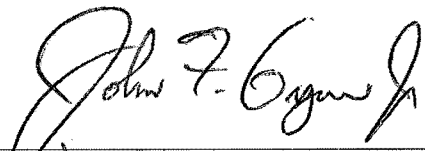
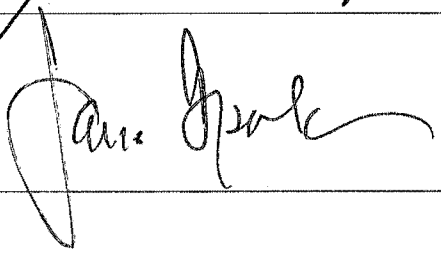
SAN FRANCISCO HEALTH PLAN

CO-32: Hospice Care

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
	CEO	11/2/20	Biennial Review
	CMO	11/2/20	

SAN FRANCISCO HEALTH PLAN

SFHP POLICY AND PROCEDURE

Hospice Care

Policy and Procedure number:	CO-32
Department Owner:	Clinical Operations
Lines of Business Affected:	☒Medi-Cal ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐ All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) covers hospice care services for members who qualify for and choose hospice care. SFHP ensures that all members who elect hospice care are provided the scope of services as defined in Health and Safety Code § 1339.44 and the California Code of Regulations, 22 CCR §51180.

PROCEDURE

I. Eligibility

A. A member is eligible for hospice program admittance when:
   1. The member has a physician certified life expectancy of 6 months or less (12 months or less for Healthy Workers HMO), if the terminal illness follows its normal course.
   2. Cure of the disease process is no longer the goal of treatment. (For specific pediatric hospice guidelines, please see section II.1 below)
   3. The primary goal for the member is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
   4. It is appropriate to direct treatment to improve the quality of the remaining days for the member and member's family.
   5. It is agreed by physician and member and/or member's representative that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations they would otherwise suffer.
   6. The member, member's family, and physician are all willing to participate in the program with the understanding that withdrawal is possible at any time.

B. Election of hospice care occurs when the member or member's representative voluntarily completes and signs the Hospice Election Form, indicates the election effective date, and selects a hospice provider. Signing this form indicates that

the member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.

II. Pediatric Hospice Guidelines

A. A member under 21 years of age may be eligible for hospice services concurrently with curative and palliative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018.
B. Voluntary election of hospice care does not constitute a waiver of any of the member's rights to be provided with covered services, including life-prolonging therapies related to the treatment of the member's condition for which a diagnosis of terminal illness has been made.
C. SFHP remains responsible for all medical care, whether related or unrelated to the treatment of the terminal illness, excluding care covered through California Children Services (CCS).
D. CCS covers the non-hospice-related medical care for a CCS-eligible condition.
    1. SFHP is responsible for the provision of all medically necessary services until the member's CCS eligibility is confirmed by the local CCS program, and the medically necessary services are being provided under the CCS program.

III. Hospice Referral

A. Providers refer members to hospice services. SFHP informs staff, network providers and other relevant programs/non-network providers, of the importance of timely recognition of a member's eligibility for hospice care services and their election of hospice care services.
B. The only requirement for initiation of out-patient hospice services is a physician's certification that a member has a terminal illness and a Member's "election" of such services.

IV. Coordination of Care

A. SFHP is responsible for provision and/or coordination of all covered medical services not related to the terminal condition.
B. The primary care provider shall continue to manage the member's medical needs including both hospice related care and medical care not related to the member's terminal condition.
C. Once a member elects hospice care services, SFHP network providers work with hospice care providers to facilitate the transfer of member services from those directed toward cure and/or prolongation of life to those directed toward palliation (except for members under age 21).
D. Ongoing care coordination is provided to ensure services necessary to diagnose, treat, and follow-up on conditions not related to the terminal illness continue to be provided or are initiated as necessary.

E. Members who elect hospice care may not be disenrolled from SFHP unless they move their legal residence outside of San Francisco County. See CS-06 regarding geographic disenrollment.

V. Hospice Benefits

A. An individual may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods in accordance with Section 1812(d)(1) of the SSA and Title 42, CFR, Section 418.21.

B. SFHP assures hospice care services provided, to all SFHP members, are at a minimum equivalent to hospice benefits provided under the Medicare program, as defined in Section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd), including:
   1. Nursing care provided by or under the supervision of a registered nurse,
   2. Physical or occupational therapy, or speech-language pathology services,
   3. Medical social services under the direction of a physician,
   4. Home health aide and homemaker services,
   5. Medical supplies (including drugs and biological) and the use of medical appliances,
   6. Physician's services,
   7. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing or hospice facility,
   8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility,
   9. Counseling, including dietary counseling, and
   10. Any other item or service specified in the care plan, which is a covered benefit.

