



TENNCARE POLICY MANUAL

Policy No: BEN 07-001 (Rev. 7)	
Subject: Hospice	
Approved by: <i>Keith Hootner</i>	Date: 2/8/13
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PURPOSE OF POLICY STATEMENT:

The purpose of this policy is to provide an explanation of the hospice benefit that is covered under TennCare and to identify the specific obligations of the managed care organizations (MCOs) regarding payment for hospice and hospice-related care. It should be noted that this policy does not address the issue of patient liability for hospice patients who are receiving room and board in a Nursing Facility. That subject is discussed in Policy PAY 07-001.

DISCUSSION:

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A participating hospice must be Medicare-certified¹ and have a valid provider agreement with a participating MCO. In order to be eligible to elect hospice care, an individual must be certified by a physician as being terminally ill.² An individual is considered to be terminally ill if the individual has a medical prognosis that his life expectancy is six (6) months or less, if the illness runs its normal course.³

The hospice benefit under TennCare is almost identical to that provided to Medicare beneficiaries under Medicare Part A. Under either program, once an individual elects the hospice benefit, that individual has chosen to end curative treatment for his terminal illness. TennCare will not pay for curative services, including drugs, relating to the treatment of the individual's terminal illness unless the individual is a child under the age of 21.⁴ TennCare will continue to pay for other services for illnesses not related to the terminal illness. See the example under the section below entitled "Coverage of services outside the hospice benefit."

TennCare follows the same hospice benefit period used by Medicare. The election periods are:

¹ TennCare Medicaid Rules 1200-13-13-.08(9); TennCare Standard Rule 1200-13-14-.08(9)

² 42 U.S.C. §1396d(o)

³ 42 C.F.R. § 418.3

⁴ 42 U.S.C. § 1396d(o)(1)(C)

- An initial 90-day period
- A subsequent 90-day period
- An unlimited number of 60-day periods.⁵

TennCare also follows the same certification procedures and election procedures, as well as statements of election, revocation, and change of hospices as used by Medicare. TennCare enrollees must obtain hospice services from hospices that are providers in their MCOs.

POLICY:

Hospice is an optional benefit under the Medicaid program.⁶ It is a covered benefit for adults and children under both TennCare Medicaid and TennCare Standard. Hospice services are covered by the MCOs.⁷ This policy includes the following sections:

1. Covered hospice services.
2. Choice of hospices.
3. Room and board.
4. Hospice services for dual eligibles.
5. Coverage of drugs for hospice patients.
6. Coverage of related services.
7. Coverage of services outside the hospice benefit.
8. Special coverage requirements.
9. Copays.
10. Hospice payment rates to be used by the MCOs.
11. Annual limitation on payments for inpatient care.
12. Annual caps on payments.
13. Hospice and CHOICES.

Section 1. Covered Hospice 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 category of service.⁸ Core hospice services (identified by asterisk) must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads or to obtain physician specialty services.⁹ Descriptions of the hospice services to be provided are found at 42 C.F.R. § 418.202.

- Nursing services*
- Medical social services*
- Physician services*
- Counseling services*

⁵ 42 U.S.C. § 1395d(d)(1) and 42 C.F.R. § 418.21

⁶ 42 U.S.C. § 1396d(o)

⁷ TennCare – MCO Contractor Risk Agreement § 2.13.5

⁸ 42 C.F.R. § 418.202

⁹ 42 C.F.R. 418, Subparts D and F

- Physical therapy, occupational therapy, and speech-language pathology
- Home health aide and homemaker services
- Medical appliances and supplies, including drugs and biologicals
- Short-term inpatient care (including short-term inpatient care as a means of providing respite for the individual's family or other persons caring for the individual at home)

Section 2. Choice of Hospices

A TennCare enrollee must select a hospice that is Medicare-certified and has a valid provider agreement with the MCO.¹⁰ As with most provider types, the enrollee's choice of providers is limited to those hospice providers that participate in the enrollee's MCO.

A full benefit dual eligible may select a Medicare participating hospice agency for services even if that agency does not participate in the enrollee's MCO, since Medicare, and not TennCare, is the primary payer.

