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Introduction

This issue brief is the second prepared by NHPCO regarding Medicaid and Hospice. The first brief focused on the Medicaid Hospice Benefit and its maintenance as an optional State benefit. This follow-up brief addresses the issues facing hospice providers as more States are implementing managed care programs to deal with increasing economic pressures.

Medicaid Managed Care

States have traditionally provided Medicaid benefits using a fee-for-service system. However, in the past 15 years, States have more frequently implemented managed care delivery systems for Medicaid benefits. In a managed care delivery system, most or all Medicaid services are provided from an organization under contract with the State. Almost 50 million recipients receive benefits through some form of managed care through Medicaid, either on a voluntary or mandatory basis.

States can allow voluntary enrollment in a Medicaid managed care program, but more frequently, States make the decision about Medicaid managed care participation and require enrollment in a Medicaid managed care program. Increasing numbers of States are using Managed Long Term Services and Supports as a strategy for expanding home and community-based services, promoting community inclusion, ensuring quality and increasing efficiency. When States implement a Medicaid managed care program, they can use any one or more of the following types of entities:

- **Medicaid Managed Care Organizations (MMCOs)** – like HMOs, these companies agree to provide most Medicaid benefits in exchange for a monthly payment from the State.
- **Limited benefit plans** – these companies may look like HMOs but only provide one or two Medicaid benefits (like mental health or dental services).
- **Primary Care Case Managers** – these individual providers (or groups of providers) agree to act as an individual’s primary care provider, and receive a small monthly payment for helping to coordinate referrals and other medical services.

ACA and Medicaid Expansion

**Medicaid Expansion and States:** As States wrapped up their legislative sessions for 2013, decisions were being made regarding implementation of Medicaid expansion included in the Affordable Care Act (ACA). As of November 2013, 26 States were moving forward with the Medicaid expansion, 22 States were not moving forward with the expansion, and debate was on-going in the remaining 3 States.¹ The

decisions by nearly half the States not to expand their Medicaid programs to cover individuals with incomes up to 138% of the poverty level will leave a major hole in the health reform effort. To view the current status by State, as this has been evolving and there is no deadline for States to implement expansion, view the Kaiser Family Foundation website located in footnote 1. This website also contains valuable information on the number of people impacted by these decisions.

**ACA Goal for Expansion of Insurance Coverage:** The primary goal of the ACA was to reduce the number of uninsured by providing for more affordable insurance coverage and mandating that almost all individuals obtain coverage, either through private insurance or expansion of States’ Medicaid programs. From a hospice perspective, reducing the number of uninsured would relieve some of the pressures to provide unfunded or charity care. The expansion of health insurance coverage could be of major benefit to hospice partners, such as hospitals. However, depending upon the configuration of the health insurance exchanges set up to offer insurance, there could also be some negative impact. For example, insurance companies participating in the exchanges may narrow down the number of contracted providers and not allow any willing provider. The expansion of Medicaid to a wider population could also create an additional financial burden to States in the long-term, requiring legislators to eliminate “optional services” such as hospice.

**Resources for States in Medicaid Discussions:** State hospice organizations must be involved in their State’s conversations on Medicaid expansion, and coverage of this population, as decisions are made. Often hospice is not intentionally excluded from coverage, but rather may be forgotten, or not well understood. See the Appendices in this document for resources that may be helpful in discussions with your State Medicaid agency, Medicaid Managed Care Organizations, and CMS.

**State Medicaid Plans**

The Medicaid program is jointly funded by the federal government and States. The percentage of payment by the federal government varies by State based on criteria such as per capita income. The federal match is called the Federal Medical Assistance Percentage (FMAP). The average State FMAP is 57%, but ranges from 50% in wealthier States up to 75% in States with lower per capita incomes (the maximum regular FMAP is 82 %).²

In order to ensure that a State abides by Federal rules and can receive Federal matching funds for their Medicaid program, the State enters into a contract with the Federal government. The plan outlines which individuals will be covered, services to be provided, how providers will be reimbursed, and compliance with the administrative requirements for participation.³ If the State desires to change its plan, the State sends a State plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) for review and approval. States may amend their plan to reflect changes in federal or State law, regulations, or court orders. Through this process, States have the flexibility to make changes and update their plans. States also have the flexibility to request permissible program changes, make corrections, or update their plan with new information.⁴ A State may also amend its plan through an application for a waiver.

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State Medicaid Waivers

Waivers are vehicles States can use to test new or existing ways to deliver and pay for health care services under Medicaid and the Children's Health Insurance Program (CHIP). States can implement a managed care delivery system using waivers. There are four primary types of Medicaid waivers and demonstration projects:

1. **Section 1115 Research & Demonstration Projects**: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.

