10.4 – Hospice Coverage

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

As defined in 42 CFR §422.320, *MA plans* must inform each enrollee eligible for hospice care about its availability. *This is true whether* a Medicare hospice program is located within the plan's service area or *if* it is common practice to refer patients to hospice programs outside the *plan's* service area.

An MA enrollee who elects hospice care, but chooses not to disenroll from the plan, is entitled to continue to receive through the plan any MA benefits other than those that are the responsibility of the hospice. Under such circumstances, the *MA* plan is paid a reduced capitation rate for that enrollee by CMS and the *MA plan* is responsible for continued coverage of supplemental benefits. CMS pays: (a) the hospice program for hospice care furnished to the enrollee and (b) the *MA plan*, providers, and suppliers for other Medicare-covered services furnished to the enrollee through the original Medicare program, subject to the usual rules of payment.

Hospice coverage is effective immediately on the date of election; the reduced rate paid to the *MA plan* begins the next month (42 CFR *§*422.320).

Table I *below* summarizes the cost-sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

Table I: Payments for Services Furnished to an Enrollee who has Elected Hospice

Type of Services	Enrollee Coverage Choice	Enrollee Cost-sharing	Payments to Providers
Hospice program	Hospice program	Original Medicare cost-sharing	Original Medicare
Non-hospice care[1], Parts A & B	MA plan or *original* Medicare	MA plan cost-sharing, if enrollee follows MA plan rules[3]	Original Medicare[2]
		Original Medicare cost-sharing, if enrollee does not follow MA plan rules[3]	Original Medicare
Non-hospice care[1], Part D	MA plan (if applicable)	MA plan cost-sharing	MAO
Supplemental	MA plan	MA plan cost-sharing	MAO

Notes:

1) The term 'hospice care' refers to original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term 'non-hospice care' refers either to services not covered by original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.

2) If the enrollee chooses original Medicare for coverage of covered, non-hospice-care, original Medicare services and also follows MA plan requirements, then, the enrollee pays plan cost-sharing and original Medicare pays the provider. The MA plan must pay the provider the difference between original Medicare cost-sharing and plan cost-sharing, if applicable.

3) An HMO enrollee who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost-sharing; a PPO enrollee who receives services out of network has followed plan rules and is only responsible for plan cost-sharing. The enrollee need not communicate to the plan in advance his/her choice of where services are obtained.

Please see the following resources for additional information:

- The Social Security Act, *section* 1853(h)(2)(B); and
- The Medicare Claims Processing Manual, *chapter* 11 - Processing Hospice Claims, *section* 30.4