Section 3. Room and Board

For purposes of the TennCare hospice benefit, a Nursing Facility may be considered the residence of an enrollee.¹¹ An enrollee living in such a setting may elect the hospice benefit. When he does, his room and board expenses in the Nursing Facility become a part of the hospice benefit and are no longer covered under the TennCare Nursing Facility program.¹²

The Nursing Facility room and board arrangements are covered by the MCOs as a part of the hospice benefit. An addition to hospice reimbursement is made in this situation to take into account the room and board provided by the facility. The MCO must pay the hospice 95% of the Nursing Facility's per diem, as established by the Comptroller's Office for the Bureau of TennCare, for the enrollee's room and board.¹³ The hospice must, in turn, reimburse the Nursing Facility 95% of the Nursing Facility's per diem for the enrollee's room and board.

TennCare does not pay for room and board services in a residential hospice. The Social Security Act provides for payment only to be made to Nursing Facilities.¹⁴

Section 4. Hospice Services for Dual Eligibles

A full benefit dual eligible individual, meaning one who has both Medicare and full TennCare Medicaid benefits, who elects hospice coverage under TennCare, must also request hospice services from the

¹⁰ TennCare Medicaid Rules 1200-13-13-.08(9); TennCare Standard Rule 1200-13-14-.08(9)

¹¹ 42 U.S.C. § 1396d(o)

¹² 42 U.S.C. § 1396d(o) and TennCare – MCO Contractor Risk Agreement § 2.13.5.3

¹³ Ibid.

¹⁴ 42 U.S.C. § 1396d(o)

Medicare program. If a dual eligible wishes to revoke the hospice benefit, he must revoke both the Medicare and the TennCare hospice benefit. He cannot have one and not the other.¹⁵

For individuals dually eligible for Medicare and TennCare Medicaid, Medicare makes the full payment for hospice services, except for room and board charges in Nursing Facilities. Individuals who are dually eligible for Medicare and TennCare Medicaid will have their room and board care in the Nursing Facility paid for by the MCO, since for dually eligible persons, the MCO is responsible for TennCare-covered services not covered by Medicare. Because room and board is not covered by Medicare, it cannot be treated as a “cross-over” item for partial payment by TennCare.

Section 5. Coverage of Drugs for Hospice Patients

As in Medicare, only drugs as defined in 42 U.S.C. § 1395x(t) and which are used primarily for the relief of pain and symptom control related to the patient’s terminal illness are covered under the TennCare hospice benefit.¹⁶ There are times when TennCare hospice patients may require TennCare-covered drugs for treatment of diagnoses unrelated to their terminal illness. When that happens, they will get their drugs through the regular TennCare pharmacy program outside of the hospice benefit. Drugs covered by the TennCare pharmacy program are provided in accordance with TennCare rules 1200-13-13-.04 and 1200-13-14-.04. Hospice patients who are children under the age of 21 and hospice patients who are adults living in Nursing Facilities have no quantity limits on the number of prescriptions per month covered by the TennCare pharmacy program.

Section 6. Coverage of Related Services

The Medicare hospice benefit states that any 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 be made by Medicare is a covered hospice service.¹⁷ The TennCare hospice benefit is the same; however, such services in the patient’s plan of care must be TennCare-covered services.¹⁸

Section 7. Coverage of Services Outside the Hospice Benefit

TennCare-covered services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the individual when medically necessary.

Example: Mr. Brown is a dual eligible adult with terminal cancer and has elected hospice care. He must waive his rights to direct payment from Medicare or TennCare for services related to his terminal illness because these services are being provided under the hospice benefit. Mr. Brown also has insulin-dependent diabetes. Services provided that are related to his diabetes would be

¹⁵ CMS State Medicaid Manual §4305.3; CMS Medicare Benefit Policy Manual Chapter 9 §20.3

¹⁶ 42 C.F.R. § 418.202(f)

¹⁷ 42 C.F.R. § 418.202(i)

¹⁸ Dear State Medicaid Director Letter, dated August 13, 1998

covered outside the hospice benefit as these are not directly related to the reason he is receiving hospice services.