2. **Section 1915(b) Managed Care Waivers**: States can apply for waivers to provide services through managed care delivery systems or otherwise limit recipients’ choice of providers.

3. **Section 1915(c) Home and Community-Based Services Waivers**: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.

4. **Concurrent Section 1915(b) and 1915(c) Waivers**: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.\(^5\)

Regardless of the State’s authority to change the Medicaid program (State plan or waiver), States must comply with the federal regulations that govern the type of Medicaid managed care approved by CMS. These regulations include requirements for a managed care plan to have a quality program and provide appeal and grievance rights, reasonable access to providers, and the right to change managed care plans, among others.\(^6\)

Hospice Payment Rates Under Medicaid

Hospices, unlike other providers, receive nearly the same payment for the Medicaid Hospice Benefit that they receive for the Medicare Hospice Benefit due to a requirement in the Social Security Act (Social Security Act §1902(a) (13) (B)). The only difference in rates is that Medicaid hospice rates do not include a co-pay for respite care or for medications. Rates for each fiscal year are set by CMS and announced in the weeks prior to the October 1 start of the federal fiscal year. For States with a Medicaid Hospice Benefit, the Medicaid statute requires that the State pay for hospice care “in amounts no lower than the amounts, using the same methodology, used under Part A [of Medicare].”\(^7\) For other healthcare providers, Medicaid can determine the rate independent of what is being paid by Medicare.

\(^5\) [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html)
\(^6\) [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html)
\(^7\) Social Security Act § 1902(a) (13) (B).
Structure of Medicaid Hospice Benefit

Since hospice is an optional Medicaid benefit, States may, but are not required to, offer the benefit to their Medicaid recipients. However, those States that do choose to include hospice in their Medicaid programs must structure the benefit to meet certain statutory requirements.

1. **Definition of “Hospice Care”**: The Medicaid statute incorporates the Medicare definition of “hospice care,” which requires that such programs provide a full range of services, pursuant to a plan of care developed for each patient by the patient’s physician and an interdisciplinary group.

2. **Definition of “Hospice Program”**: The Medicaid statute incorporates the Medicare definition of a “hospice program,” which requires that such programs be primarily engaged in providing “hospice care,” provide core services directly through employees, and maintain professional management responsibility for all services arranged by the hospice. Inpatient days must be limited to no more than 20 percent of the total days of care.

3. **Revocation and Change of Hospice Programs**: Both Medicare and Medicaid allow patients to revoke their election of hospice at any time, and allow patients to change hospices. Although the Medicare statute includes some language that is not included in the Medicaid statute, the rules are effectively the same.

4. **Payment Rates**: The Medicaid statute requires that Medicaid programs pay for hospice care “in amounts no lower than the amounts, using the same methodology, used under Part A [of Medicare]”. Therefore, Medicaid programs may pay more, but not less, than the Medicare rate for hospice services. [Note: this is unrelated to the room and board payment for nursing facility residents which is addressed separately.]

5. **Waiver of Other Benefits**: Under both Medicare and Medicaid, patients who elect hospice must waive their right to other payment for services related to their terminal condition if those services would be covered by Medicare. Federal law does not require Medicaid recipients to waive payment for other services that would be covered by Medicaid but not Medicare (e.g., certain personal care services) in order to elect the hospice benefit. However, States may require, as a condition of receiving certain non-hospice Medicaid benefits (e.g., home & community based waiver services), that recipients choose either those benefits or the hospice benefit. Under both Medicare and Medicaid, payment for physician services is not waived and continues to be paid separately.

The charts found in Appendix I fully describe the statutory requirements for the ways in which the Medicare and Medicaid hospice benefits must be the same and the ways in which they may or must differ. States and providers have found them to be a very helpful resource.

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8. Social Security Act § 1902(a) (13) (B).
9. This chart addresses the provisions of the Medicare and Medicaid statutes, which are included in Title XVIII Medicare and Title XIX (Medicaid) of the Social Security Act. This does not address the Medicare hospice regulations found in Part 418 of Title 42 of the Code of Federal Regulations, or the provisions included in various Medicare and Medicaid manuals.
Medicaid Payments for Hospice and Hospice Payments to Residents in Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

The Social Security Act provision outlined below describes payment stipulations to hospice providers when providing care to patients in nursing facilities (NF) or in intermediate care facilities for the mentally retarded (ICD-MR). This includes the “95% rule” for hospice care furnished to a resident of a nursing facility or ICF-MR. The rate paid to the hospice for “room and board” is required, by law, to be at least 95% of the rate that would have been paid by the State under the plan for facility services in that facility for that individual.

Social Security Act § 1902(a) (13) (B)

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;

The language in this section requires the State Medicaid agency to set a payment rate for hospice room and board services that is equal to at least 95 percent of the rate that would have been paid by the State for care in that facility for that individual.

