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M E M O R A N D U M

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TO: National Hospice and Palliative Care Organization

FROM: Ann Morgan Vickery
Brooke Bumpers

RE: **Comparison of the Medicare and Medicaid Hospice Benefits**

Hogan & Hartson, L.L.P. is the oldest and the largest major law firm based in Washington, D.C., providing a full range of legal services to clients throughout the United States and internationally. Attorneys in Hogan's Health Group represent clients across the entire spectrum of the health care field. Ann Vickery is managing partner of Hogan & Hartson's Washington, D.C. office and practice director of the firm's Health Group. Since 1982 she has been outside legal counsel for the National Hospice and Palliative Care Organization. Brooke Bumpers also is a member of Hogan & Hartson's Health Group. Her practice focuses primarily on regulatory and legislative issues faced by a wide variety of health care providers and organizations. She has been involved in hospice matters since 1994.

You have asked us to describe the parameters of the Medicaid hospice benefit, including the ways in which it is the same as the Medicare hospice benefit and the ways in which it differs. Since hospice is an optional Medicaid benefit, States may, but are not required, to offer it to their Medicaid recipients. Those

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States that do choose to include hospice in their Medicaid programs must structure the benefit to meet certain statutory requirements.¹

The federal laws establishing the Medicare and Medicaid hospice benefits are included in Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act ("SSA"). The Medicaid hospice benefit was added after the Medicare hospice benefit, and because it was drafted to mirror the Medicare benefit in many respects, hospice providers and others often are unaware of the ways in which Medicaid hospice requirements and benefit structures may differ from Medicare. These variations occur in several ways: either because the language of the Medicaid statute specifically requires or allows something different than the Medicare statute (*e.g.*, the Medicaid statute specifically states that hospice benefit periods need not be the same as those specified under Medicare), or because the Medicaid statute incorporates by reference some sections of the Medicare statute (*e.g.*, the definitions of hospice care and hospice program), but not other provisions (*e.g.*, the physician certification requirements).

Therefore, when statutory changes are made to the Medicare hospice benefit, these changes will not necessarily apply to the Medicaid benefit unless they are included in sections of the Medicare statute that are referenced in the Medicaid statute. This is why some of the changes to the Medicare benefit that were included in the Balanced Budget Act of 1997 ("BBA") applied to the Medicaid program and others did not. For example, BBA changes regarding the Medicare payment for hospice did apply to Medicaid because the Medicaid statute specifically states that payment for hospice must be no lower than Medicare rates, and must be calculated using the same methodology as Medicare. However, the BBA provision that eliminated the requirement that physician certification be obtained within 8 days did not apply to Medicaid because that change was made to a section of the Social Security Act that is not referenced in the Medicaid statute.²

As noted below, there are a number of issues on which the Medicaid statute is simply silent. It neither establishes Medicaid-specific requirements nor incorporates the relevant Medicare provisions. With respect to such issues, many States do follow the Medicare requirements, and the Centers for Medicare and Medicaid Services ("CMS") has indicated that they encourage States to follow the

¹ This memorandum compares the Medicare and Medicaid statutory provisions related to hospice services. Regulations have been promulgated implementing the Medicare provisions of the law (42 Code of Federal Regulations Part 418) but no Medicaid hospice regulations have been published. There are Medicare and Medicaid manual provisions that may fill in gaps that aren't addressed in the statute, particularly with respect to Medicaid, but those provisions are beyond the scope of this memo.

² The Medicaid statute does not specify any requirement for physician certification and therefore States may adopt the Medicare requirement or establish their own.

Medicare rules because it makes the Medicaid benefit easier to administer, but the States are not required to do so.

The following sets forth the aspects of the Medicaid hospice benefit that must be the same as the Medicare benefit and those that may or must differ. In a separate section, this memorandum addresses the provision of hospice services to nursing facility residents who are either dually eligible or eligible only for Medicaid services.