Coverage for treatment of services related to the terminal illness is available to individuals under the age of 21 as of March 23, 2010, in accordance with Section 2302(a) of the Patient Protection and Affordable Care Act.¹⁹

Section 8. Special Coverage Requirements

Covered under this requirement:²⁰

- **Periods of crisis:** a period in which a patient requires continuous care which is primarily nursing (RN or LPN) care to achieve palliation or management of acute medical symptoms.
- **Respite care:** short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home.
- **Bereavement counseling:** consists of counseling services provided to the individual's family for a period of one year after the individual's death. It is not separately reimbursable.
- **Special modalities:** A hospice may use chemotherapy, radiation therapy, and other modalities for *palliative purposes* if it determines that these services are needed. The use of such modalities is not for curative purposes, but for the relief and control of pain or symptom management. No additional payment is made regardless of the cost of these services.

Section 9. Copays

Hospice patients are exempt from copays under the TennCare Program.²¹

Section 10. Hospice Payment Rates to be used by the MCOs

TennCare payments for hospice care made by the MCOs must be equal to the Medicaid hospice rates established annually by CMS.²² CMS determines a daily rate for each of the four specific categories of hospice care, and MCOs provide payment for each day in which an individual is under the care of the hospice, subject to prior authorization and medical necessity determination processes.²³

There are four (4) levels of care into which each day of care is classified. Definitions for these levels of care are found at 42 C.F.R. §418.302.

- Routine Home Care
- Continuous Home Care

¹⁹ Pub. L. No. 111-148, March 23, 2010, 124 Stat 293 (codified at 42 U.S.C. § 1396d(o)(1)(C))

²⁰ 42 C.F.R. §§ 418.202-204 and CMS *State Medicaid Manual* §4305.6

²¹ 42 U.S.C. §§ 1396o(a)(2)(E) and (b)(2)(E) and 42 U.S.C. §§ 1396o-1(b)(3)(B)(iv); CMS *State Medicaid Manual* § 4306.3; TennCare Rules 1200-13-13-.05 & 1200-13-14-.05

²² MCO Contract, Section 2.13.5

²³ See 42 C.F.R. §§ 418.302 and 306, and 42 U.S.C. §§ 1396a(a)(13)(B) and 1396d(o)

- Inpatient Respite Care
- General Inpatient Care

The basic daily payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to hospice services provided to the patient, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. These activities include the establishment of the plan of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies.²⁴

If a physician is an employee of the hospice, or providing services under arrangements with the hospice, an additional payment is to be made to the hospice for other physicians' services such as direct patient care.²⁵

The hospice agency is to notify the MCO when the physician who has been designated as the attending physician is not a hospice employee. Such independent attending physicians are to be reimbursed according to the MCO's reimbursement methodology.²⁶

Section 11. Annual Limitation on Payments for Inpatient Care

Under the Medicaid hospice program, payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all of the MCO's patients in that hospice during the same period. Payments for inpatient days that are in excess of the maximum allowable number of days for the year must be reimbursed by the hospice to the MCO.²⁷

Section 12. Annual Caps on Payments

There is a limit on the overall aggregate payments made to a hospice during a hospice cap period. The cap period runs from November 1 of each year to October 31 of the following year. The total payment made for services furnished to an MCO's TennCare enrollees in a particular hospice during this period is compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. This limit is based on *services rendered during the cap year* regardless of when payment is actually made. Payments are measured in terms of all payments made by the MCO to a particular hospice on behalf of the MCO's TennCare enrollees who received services in that hospice during the cap year.²⁸ Payments made by the MCO for physician services used outside the hospice are included in

²⁴ 42 C.F.R. § 418.304 and CMS *State Medicaid Manual* §4307

²⁵ Ibid.

²⁶ Ibid.

²⁷ 42 C.F.R. § 418.302(f) and CMS *State Medicaid Manual* §4306.5

²⁸ 42 C.F.R. §§ 418.308 – 309

calculating the annual cap.²⁹ Payments made by the hospice for room and board in Nursing Facilities are not included in calculating the annual cap.³⁰

The hospice cap amount is calculated by multiplying the number of enrollees electing hospice care during the cap period by the cap amount. [The hospice cap is calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire year.] The latest hospice cap amount for the cap year ending October 31, 2012, is \$25,377.01.³¹ CMS annually announces what the hospice cap amount is for the cap period.

The computation and application of the annual limits on inpatient care and cap on payments amounts is made by the MCO at the end of the cap period. The hospice is responsible for reporting the number of TennCare enrollees electing hospice care during the period to the MCO. This must be done within 30 days after the end of the cap period.