Having the nursing home room and board payment made directly to the hospice provider creates an administrative burden. This can also turn into a reimbursement burden when the State is unable to pay the hospice in a timely manner. Likewise, with an increase in Medicaid Integrity audits, hospices have been required to correct various billing issues or auditors have made determinations about hospice eligibility for Medicare Hospice services based on a review of the nursing home room and board. While hospice providers would prefer that the payment is made directly to the nursing home, the statute is clear that payments are to be made to the hospice, and cannot be made directly to the nursing home.

Social Security Act § 1905(o) (3) (C)

(C) with respect to whom the hospice program under such title and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual’s hospice care and the facility agrees to provide room and board to the individual, instead of any payment otherwise made under the plan with respect to the facility’s services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1902(a)(13)(B) and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4). (emphasis added)
Waiver Language and Hospice

As States are preparing plan amendments or waivers, hospices need to be vigilant regarding any language concerning an exemption or waiver from complying with these specific areas of the Social Security Act (SSA). To date, States have not asked for any exemptions related to hospice, but that may not be the case in the future. The financial impact could be devastating. There has not been a legislative attempt on the part of NHPCO to eliminate payment to the hospice for room and board since the rate guarantee and "pass through" are so interconnected.

Other Medicaid Developments

Centers for Medicare and Medicaid Services – Innovations, Dual Eligibles Demos and Financial Alignment Demos

The introduction of programs for dual eligibles, that is those who are eligible for both Medicare and Medicaid, will significantly impact hospice providers, since many dual eligible recipients are nursing home residents. State hospice organizations should be actively involved in discussions at the State Medicaid agency because of the impact on recipients who elect hospice care.

The CMS Innovations Center

Congress created the Centers for Medicare and Medicaid Innovations (the Innovations Center) for the purpose of testing “innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits. The Innovations Center has further encouraged States to explore alternative models of health care delivery.

The CMS Medicare-Medicaid Coordination Office (the “Office”), established in Section 2602 of the Affordable Care Act, works with the Medicaid and Medicare programs, across federal agencies, States and stakeholders to align and coordinate benefits between the two programs “effectively and efficiently.” The Stated goals of the Office are:10

1. Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.
2. Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.
3. Improving the quality of health care and long-term services for dual eligible individuals.
4. Increasing dual eligible individuals’ understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
5. Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
6. Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

7. Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

8. Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

**Dual Eligible Demos**

According to CMS, under the State Demonstrations to Integrate Care for Dual Eligible Individuals, fifteen States across the country have been selected to design new approaches to better coordinate care for dual eligible individuals. CMS will provide funding and technical assistance to States to develop person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for dual eligible individuals. The goal is to identify and validate delivery system and payment coordination models that can be tested and replicated. The States selected to receive design contracts are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

States that engage with beneficiaries and other stakeholders and successfully complete their design contract may be eligible to receive support to implement their proposals. After federal review of the proposals, CMS will work with States to implement the plans that hold the most promise.

**Financial Alignment Demonstration**

A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address this issue, CMS will test two models for States to better align the financing of these two programs and integrate primary, acute, behavioral health, and long-term services and supports for their Medicare-Medicaid enrollees.

These two models include:

1. **Capitated Model:** A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.

2. **Managed Fee-for-Service Model:** A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

CMS is interested in testing these models across the country in programs that collectively serve up to 2 million Medicare-Medicaid enrollees. All programs will be rigorously evaluated as to their ability to improve quality and reduce costs. Meaningful engagement with stakeholders and ensuring beneficiary protections will be a crucial part of developing and testing these models.

To participate in the Financial Alignment Demonstration, each State had to submit a proposal outlining its proposed approach for the Financial Alignment Demonstration. A total of 26 States submitted proposals. For more information, see the CMS website at the following link:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html
proposals. When a State meets the standards and conditions for the Financial Alignment Demonstration, CMS and a State will develop a Memorandum of Understanding (MOU) to establish the parameters of the initiative. A complete list of States with their MOUs is available on the CMS website.12

With either of these models, it is anticipated that the traditional Medicare Hospice Benefit would remain intact for these dual eligible beneficiaries.

For more information on the dual eligibles demonstration project and its current status, also see http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8426-03-financial-alignment-demonstrations.pdf

**Concurrent Care for Children**

Section 2302 of the Patient Protection and Affordable Care Act (ACA) amended the federal Social Security Act, Section 1905(o)(1) and 2110(a)(23), and was signed into law by President Obama on March 23, 2010. The provision states that a child that has been diagnosed with a terminal condition can voluntarily elect hospice care and concurrently receive, and have Medicaid payment made for, services that are related to the treatment of the child’s terminal condition.13 This provision affects children who are eligible for Medicaid or the Children’s Health Insurance Program (CHIP). The provision in the law is not optional, has an effective date of March 23, 2010 and is required to be implemented in every State, whether or not the State has a Medicaid hospice benefit for adults. CMS expects States to continue to provide and pay for curative/life prolonging services for children from birth through age 20, concurrently with a hospice election. For more detailed information on this provision, see the Concurrent Care for Children Implementation Toolkit at http://www.nhpco.org/resources/concurrent-care-children.