Medicare and Medicaid Requirements are Essentially the Same

Definition of "Hospice Care" – Both Medicare and Medicaid define hospice care as the items and services listed below, provided to a terminally ill individual by (or by others under arrangement made by) a hospice program under a written plan of care established and periodically reviewed by the individual's attending physician and by the hospice medical director and interdisciplinary group:

- nursing care provided by or under the supervision of a registered nurse;
- physical or occupational therapy, or speech-language pathology services;
- medical social services under the direction of a physician;
- services of a trained home health aide, and homemaker services;
- medical supplies (including drugs and biologicals) and the use of medical appliances;
- physicians' services;
- short-term inpatient care (including both respite care and as necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting certain conditions;
- counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his or her death;
- any other item or service which is specified in the plan and for which payment may otherwise be made under the program.^{[3](#)}

However, with respect to Medicaid recipients who reside in a nursing facility ("NF") or intermediate care facility for the mentally retarded ("ICF/MR"), room and board is considered to be part of the "hospice care" covered by Medicaid.^{[4](#)}

^{[3](#)} Social Security Act ("SSA") § 1861(dd)(1); SSA § 1905(o)(1)(A).

Definition of "Hospice Program" –Both Medicare and Medicaid define a hospice program as a public agency or private organization (or subdivision thereof) that:

- is primarily engaged in providing the range of services described as "hospice care";
- makes these services available as needed on a 24 hour basis;
- provides bereavement counseling to the immediate family of the terminally ill individual;
- provides care and services in individuals' homes, on an outpatient basis and on a short-term inpatient basis, directly or under arrangement;
- routinely provides directly substantially all nursing, medical social services, and counseling, and maintains professional management responsibility for all services not furnished directly by the hospice, regardless of the location or facility in which they are provided;⁵
- provides assurances that the total number of days of inpatient care provided to Medicare/Medicaid patients of the hospice not exceed 20 percent of the total number of hospice days billed to Medicare/Medicaid by that hospice in a given year, although with respect to Medicaid the calculation may be made

⁴ SSA § 1905(o)(1)(A), which states "hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but *the only payment made under the State plan shall be for the hospice care.*" (emphasis added) Although there have been a number of amendments over the years that have rendered this section of the statute somewhat ambiguous, we believe this interpretation is consistent with the legislative history and with the hospice benefit as a whole. (Compare, for example, the language regarding Medicaid payment added by the Comprehensive Omnibus Budget Reconciliation Act of 1986 ("COBRA"), which refers to "a separate rate" being paid for hospice care provided to an individual residing in a SNF or ICF, and the changes made by the Omnibus Budget Reconciliation Act of 1989, which added the 95% payment requirement and changed the language to "there shall be paid an additional amount"). Note also that although this section of the statute has not been updated to reflect the changes, the Omnibus Budget Reconciliation Act of 1987 substituted the term "nursing facility" for "skilled nursing facility" and did away with the concept of an "intermediate care facility" other than an "intermediate care facility for the mentally retarded".

⁵ SSA § 1861(dd)(2); SSA § 1905(o)(1)(A). Note that this obligation to maintain professional management responsibility for all services applies to services provided to hospice patients in hospitals and nursing facilities.

without taking into account any hospice patients with AIDS.⁶

The requirements regarding professional membership of the interdisciplinary group, and the group's role in overseeing hospice care is the same in Medicare and Medicaid, as is the requirement to use volunteers and to be licensed under any applicable State law.⁷

Finally, there is a statutory provision applicable to Medicare and Medicaid requiring hospice programs to meet such other requirements "as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services" by the hospice program.⁸ Many of the details in the Medicare regulations and Medicare and Medicaid manuals derive from this authority.

Revocation and Change of Hospice – Under both the Medicare and Medicaid benefits, election of hospice may be revoked at any time, and the patient may change their hospice program.⁹ Although the Medicare and Medicaid provisions regarding revocation and change of hospice are substantially similar, the Medicare provision is more detailed and states that individuals may change their hospice program only once within each benefit period without the change being considered a revocation, whereas the Medicaid provision says a recipient may change their hospice at any time without a showing of cause. The Medicare restriction has little effect however, now that there are an unlimited number of hospice benefit periods available.