C. Hospice is responsible for the following services, related to the terminal illness, until such time as the member revokes his/her enrollment in hospice or they have been discharged by the hospice provider:
   1. Room and board at licensed skilled nursing facility (excluding Healthy Workers HMO LOB)
   2. Acute inpatient hospitalization when arranged by the hospice provider.
   3. Nursing facility (Level A or B) services beyond respite care limits
   4. Physician and/or consulting physician services not considered hospice, and when the physician is not an employee of the hospice or providing services under an arrangement with the hospice.
      a. Physician services included are:
      b. General supervisory services of the hospice Medical Director; and
      c. Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice interdisciplinary team.

D. When a member enrolled in hospice is hospitalized for a condition related to the terminal diagnosis (e.g., uncontrollable pain) or receiving hospice care at a

licensed skilled nursing facility payment for the hospitalization or room and board is a pass-through to the hospice provider, and the hospice provider pays the facility directly.

VI. Services not Covered by Hospice Provider

A. Private pay room and board or residential care.
B. Acute in-patient hospitalization when admission is not arranged by hospice provider and/or unrelated to the terminal illness.
C. Level A or Level B NF for issues unrelated to the terminal illness.
D. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
E. Other necessary services for conditions unrelated to the terminal illness.

VII. Prior Authorization Requirements

A. The four levels of hospice care include:
    1. Routine Home Care
    2. Continuous Home Care
    3. Respite Care
    4. General Inpatient Care
B. Of the four levels of hospice care, only General Inpatient Care requires prior authorization. General Inpatient authorization requests are decided within 24 hours of receipt. Requests not decided within 24 hours of receipt are deemed approved.
C. Authorization is not required for routine home care, continuous home care, or respite care levels of care, for hospice physician services, or for room and board in accordance with APL 13-014.
D. The Healthy Workers HMO hospice benefit and authorization requirements have been aligned with the Medi-Cal hospice benefit and authorization requirements outlined above, with the exception of room and board. Room and board is not a Healthy Workers HMO hospice benefit.

VIII. Dual Eligible Medicare/Medi-Cal

A. Primary coverage for hospice lies with Medicare for members with Medicare Part A. Following payment from Medicare, the hospice bills SFHP for the co-payment amounts; the total reimbursed amount must not exceed the Medicare rate (refer to 22 CCR §51544).
B. For members with Medicare Part B only, hospice benefits are covered by SFHP. No Medicare denial is required.
C. Prior authorization is not required for the hospice to bill SFHP for the room and board covered by Medi-Cal while the patient is receiving hospice care services under Medicare in accordance with Title 42, CFR, 418.112 and section 1902(a)(13)(B) of the SSA.

D. SFHP pays the room and board to the hospice provider, and the hospice is responsible for paying the licensed skilled nursing facility.

IX. Hospice at Skilled Nursing Facilities for Medi-Cal Members

A. Hospice care services at licensed skilled nursing facilities are covered services for Medi-Cal members at SFHP and are not categorized as long-term care services, regardless of the member's expected or actual length of stay in a nursing facility while also receiving hospice care.
B. Admission to a licensed nursing facility of a member who has elected hospice services does not affect the member's eligibility for enrollment in SFHP. Members in facility-based hospice may not be disenrolled from managed care, as described in CO-02 Members Admitted to Lower Level of Care (LLOC) Facilities.
    1. SFHP will not require authorization for room and board in accordance with Title 42, CFR, 418.112 and section 1902(a)(13)(B) of the SSA.

X. Member Revocation

A. A member's voluntary election may be revoked or modified at any time during an election period. A SFHP member who wishes to revoke the election must personally, or through a representative, file a signed statement with the hospice revoking the individual election for the remainder of the election period. The effective date cannot be retroactive; the member also has the right to execute a new election for the remaining election periods, and to change the designation of a hospice provider once each election period.