**Additional Resources for Hospice Providers**

State hospice organizations and providers must monitor the developments of Medicaid Managed Care in their State, including managed care for Dual Eligibles. It is important that hospice leaders are engaged with their State decision-makers who have authority over Medicaid Managed Care.

A list of contract considerations for hospice providers in their discussions with Medicaid Managed Care Organizations (MMCOs) developed by NHPCO, can be found in Appendix II. The Kentucky Association for Hospice and Palliative Care developed a set of questions that were presented to three MMCOs in Kentucky to begin the conversation about hospice coverage, and can be found in Appendix III.

Entering into relationships with MMCOs with a defined process will eliminate many hours in the prevention or resolution of problems that may arise.

This is not an all-inclusive list and must be tailored to the specifics of each State’s Medicaid managed care program and the participating MMCOs.

13. The full text of Section 1905 is included in Appendix 1. Public Law No. 111-148, as amended by the Healthcare and Education Reconciliation Act of 2010 (Public Law No. 111-152).
Appendices
Appendix I: Comparison Of The Medicare And Medicaid Hospice Benefits

The following chart sets forth the ways in which the Medicare and Medicaid hospice benefits must be the same and the ways in which they may or must differ.14 Since hospice is an optional Medicaid benefit, States may, but are not required to, offer it to their Medicaid recipients. However, those States that do choose to include hospice in their Medicaid programs must structure the benefit to meet certain statutory requirements.

**Medicare and Medicaid are Essentially the Same:**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition of “Hospice Care”</strong></td>
<td>The Medicaid statute incorporates the Medicare definition of a “hospice program”, which requires that such programs provide a full range of services, pursuant to a plan of care developed for each patient by the patient’s physician and an interdisciplinary group.</td>
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<td><strong>Definition of “Hospice Program”</strong></td>
<td>The Medicaid statute incorporates the Medicare definition of a “hospice program”, which requires that such programs be primarily engaged in providing “hospice care”, provide core services directly through employees, and maintain professional management responsibility for all services arranged by the hospice. Inpatient days must be limited to no more than 20 percent.</td>
</tr>
<tr>
<td><strong>Revocation and Change of Hospice</strong></td>
<td>Both Medicare and Medicaid allow patients to revoke their election of hospice at any time, and allow patients to change hospices. Although the Medicare statute includes some language that is not included in the Medicaid statute, the rules are essentially the same.</td>
</tr>
<tr>
<td><strong>Payment Rates</strong></td>
<td>The Medicaid statute requires that Medicaid programs pay for hospice care “in amounts no lower than the amounts, using the same methodology, used under Part A [of Medicare]”.15 Therefore, <strong>Medicaid programs may pay more, but not less, than the Medicare rate for hospice services.</strong> [Note: this is unrelated to the room and board payment for nursing facility residents which is addressed separately]</td>
</tr>
<tr>
<td><strong>Waiver of Other Benefits</strong></td>
<td>Under both Medicare and Medicaid, patients who elect hospice must waive their right to other payment for services related to their terminal condition if those services would be covered by Medicare. Federal law does not require Medicaid recipients to waive payment for other services that would be covered by Medicaid but not Medicare (e.g., certain personal care services) in order to elect the hospice benefit. However, <strong>States</strong> may require, as a condition of receiving certain non-hospice Medicaid benefits (e.g., home &amp; community based waiver services), that recipients choose either those benefits or the hospice benefit. Under both Medicare and Medicaid, payment for physician services is not waived and continues to be paid separately.</td>
</tr>
</tbody>
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14. This chart addresses the provisions of the Medicare and Medicaid statutes, which are included in Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act. This does not address the Medicare hospice regulations found in Part 418 of Title 42 of the Code of Federal Regulations, or the provisions included in various Medicare and Medicaid manuals.

