



Patient Protection and Affordable Care Act (PPACA) Section 2302: Concurrent Care for Children

PROVIDER QUESTIONS AND ANSWERS FROM CMS
FEBRUARY 8, 2011

1. Does a state have to have a Medicaid hospice benefit to offer concurrent care for children through Medicaid or CHIP? And if a state eliminates their hospice benefit, does that mean that they no longer have to offer concurrent care for children because there is no Medicaid Hospice benefit?

CMS Response: Eliminating the hospice benefit is really only possible for adults. Hospice is a 1905(a) service, and would therefore need to be provided to individuals from birth through age 20 when medically necessary, regardless of whether hospice is offered to individuals over age 21. States MUST comply with 2302, whether or not they offer hospice to adults.

2. If we look at 2302 in its simplest form it states "to make hospice services available without forgoing any other services for which the child is eligible." Our state interpreted this to mean, remove all edits in the systems, but we are still responsible for everything that we state we will cover under the Hospice Benefit. But EPSDT and aggressive treatment and "other things" can be provided. So, the "other things" is where it gets sticky.

CMS Response: This is similar to other questions we've received, so I'll take a crack at answering. A good first step in implementing 2302 is to remove system edits that prohibited payment of curative treatment on top of hospice care. Hopefully there are also conversations happening between the State Medicaid Agency and the provider community to make sure everyone is aware of this provision and what it means.

Many hospices had been hoping that 2302 meant relief from some of the services they had had responsibility to provide, especially more expensive treatment options. But that's not how CMS is interpreting this provision. If a service is appropriate under the hospice benefit, it remains the responsibility of the hospice to provide it. We've had some tough conversations with hospices calling me about specific medications that are ghastly expensive, hoping that CMS would deem the medication "curative," and therefore not their responsibility to provide. A very uncomfortable position for CMS to be in. What's curative for one child could be palliative for another. We've instead reinforced the parameters of what's palliative – pain and symptom relief of the terminal condition. If a service fits that characteristic, it's part of the hospice benefit.

3. What about waiver programs, will children still be able to access Home and Community Based Waiver, SCL Waiver or Michelle P Waiver and the Hospice Benefit?

CMS Response: We've also received many questions about how this provision dovetails with waiver programs. The basic rule used to be that a State Plan service must be exhausted prior

to using waiver services. The general rule now is that service duplication needs to be avoided, but there is no hard and fast rule about which service needs to be exhausted “first”. Since the waiver respite care is different from State Plan hospice respite care in the use of family members as providers, children could elect hospice under the State Plan AND receive waiver respite care. This is a relatively new policy decision that CMS is working to publicize.

4. How much can the states tailor the new guidelines for pediatrics? Could they adjust the benefit to better suit pediatrics or is that a federal issue? For example remove the "life expectancy aspect" of the benefit or change it to state “expected to die before adulthood”?

CMS Response: Section 2302 of the Affordable Care Act does not change eligibility for the hospice benefit, i.e. a physician must certify that the child’s life expectancy is six months or less in order to qualify for hospice services.

5. Is it up to the states to decide what falls under “curative” therapies? For example a scan to detect disease progression maybe for chemo maybe just to know the situation, would that be the hospice's expense or straight Medicare?

CMS Response: It is CMS’ expectation that States work out a process with hospice providers about how services should be billed. The process should reflect an understanding that each child’s circumstances are unique and that decisions about what is “curative” reflect each child’s unique needs and be based on the State’s medical necessity criteria for the needed service. Ultimately, therefore, determinations of what are “curative” services for a child must be made on a case-by-case basis.

6. What about blood transfusions, as an example - not really curative but certainly part of a curative therapy regimen for some conditions. These are common end of life treatments in some pediatric conditions, but not so common in adult hospice. Who would pay for the transfusions? Hospice or Medicaid?

CMS Response: In addition to our answer to question 2 above, we think it is also important to bear in mind the particular purpose of the service. In your example, if the purpose of the blood transfusion was a curative treatment for the terminal condition, then the State’s Medicaid program would be responsible for the expense. If, on the other hand, it was for pain or symptom control, then the hospice provider absorbs the expense. A review of the physician’s orders or the hospice plan of care may assist the hospice provider and the State Medicaid agency in determining the purpose of the service or treatment. Thus, States would reimburse other providers for curative services, but would continue to reimburse hospice providers for hospice services.

7. Who would make the decision of where things are billed?

CMS Response: States would continue to pay providers of curative services using the payment methodology approved for those services. States will continue to reimburse hospices for services within the hospice benefit. We would expect States to have a process to ensure

collaboration with the provider community to take each child's case into account in determining whether a service is curative or palliative.

8. Do we know what details are left up to the state? Can pediatric healthcare professionals in various states get together to suggest guidelines for state Medicaid agencies to follow?

CMS Response: State Medicaid agencies must make the determinations of whether a particular service for a child meets the State's medical necessity criteria for that service. We encourage and expect States and hospice providers to discuss and agree on a process that would address operational details in implementing section 2302 of the Affordable Care Act. Accordingly, we think that any assistance pediatric healthcare professionals can contribute to that effort would be worthwhile.