Payment Rates – State Medicaid programs must provide for "payment for hospice care in amounts *no lower than* the amounts, using the same methodology, used under part A of title XVIII [Medicare]".¹⁰ Therefore, Medicaid programs may pay more, but not less, than the Medicare rate for hospice services, and any changes in Medicare hospice rates or payment methodology also apply to Medicaid. This is separate, however, from the additional payment to a hospice for room and board for nursing facility residents, since there is no comparable Medicare payment. The issue of room and board payment is addressed below.

⁶ SSA § 1861(dd)(2)(A)(iii); SSA § 1905(o)(1)(B). For purposes of this inpatient care limitation (also referred to as the "80/20 rule"), the calculation must be made separately for Medicare and for Medicaid.

⁷ SSA § 1861(dd)(2); SSA § 1905(o)(1)(A).

⁸ SSA § 1861(dd)(2)(G); SSA § 1905(o)(1)(A).

⁹ SSA § 1812(d)(2)(B) and (C); SSA § 1905(o)(2)(c).

¹⁰ SSA § 1902(a)(13)(B) (emphasis added).

Waiver of Other Benefits – As under Medicare, Medicaid recipients who elect hospice must waive their right to have payment made for hospice care provided by a hospice program other than the one they elected, or for services related to the treatment of the individual's terminal condition or those equivalent to hospice. In addition, Medicaid beneficiaries waive "intermediate care facility services"¹¹ (which is the level of nursing facility care not covered by Medicare).¹² Medicaid recipients who elect hospice do not, however, waive their right to have payment made for other Medicaid-covered services that would not be covered by Medicare (e.g., certain personal care services). So, in this way the benefits differ slightly. As under Medicare, the waiver does not apply to physician services furnished by the attending physician or to services provided, or arranged, by the hospice.¹³

Medicare and Medicaid Requirements May or Must Differ

Eligibility for Hospice – The Medicaid statute states that hospice care is care provided to a terminally ill individual but it does not define "terminally ill" and does not incorporate the Medicare statutory provision that defines this term.¹⁴

Election of Hospice – Under the Medicaid statute, 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.¹⁵

Certification of Terminal Illness – As noted above, the Medicaid statute does not address certification of terminal illness. Many States follow the Medicare law regarding certification, but they may establish different requirements.

Benefit Periods – States may establish their own hospice benefit periods, and the length or number of these periods need not be the same as those established under

¹¹ This is a term no longer used under Medicaid. See footnote 4 above.

¹² SSA § 1812(d)(2)(A); SSA § 1905(o)(1)(A). This reference to waiving "intermediate care facility services" refers to services other than residential services in such a facility, since the statute has always made clear that a separate payment for room and board may be made for individuals residing in an ICF/MR (or an ICF when that term was still used).

¹³ SSA § 1812(d)(2)(A); SSA § 1905(o)(1)(A).

¹⁴ However, there is a good argument that a State may not define "terminally ill" more narrowly than the Medicare definition, based on the statutory requirement that medical assistance for hospice care "may not be made available in an amount, duration or scope" less than that provided under Medicare (SSA § 1902(a)(10)).

¹⁵ SSA § 1812(d)(2); SSA § 1905(o)(2)(A).

the Medicare program.¹⁶ However, now that there are an unlimited number of benefit periods available to Medicare beneficiaries, it is our view that a State could not limit the total number of days that Medicaid recipients may receive services under the Medicaid hospice benefit, assuming all other requirements are met, because the Medicaid statute requires that "medical assistance for hospice care... may not be made available in an amount, duration or scope less than that provided under [Medicare]".¹⁷

Cap on Payments – The Medicaid statute does not incorporate the Medicare statutory provision that establishes a cap on the amount of Medicare reimbursement a hospice may receive annually. However, States have the option of establishing a Medicaid cap, and CMS' State Medicaid Manual includes provisions regarding how to calculate the cap amount, based on the Medicare methodology. ^{18/} Medicaid payments to a hospice for "room and board" for hospice patients who reside in nursing facilities are not counted in determining whether a hospice has exceeded its cap amount.