Medicare and Medicaid Requirements May or Must Differ:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility for Hospice</strong></td>
<td>Hospice is available to individuals who have been certified as “terminally ill”, which is defined as an individual with a medical prognosis that their life expectancy is 6 months or less</td>
<td>The law states that hospice care is care provided to a “terminally ill individual” but does not define “terminally ill” and does not incorporate the Medicare definition. Arguably, a state could define “terminally ill” more, but not less, broadly than the Medicare definition because there is a separate Medicaid provision stating that hospice care may not be made available “in an amount, duration or scope” less than that provided under Medicare.¹⁶</td>
</tr>
<tr>
<td><strong>Election of Hospice</strong></td>
<td>Individuals must elect to receive hospice care provided by, or under arrangements made by, a particular hospice program instead of certain other benefits to which they would otherwise be entitled. The Medicare hospice regulations specify certain election procedures that must be followed and certain information that must be provided to beneficiaries electing hospice.</td>
<td>States are to establish their own procedures for electing hospice but the election must be voluntary and the procedures must be “consistent with” the procedures established under the Medicare program. Therefore, states may adopt the Medicare election procedures, but are not required to.</td>
</tr>
<tr>
<td><strong>Certification of Terminal Illness</strong></td>
<td>At the beginning of the first 90 day period the patient’s attending physician and a hospice physician must each certify in writing that the patient is terminally ill, based on their clinical judgment regarding the normal course of the individual’s illness. At the beginning of each subsequent period, the attending physician or hospice physician must recertify that the patient is terminally ill.</td>
<td>The Medicaid statute does not address certification of terminal illness. Many states follow the Medicare rules regarding certification, but they may establish different requirements.¹⁷</td>
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</table>

¹⁶ Social Security Act section 1902(a)(10). The meaning and scope of this provision have not been tested, so it’s unclear to what extent it would protect Medicaid hospice recipients from state efforts to impose certain restrictions.

¹⁷ Some states continue to use the Medicare requirements that were in effect prior to passage of the Balanced Budget Act of 1997 (“BBA”). Although the BBA eliminated the Medicare requirement that written certification be on file within a certain number of days, states are not required to follow suit.
<table>
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<tr>
<th>Issue</th>
<th>Medicare</th>
<th>Medicaid</th>
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<tbody>
<tr>
<td>Benefit Periods</td>
<td>Medicare provides for two benefit periods of 90 days each, followed by an unlimited number of 60 day periods.</td>
<td>States may establish their own benefit periods, and the length and number of these periods need not be the same as those established under the Medicare program. However, since Medicare has an unlimited number of benefit periods, arguably a State could not limit the total number of days that recipients could receive hospice services because of the separate Medicaid requirement that hospice care may not be made available “in an amount, duration or scope” less than that provided under Medicare.</td>
</tr>
<tr>
<td>Annual Cap on</td>
<td>The Medicare statute establishes a limit, adjusted annually, on the total amount of Medicare reimbursement the hospice may receive during the year.</td>
<td>The Medicaid statute does not incorporate the Medicare cap on payments, but States have the option of establishing a Medicaid cap. Provisions in the CMS State Medicaid Manual provide instructions, which largely mirror the Medicare cap provisions. “Room and board” payments for nursing facility residents are excluded from calculations regarding the hospice cap.</td>
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18. The Centers for Medicare and Medicaid Services ("CMS") has advised States that it generally is easier to administer the Medicaid hospice benefit when the periods for the benefit are the same as under Medicare, but they have no legal authority to require States to establish any particular benefit periods.

19. Social Security Act section 1902(a)(10). As noted above, the meaning and scope of this provision have not been tested, so it’s unclear to what extent it would protect Medicaid hospice recipients from State efforts to impose certain restrictions.
### Hospice for Nursing Facility Residents

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
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</table>
| The Medicare hospice benefit does not include payment for residential services, but it does pay (primarily at the routine home care rate) for hospice care provided to Medicare beneficiaries who reside in a nursing facility ("NF") or intermediate care facility for the mentally retarded ("ICF/MR"). | The Medicaid benefit requires States to make a separate payment to hospices to cover the “room and board” costs of individuals who have elected hospice and whose residence in a NF or ICF/MR would otherwise be covered by Medicaid. In all cases, this payment for “room and board” must be made to the hospice and must be “equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual.”


21. The hospice must have entered into an agreement with the NF or ICF/MR under which the hospice takes full responsibility for the professional management of the individual’s hospice care and the facility agrees to provide room and board.

**Dual Eligibles:** For individuals who (1) are eligible for both Medicare and Medicaid, (2) have elected hospice, and (3) reside in a NF or ICF/MR paid for by Medicaid, the Medicaid program must make the room and board payment to the hospice even if the State does not provide a Medicaid hospice benefit.

**Medicaid-Only Recipients:** If a Medicaid program provides a hospice benefit, they must make the additional room and board payment to the hospice if the individual electing hospice is eligible for Medicaid covered services in a NF or ICF/MR and is receiving hospice care while residing in such a facility.

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Appendix II: Medicaid Managed Care Organizations (MMCOs)
Contract Considerations for Hospice Providers

Hospice providers are encouraged to actively engage their State Medicaid, managed care and other related healthcare agencies to influence the delivery framework for hospice services to Medicaid recipients. The following considerations and questions may be helpful in such discussions and in strategic planning activities. This is not an all-inclusive list and some issues may not be applicable to all States.