9. How does this work in states with Medicaid waivers at the moment?

CMS Response: The answer to this question could be different depending on the type of waiver. For 1915(c) Home and Community Based Services waivers offering hospice care in conjunction with curative treatment, the passage of section 2302 does not have a fundamental impact on waiver operation. Services offered through the Medicaid State Plan, which now includes both hospice care and curative treatment, would be accessed prior to accessing waiver services. However, to the extent that services in the waiver include services outside the State Plan, such as respite care, or involve the provision of hospice services outside the life expectancy of six months, those services can be accessed any time.

10. Do all states have to pay for concurrent care for children with Medicaid? What is the interface with the state's Medicaid hospice benefit?

CMS Response: Yes, States are responsible for covering, and Federal reimbursement is available for, the concurrent provision of curative care and hospice services for Medicaid-eligible children. CMS issued a letter to all State Medicaid Directors (SMD # 10-018) on September 9, 2010, providing guidance on section 2302 of the Affordable Care Act which was effective on March 23, 2010. All Medicaid programs, including CHIP programs operating as Medicaid expansions, are required to continue to provide medically necessary curative services, as well as, hospice services for children. We encourage providers to contact their State Medicaid Agencies to discuss an implementation strategy for this provision.

11. Does the state have the opportunity to decide what is considered "related" to the terminal illness?

CMS Response: Yes, the State Medicaid Agency determines the standards or procedures for determining the medical necessity for any Medicaid service. Further, section 2302 of the Affordable Care Act requires States to remove any limits on the receipt of curative treatment, other than medical necessity, for children also receiving hospice services. We would expect States to have a process to ensure collaboration with the provider community to take each child's case into account in determining whether a service is curative or palliative.

12. Has there been discussion on how cost neutrality will be calculated with the new requirements?

CMS Response: There is no "cost neutrality" requirement under the State Plan. Section 2302 requires States to reimburse for medically necessary services found at Section 1905(a) of the Social Security Act, even after the hospice benefit is elected by or on behalf of a child.

13. Are children receiving care under the Hospice benefit also eligible to receive FIT/EI services as well?

CMS Response: Section 2302 of the Affordable Care Act means that States must comply with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement to provide any medically necessary 1905(a) service to a child from birth to age 21, even after election of the hospice benefit by or on behalf of a child. Therefore, eligible children receiving care under the Hospice benefit should receive FIT/EI services as well, to the extent these services are medically necessary and are provided pursuant to a service authorized under section 1905(a).

14. The letter seems to imply that the states would have to pay separately under Medicaid for the concurrent services. Is this the case or would hospices have to absorb the cost of curative care under the hospice benefit daily rate. The language in the letter does not specifically state that the states would continue to concurrently pay separately for curative services just that curative service would not be excluded from the services available to children with life expectancy of 6 months or less.

CMS Response: States would continue to pay providers of curative services using the payment methodology approved for those services. States will continue to reimburse hospices for services within the hospice benefit. We would expect States to have a process to ensure collaboration with the provider community to take each child's case into account in determining whether a service is curative or palliative. Hospices are not responsible for providing or paying for curative treatment.

15. Moving forward with the application of this new provision of concurrent care for children - hospice and "curative" focus, will there be certain parameters placed on current state-provided services e.g. state provided in-home nursing, hospitalizations for hospice appropriate children? What will need to be included in documentation to substantiate that these services and treatments are "medically necessary." Have there been any guidelines or language given for us to observe?

CMS Response: Implementation of this new provision for concurrent care for children should be determined at the State level, particularly with regard to determining medical necessity. Whatever standards or procedures the State currently uses to determine medical necessity for any Medicaid service would continue to apply to curative services provided to children who

elect the hospice benefit. States should not place any restrictions or limitation on the receipt of curative treatment, other than medical necessity. CMS does not plan to issue any further guidance on this provision, but we are available to provide technical assistance to States on the parameters of this new provision.

16. The notification sent out today indicated that "appropriate forms and language for any revisions to the State Medicaid Plan" will be provided but the provision of this concurrent coverage is to begin immediately. However, in the next paragraph, it states that "This letter should be seen as a 'first step' in the implementation of (this care)... By releasing this transmission to the states, CMS has merely begun a process of dialogue on the provision and will now have more flexibility to field questions from the stakeholders."

CMS Response: The issued State Medicaid Directors letter represents the universe of guidance CMS intends to release at this time. At the point when the revised pre-print is ready to be released, CMS will issue a subsequent letter. However, given that the effective date of section 2302 was upon enactment of the Affordable Care Act, we expect States and providers to immediately collaborate to determine how to implement this provision.

17. Please clarify: the concurrent care can commence immediately, forms will be forthcoming (what and when?), and the dialogue process has just begun. Using the directive that this care is to begin immediately, then, for those of us who have hospice appropriate children with Medicaid coverage, we should admit these children into hospice care, documenting medical necessity for all care, and move forward.

CMS Response: As CMS stated in our State Medicaid Letter (SMD # 10-018), dated September 9, 2010, this provision was effective upon enactment of the Affordable Care Act on March 23, 2010. Therefore, under Medicaid, including CHIP programs operating as Medicaid expansions, we expect States will continue the provision of medically necessary curative services. States operating stand-alone CHIP programs that offer the optional hospice benefit must now provide it concurrently with medically necessary services.

CMS refers you to your State Medicaid officials responsible for implementing this new provision. We do expect that States will now have processes and systems in place to accept and process claims for children receiving curative treatment after election of the hospice benefit. We emphasize that the Affordable Care Act statute does not make the hospice financially responsible for any care that it would not have provided previously. States would continue to provide and reimburse for curative care separately from hospice services.