The MCO will submit reports for the annual limits on inpatient care and cap on payments amounts to the Bureau of TennCare. The Bureau will perform a programwide calculation to determine if limits were exceeded. If a limit is exceeded, notification of agencies with overages will be made to MCOs.

Section 13. Hospice and CHOICES.

Hospice care is not a long-term care service under CHOICES. However, when a member enrolled in CHOICES chooses to receive hospice services certain programmatic changes occur. NOTE: A CHOICES member does NOT lose TENNCARE eligibility because he chooses to receive hospice care either in his home or in a Nursing Facility (NF).

If a CHOICES member (CHOICES Group 1) is living in an NF at the time he opts to receive hospice care for his terminal illness, he will be disenrolled from the CHOICES program. He remains enrolled in the TennCare program for all covered services. As described above, his room and board at the NF becomes a part of the hospice benefit and it is no longer paid directly to the NF by his MCO. The enrollee will continue to have a patient liability for which he is responsible. See *TennCare Policy Statement PAY 07-001 (Hospice and Patient Liability)*.

An individual enrolled in CHOICES Group 2 (HCBS) may elect hospice and continue to receive HCBS. However, the MCO is responsible, in the needs assessment and care planning process, for ensuring that services available under the hospice benefit are not supplanted by services provided through CHOICES. If a service that a member needs can be provided through the hospice benefit, it must be provided through the hospice benefit and not through CHOICES. CHOICES services may supplement but **not** supplant hospice benefits available to the member through either Medicare or TennCare.

If a CHOICES Group 2 member receiving hospice services in his home later decides to enter a NF, the process described above for a CHOICES Group 1 member will apply. That is, he will be disenrolled from CHOICES, but NOT from TennCare, as the NF room and board is a part of his hospice benefit. A patient

²⁹ 42 C.F.R. § 418.304

³⁰ CMS *State Medicaid Manual* § 4308.2

³¹ CMS *Hospice Payment System Fact Sheet* (accessed December 14, 2012, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf)

liability amount will be calculated for the individual by DHS for which he will responsible for making payment to the NF.

DEFINITIONS:

Change of hospices: A change of hospices occurs when an individual wishes to change the hospice from which services are being received. An individual may change hospices once per election period.

Election periods: The periods for which a TennCare enrollee who has a terminal illness may elect to have hospice services provided.

Room and board [for services provided in a nursing facility]: includes the performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the enrollee's room, and supervision and assisting in the use of DME and prescribed therapies.

Statement of election: The process whereby an individual submits documentation to a particular hospice of his/her desire to receive hospice services.

Statement of revocation: The documentation a patient submits to the hospice when he/she no longer desires hospices services.

Terminal illness: An illness that, if it runs its normal course, has a medical prognosis of six (6) months or less to live.

OFFICES OF PRIMARY RESPONSIBILITY:

Office of Managed Care Operations
Office of the Medical Director
Office of Long-Term Services and Supports (for CHOICES)

REFERENCES:

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, March 23, 2010, 124 Stat 293
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf

42 U.S.C. §§ 1396d; 1396o; and 1396o-1
<http://www.gpo.gov/fdsys/search/submitcitation.action?publication=USCODE>

42 C.F.R. Part 418
http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr418_main_02.tpl

Federal Register 70 FR 70532; November 22, 2005
<http://edocket.access.gpo.gov/2005/pdf/05-23078.pdf>

Dear State Medicaid Director Letter, dated August 13, 1998
<http://www.cms.hhs.gov/smdl/downloads/SMD081398.pdf>

CMS State Medicaid Manual, Chapter 4 – Services
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

CMS Internet-Only Manual, Pub 100-02: *CMS Medicare Benefit Policy Manual*, Chapter 9 – Coverage of Hospice Services Under Hospital Insurance (Rev. 156, June 1, 2012)
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf>

CMS Internet-Only Manual, Pub 100-04: *Medicare Claims Processing Manual*, Chapter 11 – Processing Hospice Claims (Rev. 2448, February 3, 2012)
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf>

CMS Hospice Payment System Fact Sheet
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf

TennCare Medicaid Rules and Regulations 1200-13-13-.04, -.05, and -.08(9) and 1200-13-14-.04, -.05, and -.08(9)
<http://www.tn.gov/sos/rules/1200/1200-13/1200-13.htm>

MCO Statewide Contract
<https://tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf>

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