Information Gathering for the Hospice Provider

- Determine if hospice will be carved-in or a carve-out of the MMCO (will the MMCO or State reimburse the hospice?).
- Determine what type of waiver the State has, if any (e.g. 1115 Waiver, 1915(b) Waiver, etc.):
  - CMS website https://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp
  - Research your State Medicaid website for information
  - Request this information under the Freedom of Information Act
- Obtain a copy of the waiver application submitted by the State to CMS to determine if waivers were achieved from actual Hospice statutory requirements.
- Obtain a copy of the State Plan Amendment.
- Obtain a copy of contract between MMCO and Department of Medicaid Services and identify all hospice language:
  - Does the MMCO contract address contracting with all willing Hospice providers?
  - If not, what is the application/selection process?
  - How have Plans been educated as to how hospice care will work, be compensated, etc.?
  - Will the State Medicaid Managed Care Plan have mandatory or voluntary enrollment?
  - Will some categories of recipients be left in the fee-for-service (FFS) system?
  - Obtain a list of what is inside the Plan and what is still FFS.
  - Clarify the eligibility process for hospice services.
  - How will recipients be assigned/enrolled in the Plans?
  - Obtain provider relations contacts at MMCOs.
  - What other States have the selected MMCOs operated in, if any? Get information on how they worked in those States with hospice providers.
  - Where are the physical offices of each participating MMCO?
  - What are the important contact numbers for eligibility, authorization, billing, appeals, etc.?
  - How do Medicaid Medical Homes interact with the MMCO?
  - Will the current patient’s primary care provider be changed at implementation?
  - Get copies of the MMCO plan handbooks.
  - Check to see if there will be an advisory/oversight committee at the State level and encourage your State hospice association to get involved.
Contracts for Hospice Services

- Consider proposing in contract negotiations to have certain items, procedures outside of the contract—transfusions, certain medications, etc.
- Check if there are provider contract templates and obtain them.
- See if the hospice provider can use its own contract or will there be a MMCO contract.
- How difficult will it be to make amendments to the contract?

Eligibility/Authorization for Hospice Services

- Make sure what is established for hospice does not contradict either the current hospice licensing laws and/or the Medicaid Billing Manual.
- Will this function be outsourced or at the MMCO Plan?
- Determine eligibility and authorization process and establish consistent criteria and uniform hospice authorization processes between MMCOs.

Services Included/Excluded under Hospice

- Will hospice have any barriers to case management of the patient?
- What services are part of the hospice contract and which ones are pulled out?
- How are Pharmacy, DME and Supplies handled?
- Are ambulance, nutrition and physician services covered outside the hospice rates?
- What other services might overlap with hospice? How will this be coordinated?
- How will pediatric concurrent care be handled?
- Have the MMCOs been educated about inclusions and exclusions?
- Clarify EPSDT – hospices may provide the service, particularly with in-home respite.
- Are there any prescriptions limits under Medicaid? Will the MMCO waive them for hospice patients?

Billing/Reimbursement for Hospice Services

- Rates are statutory. Check on which provisions in the Social Security Act the State asked to have waived. How were they handled in waiver and contract?
- Has the State instituted the optional aggregate payment cap or the 80/20 rule?
- Clarify billing process and see if you can make it consistent between all MMCOs.
- How will IT systems work with MMCOs?
- Each MMCO is responsible for its own software so clarify billing issues/procedures.
- How will Hospice interface with MMCO’s billing structure?
Room and Board Issues

- What part of Long Term Care (LTC) are the MMCOs responsible for, e.g. first and second month only, all LTC?
- Determine if hospice room and board payments will be carved-in or carved-out.
- Does the waiver allow Medicaid to pay for room and board outside of hospice?
- Is room and board handled differently if the patient is in hospice verses if they are not receiving hospice services? If so, how have the MMCOs been notified?
- Clarify nursing home bed hold days - allowed hospital days.
- How will the patient liability/share of cost for room and board be handled?

Appeals Process

- Determine provider and beneficiary appeal rights.

Data/Utilization Tracking

- Check contract for mandated edits, etc. for providers.

Quality Measurement

- The contract should specify which quality measures the MMCO must report.
- Will there be any measures that impact hospice?
- Will the MMCOs require quality measurement from contracted hospices?

Forms

- Clarify the use of current forms in Medicaid Hospice.
Appendix III: Additional Billing Questions for Medicaid Managed Care Organizations (MMCOs)

Hospice providers may find it helpful to pose these additional billing questions to all MMCOs in their area. This appendix, developed by the Kentucky Association of Hospice and Palliative Care, provides hypothetical responses to the questions from three different MMCOs. The references to MMCO 1, 2 and 3 simply refer to different MMCOs in a given area and are meant to show the differences in how different Medicaid Managed Care Organizations treat hospice issues.

