Hospice: An Open Access Model of Concurrent Care

I. *Policy*

Hospice care for terminally ill patients and life-prolonging therapy have been mutually exclusive regimens for most government and commercial payment plans in the past. University Health Alliance (UHA) endorses Concurrent Care or an "Open Access" model of hospice service. Palliative care, in this model, can involve radiation, chemotherapeutic and surgical therapies alongside typical palliative interventions including pain and other symptom management. Psychosocial needs are critical to this paradigm. UHA will reimburse for Concurrent Care/Open Access Hospice for terminally ill patients when it meets the criteria guidelines (subject to limitations and exclusions) indicated below. Nothing in this policy should be construed to suggest that this model of hospice is a substitute for routine services and coverage for chronic, albeit complex, diseases. Rather, it is for the FINAL stages of catastrophic disease processes including, but not limited to advanced cancer, end stage heart, lung, or neurologic disease.

This benefit contemplates entry into an interdisciplinary program which establishes the clinical plan for palliation of symptoms, creation of rational goals of care, assistance with the acquisition of necessary DME and coordination of care as well as continuous access to healthcare professionals with personal knowledge of the terminally ill member's and family's circumstances and needs The dual goals of comprehensive palliative care without high intensity therapeutics at the end of life should be paramount. Avoidance of hospitalizations and intensive care to the full extent possible are priorities. However, it is anticipated that a member's needs will not remain at any one level continuously and that Concurrent Care/Open Access Hospice might be interrupted when and if the member reaches a level of self or care giver assisted independence with the care plan. The contracted fees will reflect different intensities of service and care according to the needs of the patient.

II. *Criteria/Guidelines*

A. Concurrent Care/Open Access Hospice services are covered when the following criteria are met:

1. Services are prescribed in writing by an attending physician with an intimate knowledge of the disease process(es).
2. Services are provided by a Medicare-certified hospice agency under contract with UHA.
3. The patient carries the diagnosis of a disease which is active, progressive, and irreversible (end-stage), and which will result in a greatly reduced life expectancy for which palliative and supportive interventions are medically necessary. A certification/attestation of life expectancy is NOT required. The member must be "homebound" as defined by CMS unless this criterion is explicitly waived by UHA.
4. Concurrent Care/Open Access Hospice is for the FINAL stages of a terminal disease process and is NOT custodial care. UHA understands that the duration of such care is not easily predictable, and the intent is to have members enrolled as soon as palliation becomes the primary goal of care. As noted throughout this policy, "palliation" can include treatments which might prolong life while primarily addressing symptom relief. This is an important distinction resting upon intent to palliate and not extend terminal suffering.
5. Interdisciplinary hospice care team management is ongoing, medically necessary, and appropriately documented.
    a. A patient specific plan of care which should address family and other support needs must be created and followed and will be reviewed by UHA. It must be unique to the case and must be patient centered and the clear result of joint decision making. Any deviation from the plan must be reported immediately to UHA.

6. End-of-life goals of care, including but not limited to, symptom management, fully informed consent regarding resuscitation and the circumstances under which it might be pursued, prioritization of personal values, coordination of care with all responsible parties, and advanced care planning (e.g., Health Care Decision Maker designation) and other end-of-life issues will be initiated and pursued rigorously from the outset of engagement. If the member is unprepared to make symptom management the goal, as opposed to pursuing curative or life prolonging treatments, Concurrent Care/Open Access Hospice will not be pursued.
7. If Concurrent Care/Open Access Hospice is discontinued for any reason, UHA and the hospice provider will mutually assist with alternative benefits including care coordination with public programs such as qualifying home health services or transition into traditional acute or other levels of care.
8. The initiation of any extraordinary therapy such as hemodialysis or vasopressor support must be clearly indicated as a very short term "bridge" to a return to the prior clinical status. For example, acute kidney injury with a very high likelihood of short-term recovery might justify hemodialysis. This would apply most to patients with diagnoses for which even advanced disease in need of palliation might progress sufficiently slowly that such an intervention would be rational (examples of such situations might, conceivably, include advanced breast cancer or late-stage multiple sclerosis). Such therapies should be discussed with UHA in advance of their initiation whenever possible. The Chief Medical Officer or Medical Director can be reached at any time for such conversations and approvals of necessity (see below).
9. Surgical care, chemotherapy and radiation should be given for symptom control with a reasonable expectation of efficacy.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries. The Hawaii Revised Statutory definition of "Medical Necessity" is always applicable.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria considering any supporting documentation.

III. *Limitations/Exclusions*

A. Interdisciplinary palliative and concurrent care must be provided by a Medicare-certified Hospice agency under contract with UHA.

B. Concurrent Care/Open Access Hospice services should be suspended after the first day of admission to an acute care hospital and/or skilled nursing facility and may be reinstated once reassessed for discharge home.

C. Disease processes are unpredictable for many reasons and the hospice provider must be alert to the fact that performance status and intensity of service may improve and decrease (respectively) to the point that a member should be discharged from Concurrent Care/Open Access Hospice entirely. It is the provider's duty to understand exit criteria for a specific patient and to apply honest clinical judgment. Collaboration with UHA is encouraged and both prospective and retrospective reviews may be undertaken.

IV. *Administrative Guidelines*

A. Prior authorization is not required for the initial 14 days of Concurrent Care/Open Access Hospice to allow for the development of a descriptive and analytic care plan. Documentation supporting the rationale for Concurrent Care/Open Access Hospice must be maintained in the patient's records and available for UHA to review upon request. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

B. Prior authorization is required following the initial 14-day Concurrent Care/Open Access Hospice period and should be recertified every 90 days. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

    1. All the following documentation must be submitted:

        a. Initial evaluation

        b. Patient specific plan of care (as noted in II.A.5a above)

        c. Documentation of services provided and planned, and actual number of visits per discipline, per week

C. Special clinical or social nuances for any given member may be discussed at any time with Healthcare Services leadership (808-532-4006, or at 808-522-7891 at night and on weekends.)

D. A certification/attestation of a specific life expectancy is NOT required.

E. Levels of care and assigned fees will be developed and updated by the Director of Medical Informatics, Pharmaceuticals, Data, and Payment Integrity in concert with the UHA Provider Contracting department.

V. *Policy History*

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