Benefit Guidelines: Hospice

Service: Hospice
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Products: Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO), Medica Choice Care℠ (Minnesota Senior Care Plus, or MSC+) Medica AccessAbility Solution® (Special Needs Basic Care, or SNBC), and Medica AccessAbility Solution Enhanced® (Integrated SNBC or I-SNBC)

Definition of Service:

Hospice is end-of-life care generally provided in the patient's home. Hospice care is also provided in free-standing hospice centers, hospitals, and nursing homes. Typically, a family member serves as the primary caregiver. Hospice staff makes regular visits to assess the patient and will provide additional care as needed. The goal is to make the patient comfortable easing their pain and other symptoms, as well as support the family and caregivers. When a member choses hospice care, they decide they no longer want to cure their terminal illness and/or the doctor determines that efforts to cure the illness isn't working. Depending on what coverage a member has, the Hospice services may be paid for by Medica under Medicare and/or Medical Assistance (MA) benefits, or the primary payer of services may be outside of Medica for members with non-integrated Medicare or other primary coverage.

Eligibility: Eligibility for the hospice benefit is established when a person meets all the following criteria:

- Agrees to receive only palliative care for the terminal illness or condition.
- Life expectancy of six months or less
- Certified terminally ill by a physician.
- Voluntarily enrolls in the benefit.
- May be "recertified" as necessary.

** The person may revoke his or her election of the Hospice benefit at any time.

Covered: Hospice benefits include coverage for the following services when provided directly in response to the terminal illness. The following are services that may be included in the hospice plan based on the member's individual needs. Each hospice provider may differ in the level of services provided.

- Physician services
- Nursing services
- Medical social services
- Counseling (Bereavement counseling does not qualify for additional payment)
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services

- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services.

Not Covered:

Members aged 22 and older who choose hospice care waive certain services while the member is in hospice care. These include forms of health care for treatment of the terminal illness for which hospice care was elected. The care coordinator will work directly with the hospice provider, and refer to Department of Human Services (DHS) and Center for Medicare and Medicaid Services (CMS) hospice resources. In addition, the member may no longer need certain waiver or state plan home care services once they have elected hospice. To determine this, the care coordinator will work closely with the member and hospice provider to determine what those might be and end services through the Denial Termination Reduction (DTR) process when necessary.

Hospice Provider Responsibility: Per the DHS Minnesota Health Care Programs (MHCP) provider manual, the hospice provider is required to lead the collaboration efforts, to include communication with the assigned care coordinator. In addition, the hospice provider will be doing the following:

- Develop an individualized plan of care to identify a person's needs related to the terminal illness and how those needs will be addressed.
- Notify the care coordinator of member's election of the hospice benefit and communicate with the assigned care coordinator.
- Notify Medica of member′s hospice enrollment.

Care Coordinator Responsibility:

- It is essential for the care coordinator to be in communication with the member's interdisciplinary team, which includes the hospice provider and revise the service plan as needed to prevent duplication of services.
- For members on Elderly Waiver (EW), the care coordinator (CC) must review the member's current EW services and continued EW eligibility. If there are services no longer needed, the care coordinator will follow the DTR process.
- If there are new EW service needs, the care coordinator will also review these with the member and the hospice provider to ensure there is not duplication of services.
- Members not on EW but are receiving state plan home care services such as Skilled Nurse Visits (SNV), Home Health Aide (HHA) and Personal Care Assistance (PCA), the care coordinator will work closely with the member, their family and the hospice provider to determine what services may no longer be necessary and follow the DTR process.
- At the time of enrollment with hospice, the CC will coordinate with the hospice program what DME and supplies hospice will begin to cover and update any related authorizations with an end date the date of member's enrollment with hospice. The CC will coordinate with hospice to determine who will communicate the changes with providers.

- Explain CC's role with the member and be available to assist with referrals that would be for any Medical Assistance or Elderly Waiver covered services that do not fall under hospice's responsibility. The CC will coordinate maximizing the hospice program benefit before utilizing medical assistance or waiver home services/items.
- Complete DHS 5181 Financial Worker Communication form informing of hospice election, name of hospice provider, start date and any address changes.
- If applicable, complete the DHS 5841 Managed Care Organization/County/Tribal Agency Communication Form and continue to communicate with member's waiver worker.
- Update Care Plan and the Service Agreement to reflect hospice services.

Considerations:

Per the DHS MHCP manual: A member should never be asked to make an "either/or" choice between an otherwise MA-covered, medically necessary service that is not related to the terminal condition, and covered hospice services. Because some hospice benefit services and Medical Assistance-covered services may be similar, this determination process should focus on the purpose rather than the type of service; which member need is the service addressing? Refer to the following considerations to help determine the purpose of a service by asking whether it is to:

- Address a pre-existing condition or pre-existing need?
- Address a health care problem that would have existed even without the terminal illness?

References:

DHS MSHO/MSC+ Contracts
DHS SNBC Contracts
DHS Community-Based Service Manual (CBSM)
Minnesota Health Care Programs (MHCP) Provider Manual
Medicare.gov Hospice

This Medica Benefit Guideline for Care Coordination Products is intended to guide service plan development. This reflects current interpretation of the product benefit set and/or parameters for obtaining services. Medica staff should be consulted for further guidance or to vary from these recommendations.