<table>
<thead>
<tr>
<th>Question</th>
<th>Example MMCO 1</th>
<th>Example MMCO 2</th>
<th>Example MMCO 3</th>
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</thead>
<tbody>
<tr>
<td>1. Can hospice claims be submitted using Direct Data Entry (DDE)?</td>
<td>Will need to use a clearing house or send a hard copy. Phone number 800-xxx-xxxx, ID XXXXX.</td>
<td>We will need to confirm with our IT Department.</td>
<td>Yes. Steps for using DDE are available at your secure MMCO 3 portal.</td>
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<tr>
<td>Currently hospice can key claims directly/electronically to Medicaid.</td>
<td>You can use your current clearing house and give them the MMMCO 1 ID number. Or you can send a hard copy to MMCO.</td>
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<td>Will that continue or will providers need to use a clearinghouse or hard copy?</td>
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| 2. Please clarify authorization process. | Prior Authorization (PA) can be obtained by calling MMCO M-F from 7a-7p or faxing a request to 24hrs a day. MMCO will have a continuity of care period with relaxed PA process for the first 30 days. During this period you will need to get PA for all new patients. | Request for Hospice Services (non-institutional) should be faxed to MMCO. The request should include a signed certificate of need by the physician and the services being requested. MMCO will process the request within 2 business days. | The PA process is outlined in the Provider Resource Guide as well as the Quick Resource Guide (refer to your packet). The following, minimum, information is requested for all authorizations: **Member Name, Member ID#,**  
- Provider ID and NPI or name of treating physician, Facility ID and NPI or name where services will be rendered,  
- Provider and/or Facility fax#  
- Date(s) of service Diagnosis and diagnostic codes  
- Authorization can be checked online at your secure website.  
- For the first 90 days, the PA process will be more relaxed. During that 90 day period you will need to get PAs for all new patients.  
- PA must be signed by the physician prior to submitting the PA form. |
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<tr>
<td>2a. Do you require hospice to use a specific authorization form?</td>
<td>MMCO has multiple PA forms: general PA, and State Home Health Form. Hospice can use the general or the home health form. MMCO is requesting a letter of necessity from the attending physician and the MAP 374 for enrollment</td>
<td>Hospice Services do not require a specific prior authorization form</td>
<td>No. The Inpatient and Outpatient PA Forms are found at <a href="http://www.MMCO3.com">www.MMCO3.com</a> under the Resources tab. The Inpatient form includes a specific box for Hospice</td>
</tr>
<tr>
<td>2b. Does hospice have to wait for authorization before admitting a patient? We are concerned that we will not be able to admit critically ill patients on the day of referral.</td>
<td>Emergency care requires call-in w/in 24 hours. Non-emergent care needs to be PA as well for care. The Hospice Provider should call MMCO department for these types of admissions in order to expedite the review process</td>
<td>The Inpatient Services PA includes a section for Expedited Requests. The Quick Reference Guide also includes a phone number for Urgent Authorization Requests and Admission Notifications</td>
<td></td>
</tr>
<tr>
<td>2c. Does hospice fax the MAP 374 Hospice Election Form to the MMCO and State Medicaid Office?</td>
<td>Yes</td>
<td>Yes</td>
<td>No response.</td>
</tr>
<tr>
<td>2d. Do all hospice levels of care need to be preauthorized? We are concerned that patients may appear at the ER and be admitted before we learn about the admission, also emergency admissions and emergency continuous care.</td>
<td>Non emergent care needs to be PA. Emergent care does not require a PA but notification. MMCO requires authorization for non-institutional hospice care. The Hospice Provider would be responsible for services related to the member's hospice diagnosis.</td>
<td>Yes</td>
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</table>

