Hospice

Policy Number: BIP078.M
Effective Date: July 1, 2024

➲ Instructions for Use

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Related Policies
None

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

Oklahoma

Oklahoma Department of Insurance Title 74, Chapter 37, Section 1303

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=440536

15. "Comprehensive benefits" means benefits which reimburse the expense of hospital room and board, other hospital services, certain outpatient expenses, maternity benefits, surgical expense, including obstetrical care, in-hospital medical care expense, diagnostic radiological and laboratory benefits, physicians' services provided by house and office calls, treatments administered in physicians' office, prescription drugs, psychiatric services, Christian Science practitioners' services, Christian Science nurses' services, optometric medical services for injury or illness of the eye, home health care, home nursing service, hospice care, and such other benefits as may be determined by the Board. Such benefits shall be provided on a copayment or coinsurance basis, the insured to pay a proportion of the cost of such benefits, and may be subject to a deductible that applies to all or part of the benefits as determined by the Board.

Washington

WA 284-96-500 Alternative Care-General Rules as to Minimum Standards

https://apps.leg.wa.gov/wac/default.aspx?cite=284-96-500

(1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every group or blanket disability insurance policy, contract or certificate issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.
(2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.
(3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.
(4) An insurer may require that home health agencies or similar alternative care providers have written treatment plans, which are approved by the insured patient's attending physician or other licensed health care provider.

(5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the policy or contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's policy or contract.
(6) This section shall not apply to long-term care, Medicare supplement, or disability income protection insurance policies or contracts. This section shall not apply to guaranteed renewable disability insurance policies issued prior to January 1, 1995.

RCW Section 48.44.320 Home Health Care, Hospice Care, Optional Coverage Required-Standards, Limitations, Restrictions-Rules-Medicare Supplemental Contracts Excluded

https://app.leg.wa.gov/rcw/default.aspx?cite=48.44.320

(1) Every health care service contractor entering into or renewing a group health care service contract governed by this chapter shall offer optional coverage for home health care and hospice care for persons who are homebound and would otherwise require hospitalization. Such optional coverage need only be offered in conjunction with a policy that provides payment for hospitalization as a part of health care coverage. Persons seeking such services for palliative care in conjunction with treatment or management of serious or life-threatening illness need not be homebound in order to be eligible for coverage under this section.
(2) Home health care and hospice care coverage offered under subsection (1) of this section shall conform to the following standards, limitations, and restrictions in addition to those set forth in chapters 70.126 and 70.127 RCW:
  (a) The coverage may include reasonable deductibles, coinsurance provisions, and internal maximums;
  (b) The coverage should be structured to create incentives for the use of home health care and hospice care as an alternative to hospitalization;
  (c) The coverage may contain provisions for utilization review and quality assurance;
  (d) The coverage may require that home health agencies and hospices have written treatment plans approved by a physician licensed under chapter 18.57 or 18.71 RCW, and may require such treatment plans to be reviewed at designated intervals;
  (e) The coverage shall provide benefits for, and restrict benefits to, services rendered by home health and hospice agencies licensed under chapter 70.127 RCW;
  (f) Hospice care coverage shall provide benefits for terminally ill patients for an initial period of care of not less than six months and may provide benefits for an additional six months of care in cases where the patient is facing imminent death or is entering remission if certified in writing by the attending physician;
  (g) Home health care coverage shall provide benefits for a minimum of one hundred thirty health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit;
  (h) The coverage may be structured so that services or supplies included in the primary contract are not duplicated in the optional home health and hospice coverage.
(3) The insurance commissioner shall adopt any rules necessary to implement this section.
(4) The requirements of this section shall not apply to contracts or policies governed by chapter 48.66 RCW.
(5) An insurer, as a condition of reimbursement, may require compliance with home health and hospice certification regulations established by the United States department of health and human services.