Hospice Care Provided to Nursing Facility Residents

Unlike the Medicare hospice benefit, which does not provide payment for residential services for hospice patients, the Medicaid hospice benefit includes payment for "room and board" for certain individuals who reside in NFs or ICF/MRs, and who have elected hospice.¹⁹ This room and board payment is not for a separate level or type of hospice care, but rather represents the amount that Medicaid would have paid directly to the nursing facility had the patient not elected the hospice benefit. Regardless of whether the patient is receiving both hospice benefits and room and board under the State's Medicaid program, or is eligible for both Medicare and Medicaid ("dually eligible") and has elected the Medicare hospice benefit, the only payment made by the State Medicaid program is to the hospice. The room and board payment 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*

¹⁶ SSA § 1905(o)(2)(B). CMS has stated that "States have generally found it easier to administer the Medicaid hospice benefit when the periods for the benefit are the same as under Medicare" (August 13, 1998 letter to State Medicaid Directors regarding implementation of the hospice provisions in the Balanced Budget Act of 1997) but CMS has no authority to *require* States to establish any particular benefit periods.

¹⁷ SSA § 1902(a)(10).

^{18/} State Medicaid Manual §§ 4308 and 4308.1.

¹⁹ Although the Medicare hospice benefit includes payment rates for respite care and general inpatient care, which may be provided in a hospital, NF or freestanding hospice inpatient setting, both of these payment rates are intended to be used for short term stays and not to provide a residential hospice component.

individual."²⁰ States may not pay less than this amount, and the amount must be the same as what would have been paid for that individual in that facility, to the extent that the State's Medicaid payments to nursing facilities vary by patient or facility.

Dually Eligible Individuals - In the case of individuals: (1) who are residing in a NF or ICF/MR and whose services in such a facility are paid for by the State Medicaid program, (2) who are entitled to Medicare Part A benefits and have elected the Medicare hospice benefit, and (3) whose NF or ICF/MR has entered into a written agreement with the hospice program 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, the Medicaid program must make an additional payment to the hospice program for the room and board services furnished by the facility. As noted above, this payment 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 State Medicaid program must make this room and board payment to hospices on behalf of dually eligible individuals even if the State has not elected to cover Medicaid hospice services, since the individual's hospice care is being covered by Medicare.²²

Medicaid-Only Recipients

In States that cover hospice services under their Medicaid programs, the State also must make an additional room and board payment for individuals who are not eligible for Medicare benefits but who are eligible for Medicaid covered services in a NF or ICF/MR, and who are receiving Medicaid covered hospice care in such a facility. As with dually eligible individuals, the payment is 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."²³

Conclusion

While the basic definitions of the Medicare and Medicaid benefits are either identical or similar, there are some instances in which the two programs are not

²⁰ SSA § 1902(a)(13)(B) (emphasis added).

²¹ Id.

²² This requirement was added to the Medicaid statute as part of the Omnibus Budget Reconciliation Act of 1990 ("OBRA '90"), and the legislative history states that it "clarifies that the additional amount be paid for dually eligible nursing facility residents electing hospice under Medicare." OBRA '90 Conference Report, H.R. Rep. 101-964, 101st Cong., 2d Session, p. 869.

²³ SSA § 1902(a)(13)(B).

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mirror images of each other. To some extent this is a result of the many amendments made to the underlying statutes over the years (*e.g.*, 8 day certification requirement for Medicare). Other differences flow from the underlying differences between Medicare and Medicaid (*e.g.*, Medicaid covers long-term nursing facility care and Medicare does not).

Please contact either of us if you have questions concerning this very complex and confusing area of the law.