MONITORING

1. Aggregate authorization and claims data is subject to retrospective analysis by SFHP's Clinical Operations Department in order to evaluate over- and under-utilization of services.
2. SFHP's Clinical Operations Department monitors turnaround times of internal processing for compliance with standards.
3. SFHP's Clinical Operations Department performs inter-rater reliability audits as outlined in the policy at least annually for both physician and nurse reviewers.
4. SFHP's Health Outcomes Improvement Department evaluates member grievances and appeals, as well as SFHP's member and provider satisfaction survey responses, to identify patterns.
5. The SFHP Chief Medical Officer (CMO), Medical Director, or physician designee identifies potential quality issues (PQI), including provider preventable conditions (PPCs), and follows the PQI process defined in QI-18.
6. On a monthly basis, the Utilization Management Committee (UMC) reviews Appeals, IMRs, and State Fair Hearings resulting in authorization decision made by SFHP or one of its delegated medical groups. The UMC recommends corrective action and/or identifies where the Clinical Operations Department can revise the authorization process, if necessary, to improve the member experience, to address any barriers, and ensure the utilization management

criteria are consistent with current industry and evidence-based practices. The Quality Improvement Committee reviews an Appeals Report (overturned and upheld appeals) every quarter regarding the activity of pharmacy and medical authorizations.

7. Reports regarding SFHP's Clinical Operations Department's monitoring activities are reviewed at the Utilization Management Committee (UMC) on a monthly basis and are presented to the Quality Improvement Committee (QIC) at least annually for evaluation and corrective actions as needed.
8. The policies of medical groups that are delegated to perform utilization management are reviewed though annual audits performed by the Clinical Operations and Delegation Oversight Teams. In the event a medical group is non-compliant, the Delegation Oversight Team or designee notifies the medical group in writing that corrective action is required. The medical group has 30 calendar days from the date of receipt to submit a corrected policy to SFHP.

DEFINITIONS

Continuous Home Care: Continuous home care, as defined in 22 CCR **§ 51180.4,** means care provided in the individual's residence, which consists predominately of skilled nursing care, for a mini mum of eight hours in a 24-hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the patient's care.

General Inpatient Care: General inpatient care, as defined in 22 CCR **§ 51180.6,** means services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management.

Respite Care: Respite care, as defined in 22 CCR **§ 51180.5,** means short-term inpatient care in an acute hospital, skilled nursing facility/Level B, intermediate care facility/Level A, or a hospice facility which is organized to provide inpatient care directly, when necessary to relieve family members or others primarily caring for the individual.

Routine Home Care: Routine home care, as defined in 22 CCR **§ 51180.3,** means care provided in the individual's residence which is not continuous care.

Terminal Illness: Terminally ill, as defined in 22 CCR §51180.2, means that an individual's medical prognosis as certified by a physician results in a life expectancy of six (6) months or less. Health and Safety Code §1746(7)(p) expands that definition for all licensed health care service plans to include "a medical condition resulting in a prognosis of life of one (1) year or less, if the disease follows its natural course. 42 CFR §418.22(b) requires that the physician certification contain the qualifying clause: "if the

terminal illness runs its normal course." Pursuant to contractual requirements, plans may not deny hospice care services to members certified as terminally ill.

AFFECTED DEPARTMENTS/PARTIES

Care Management
Claims
Compliance and Regulatory Affairs- Delegation Oversight
Customer Service
Health Outcomes Improvement
Provider Network Operations
Utilization ManagementClincial Operations

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. CO-02: Medi-Cal and Dual Eligible Members Admitted to Lower Level of Care (LLOC)
2. CO-20: California Children's Services
3. CO-22: Authorization Requests
4. CO-58: Palliative Care
5. PR-18: Members Receiving Care from Terminating Providers
6. PR-19: New Members Receiving Care from Non-Participating Providers

REVISION HISTORY

Effective Date: July 8, 2008

Revision Date(s): July 8, 2008, October 10, 2013, April 9, 2015, March 1, 2018; December 12, 2019

REFERENCES

1. DHCS MMCD All Plan Letter 13-014 – Hospice Services and Medi-Cal Managed Care
2. DHS N.L. 04-0207 – Palliative Care Options for CCS Eligible Children
3. 22 CCR §§51349, 51180, 51180.2, 51544 – Criteria Manual Chapter 11, Criteria for Hospice Care
4. Health and Safety Code - HSC § 1339.44 – California Hospice Licensing
5. Health and Safety Code §1746(7)(p) – California Hospice Licensure Act of 1990
6. 42 U.S.C. §1395x(dd) (Section 1861(dd) of the Social Security Act) – Hospice Care; Hospice Program
7. 42 C.F.R. §418.22(b) – Content of Certification of Terminal Illness
8. DHCS/SFHP Contract – Exhibit A, Attachment 10, Provision 8C – Hospice Care