WAC Section 284-43-5642 Essential Health Benefit Categories

https://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5642

(1) A health benefit plan must cover "ambulatory patient services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "ambulatory patient services" those medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury.
  (a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:
    (ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;
  (c) The base-benchmark plan's visit limitations on services in the ambulatory patient services category include:
    (iii) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime; and

WAC Section 284-44-500 Alternative Care-General Rules as to Minimum Standards

https://apps.leg.wa.gov/wac/default.aspx?cite=284-44-500

1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual or group contract of a health care service contractor issued, amended, or renewed on or after January 1, 1995, which provides coverage for

hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.
2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.
3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.
4) A health care service contractor may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.
5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's contract.
6) This section shall not apply to long-term care or Medicare supplement insurance contracts. This section shall not apply to guaranteed renewable contracts issued prior to January 1, 1995.

WAC Section 284-46-500 Alternative Care-General Rules as to Minimum Standards

https://apps.leg.wa.gov/wac/default.aspx?cite=284-46-500

1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual or group agreement of a health maintenance organization issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care by home health, hospice and home care agencies licensed under chapter 70.127 RCW at equal or lesser cost, or by employees of the health maintenance organization.
2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice, or home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.
3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.
4) A health maintenance organization may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.
5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the agreement, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's agreement.
6) This section shall not apply to long-term care or Medicare supplement insurance contracts. This section shall not apply to guaranteed renewable agreements issued prior to January 1, 1995.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine the coverage eligibility.
Hospice services are covered only:

- For those members who have been certified by their attending physician as terminally ill.
  Note: Should the member continue to live beyond the original hospice qualifying life expectancy, the member's attending physician needs to re-evaluate the member's condition and determine the appropriateness of continuing hospice.
- When provided by a licensed hospice facility directly or indirectly when arrangements are made by the selected hospice.
- If a written plan of care is established by the member's interdisciplinary team, which includes, but is not limited to, the member, the member's primary care physician, a registered nurse, a social worker and a spiritual caregiver.

There are no day limits; however, the member may be under case management or designee.

Respite care is only covered if it is part of an authorized hospice plan and is needed to relieve the primary caregiver. The following limitations apply to respite care:
- **Oklahoma, Texas and Washington**: Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time.
- **Oregon**: Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time with a lifetime maximum of 30 days.

Hospice is responsible for providing any and all services indicated as necessary for the palliation and management of the Terminal Illness and related conditions in the plan of care.

Examples of covered benefits include, but are not limited to:
- Nursing care provided by or under the direct supervision of a qualified registered nurse;
- Medical social services provided by a licensed social worker and under the direction of a physician;
- Physician services performed by a physician except that the services of the hospice medical director or the physician member of the interdisciplinary group (the hospice team) must be performed by a medical doctor (M.D.) or doctor of osteopathy (D.O.);
- Inpatient hospital services in an appropriately licensed hospice facility when the member's interdisciplinary team has determined that the member's care cannot be managed at home;
- Medical equipment, supplies, and drugs that are used primarily for the relief of pain related to the terminal illness. Equipment includes durable medical equipment and other items related to the management of the terminal illness. Equipment for use in the member's home is provided by hospice;
- Certified home health aide and home health aide services that must be provided under the general supervision of a qualified registered nurse;
- 24-hour continuous care when required by a member to achieve palliation or management of acute medical symptoms;
- Physical, occupational, and/or speech therapy if provided for the purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills;
- Counseling and bereavement services.

Note: Covered hospice services are available in the home on a 24-hour basis when medically necessary, during periods of crisis, when a member requires continuous care to achieve palliation or management of acute medical symptoms.

Not Covered

- Members who do not meet the definition of terminally ill.
- Hospice services that are not reasonable and needed for the management of a terminal illness (e.g., care provided in non-certified hospice programs).
- Respite care is not covered, unless part of an authorized hospice plan and is needed to relieve the primary caregiver.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
07/01/2024	All	• Routine review; no change to coverage guidelines • Archived previous policy version BIP078.L

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.