22. MAP 374 is the Hospice Election Form for Kentucky Medicaid.
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<tr>
<td>2e. What is the length of the authorization? What is the time span? Is</td>
<td>Initial authorization is 90 days. 1st re-cert is 90 days, 2nd re-cert is 90</td>
<td>Hospice review determinations will be given in 6 month timeframes.</td>
<td>Length of the authorization is based upon the patient need as requested initially.</td>
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<tr>
<td>the authorization represented on the claim form?</td>
<td>days forward require MD review every 60 days.</td>
<td>Authorization number is not required to be billed on the claim form.</td>
<td>Time span dictated by the provider requesting. The authorization should be</td>
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<td>logged in our system (and will be when they submit it or call), but not</td>
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<td>necessarily on the claim form.</td>
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<td></td>
<td>Initial authorization is 90 days. 1st re-cert is 90 days, 2nd re-cert is 90</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>days forward require MD review every 60 days.</td>
</tr>
<tr>
<td>2f. How will the authorization for non-related services be handled? Will</td>
<td>Non-related services should be handled by the ordering MD.</td>
<td>If the service is not related to the member's hospice diagnosis, the ordering</td>
<td>Ordering providers are responsible for obtaining their own authorizations.</td>
</tr>
<tr>
<td>other providers be responsible for authorizing services that they will be</td>
<td>Same as anybody's services.</td>
<td>or servicing provider will be responsible for obtaining authorization for service(s)</td>
<td>If the Hospice pharmacy is a MMCO provider, they can bill for non-related</td>
</tr>
<tr>
<td>providing? Example, non-related hospitalizations, medications, therapies.</td>
<td>Yes.</td>
<td>which require authorization from the Plan.</td>
<td>services and the claim will not be denied.</td>
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<tr>
<td>2g. Will other providers be blocked from providing services for hospice</td>
<td>Non-hospice related care needs a PA. Non-related drugs will need to go through</td>
<td>Awaiting Response</td>
<td>Any provider that is a participating MMCO provider, including pharmacies, can</td>
</tr>
<tr>
<td>patients? Example, will pharmacies be able to bill for non-related drugs?</td>
<td>the Rx PA process through Pharmacy Benefit manager.</td>
<td></td>
<td>provide services. Non-participating providers can also provide services but</td>
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<td>are aware that it will be at a lower reimbursement.</td>
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<tr>
<td>3. Hospice employed physicians—do we submit their visits to hospice patients on the hospice claim or will we submit on a separate claim?</td>
<td>Under the Medicaid Hospice Benefit, Ambulance, Total Nutrition and Physician services are outside the hospice benefit and are a separate claim.</td>
<td>These claims should continue to be handled in the same manner as current Medicaid.</td>
<td>No response.</td>
</tr>
<tr>
<td>3a. If we submit the hospice employed physician claim on a separate claim form, which form do we use, UB or 1500?</td>
<td>1500</td>
<td>These claims should continue to be handled in the same manner as current Medicaid.</td>
<td>No response.</td>
</tr>
<tr>
<td>4. Total nutrition is outside the benefit— which all have agreed. Do we submit total nutrition on the UB claim using 250 revenue code? Does total nutrition have to be pre-authorized?</td>
<td>Need to check on this. Yes, PA is required.</td>
<td>As total nutrition is outside the benefit, the Hospice Provider would have to request authorization for this service as it would be an exception to the covered benefits.</td>
<td>There is a separate nutrition form but will need to clarify the process.</td>
</tr>
<tr>
<td>5. Hospice pediatric patients—do services that are considered appropriate for Pediatric Concurrent Care have to be pre-authorized?</td>
<td>Will need to clarify. Yes, PA will be required.</td>
<td>Yes, authorization is required.</td>
<td>No response.</td>
</tr>
<tr>
<td>6. How will revocations be handled? Do we fax the revocation to the MMCO and Medicaid?</td>
<td>Yes</td>
<td>Yes, fax the revocation to MMCO and to Medicaid.</td>
<td>No response.</td>
</tr>
<tr>
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<tr>
<td>6a. If a patient leaves the service area to go to another hospital and revokes the hospice benefit and then returns 2 days later, does the hospice have to get another authorization?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6b. Do hospices fax the termination MAP to the MMCO and Medicaid?</td>
<td>Yes</td>
<td>The Hospice Provider should fax the hospice termination to both MMCO and Medicaid.</td>
<td>Yes</td>
</tr>
<tr>
<td>7. If a hospice homecare patient is admitted to a nursing facility—and in the 1st 30 days goes to the hospital, does the MMCO pay the bed hold days.</td>
<td>No, MMCO does not pay bed hold days.</td>
<td>No payment of nursing home hold beds.</td>
<td>MMCO does not pay the bed hold days.</td>
</tr>
<tr>
<td>8. Please give a contact for billing issues at each MMCO.</td>
<td>XXX-XXX-XXXX</td>
<td>Billing issues can be addressed by calling XXX-XXX-XXXX and selecting the claims option.</td>
<td>This information is available in the Quick Reference Guide. For questions related to claims submissions contact XXX-XXX-XXXX. For inquiries related to electronic submissions contact via email.</td>
</tr>
<tr>
<td>9. Please give a provider relations contact at each MMCO.</td>
<td><a href="mailto:MMCO@MMCO1.com">MMCO@MMCO1.com</a></td>
<td>Phone #: xxx-xxx-xxxx</td>
<td>xxx-xxx-xxxx. <a href="mailto:MMCO@MMCO3.com">MMCO@MMCO3.com</a></td>
</tr>
<tr>
<td>Note: Emails are just an example and are not valid.</td>
<td></td>
<td>Email: <a href="mailto:MMCO@MMCO2.com">MMCO@MMCO2.com</a></td>
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