70.3 - Enrollees Electing Hospice

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Enrollees Electing Hospice in CCP and PFFS Plans. Effective CY 2006 for CCP and PFFS plans, during the time the hospice election is in effect, CMS pays the MA organization the portion of the monthly payment attributable to the rebate, minus the amounts (if any) of rebate allocated to reduce the Part B premium and the Part D basic premium, plus the amount of the subsidy CMS pays the MA organization for a plan enrollee related to basic prescription drug coverage (if the enrollee is in an MA-PD plan).

- The amount by which the plan reduces enrollees' Part B premium is foregone revenue that remains in the Treasury, allowing CMS and SSA to decrease the enrollee's Part B premium by this amount. The amount by which the plan reduces the basic Part D premium is reflected in the Part D payment to the plan.

- Regarding the Part D benefit, if an MA-PD plan enrollee electing hospice needs prescription drugs for conditions not related to hospice care, these costs are the MA organization's responsibility (to the extent that the drugs are covered under Part D or under the plan). CMS pays MA-PD organizations the Part D subsidy for all enrollees, including those electing hospice.

Enrollees Electing Hospice in an MSA Plan. Beneficiaries who have elected hospice are not allowed to enroll in an MSA plan. Members may elect hospice and remain in the MSA plan. CMS' monthly capitation payment will be zero, because there is no portion of the monthly payment from CMS for the high deductible health plan that is attributable to supplemental benefits. Moreover, MSA plans cannot offer Part D coverage.

70.3.1 - CMS' Payments to Hospice Programs

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The hospice is paid through the original Medicare program, subject to the usual rules of payment, for hospice care furnished to the Medicare enrollee. See the Medicare Claims Processing Manual, Chapter 11 on Hospice on the CMS Web site at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html

Section 40.2.2(B) of Chapter 11 notes that Medicare hospices will bill the *A/B MAC (HH)* for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage.

Original Medicare pays physicians, providers and suppliers for other Medicare-covered services furnished to enrollees who have elected hospice. "Other services" refer to non-hospice A/B services that are not related to the terminal illness.

For other Part B services furnished to enrollees who have elected hospice, original Medicare will also pay the MA organization to the extent a claim has been reassigned to the MA organization. Under §1861(u) of the Act, Part A claims from "providers of services" cannot be reassigned.

The MA organization is responsible for making available to its members who have elected hospice all Medicare-covered non-hospice services and also any non-hospice services that are not Medicare-covered, but that are offered as supplemental benefits under the plan. For example, services provided by an attending physician to an MA enrollee who has elected hospice are considered non-hospice services, if the physician is not employed or contracted by the enrollee's hospice program, and may be reimbursed by original Medicare.

Since an MA organization cannot bill *an A/B MAC (A),* nor can an *A/B MAC (A)* make payments to MA organizations, below are examples of how MA organizations may choose to handle billing for non-hospice ("other") services by <u>contracted</u> providers:

- The MA organization can authorize the provider (e.g., hospital or physician) or supplier to bill the *MAC* directly. (In such a situation, the MA organization might also choose to incorporate rate adjustments in contracts to account for the provision of non-hospice services by providers and suppliers that bill original Medicare directly.)

- In the case of physician and supplier services, the MA organization may direct them to submit claims for non-hospice services to the MA organization. The MA organization would bill the *A/B MAC (B)* and make payments to the physicians/suppliers.

Under original Medicare (and thus under the MA program during hospice elections), the beneficiary is responsible for certain cost sharing for hospice services:

- Co-pay for Part B drugs and biologicals: No more than $5 for each drug and other similar products for pain relief and symptom control.

- Co-pay for a respite care day: 5 percent of the payment that Medicare makes for a respite care day, not to exceed the hospital inpatient deductible.

70.3.2 - Hospice and PACE Enrollees
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CMS will not make payments to Program of All-inclusive Care for the Elderly (PACE) organizations for enrollees who have elected hospice. Enrollees in PACE organizations must elect either their PACE organization or the hospice benefit as their provider of Medicare services. An enrollee who elects to enroll in hospice is thereby disenrolled from the PACE benefit. However, PACE organizations provide a service similar to hospice known as “end-of-life-care.”