08-05*:

Table 1 – Unweighted Amounts for Hospice LOC

Description	Unweighted Amount
Routine Home Care	$39.63
Continuous Home Care	$231.09
Inpatient Respite Care	$63.18
General Inpatient Care	$202.51

Some billers have indicated that this information facilitates the billing process with their software so the IHCP is providing this additional information in this bulletin.

Medicaid Hospice Authorization Changes

Hospice providers are reminded that the Medicare and Medicaid hospice programs are primary for the treatment of the terminal illness and related conditions. HCBS waiver services and CHOICE are supplements to Medicare or Medicaid hospice. From a funding stream perspective, the IHCP has always noted that there is a hierarchy of funding streams as follows:

- Private Pay/Medicare (Medicare Hospice)
- Medicaid (Medicaid Hospice)
- Home-and-Community Based Services (HCBS)Waiver Programs
- CHOICE

The IHCP and the Indiana State Department of Health (ISDH) have received intermittent consumer complaints that some hospice providers are not providing all hospice covered services in frequency and scope to treat the terminal illness when a member is receiving HCBS or CHOICE. Federal Medicare regulations require the hospice to list on the plan of care in frequency and scope all hospice covered services needed to treat the terminal condition. Practices have included but are not limited to the following examples:

- Hospices indicating that homemaker services are not covered under the hospice program when the Medicare and Medicaid hospice per diems include homemaker services.
- Hospices indicating that the member has declined home health aide services and that the family is providing these services when the corresponding HCBS waiver plan of care or CHOICE plan of care reflects that the member is receiving attendant care or home health aide services under these programs.
- Hospice providers indicating that home health aide services can only be provided two times weekly and failing to explain what medical conditions or changes in the patient's medical acuity would warrant that the hospice plan of care may be modified to increase the frequency and scope to meet the member's change in medical acuity.
- Hospice core nursing services being delegated to the HCBS waiver respite nurse.
- Hospice durable medical equipment (DME) not being provided for the terminal illness while permitting HCBS waiver program to provide DME for the terminal illness.
- Hospice covered medications not being included in the hospice plan of care and while the HCBS waiver program continued to pay for the medications required to treat the terminal diagnosis.

In an effort to ensure better coordination among the personal care services, the IHCP will require hospice providers to take these additional documentation requirements, effective 45 days from the release of this bulletin. The changes are as follows:

- On the *Indiana Prior Review and Authorization Form*, the hospice must list other caregiving services received by the member, including, but not limited to, services provided by HCBS waiver programs or CHOICE.
- The hospice plan of care must list the frequency and scope of the visits planned by each discipline to treat the member's terminal illness and related conditions.
- The hospice plan of care must also list the frequency and scope of overlapping services that are provided by the HCBS waiver program or CHOICE for the member's non-terminal condition(s).

Hospice providers are reminded that the IHCP is requesting this additional information to ensure there is coordination among the different case managers. The Medicaid prior authorization unit can only approve the medical necessity with regards to the hospice care. The HCBS waiver case managers and CHOICE case managers must adjust their respective care plans. Hospice providers are reminded the IHCP or the Family and Social Service Administration (FSSA) has the discretion to review care plans from various programs to ensure that there is no duplication of service across programs lines when serving a member.

Documentation Standards

The IHCP has specified in the *IHCP Hospice Provider Manual* that the IHCP hospice authorization forms are legal documents that must adhere to medical records standards. Here are some documentation practices that will result in the HCE PA Unit suspending a request for additional information.

- The Conditions of Participation direct the provider to include frequency of visits for each discipline and PRN orders including what is the reason for the PRN visit.. Refer to Hospice Regulations found at *42 CFR 418.58* (c) Condition of Participation – Plan of Care. *42 CFR 418.58* (c) states, "The plan must include an assessment of the individual's needs and identification of services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs." PRN frequencies should reflect this language as well.
- An unfilled section on the IHCP hospice plan of care is unacceptable. Each discipline on the plan of care must provide the frequency and scope of the service provided. If a service is not provided, the hospice must specify why the service is not provided.

Contact Information

Providers with questions regarding this bulletin may contact Customer Assistance at (317)347-4511, local Indianapolis area, or 1-800-457-4518.

Providers with questions regarding Medicaid hospice authorization may contact the HCE Prior Authorization Unit at (317)347-4511, local Indianapolis area, or 1-800-457-4518.