ELECTION OF HOSPICE CARE

An election statement for hospice care must be filed by the beneficiary or by a person authorized by law to consent to medical treatment for the beneficiary. (See Appendix A for details regarding the Notice of Election (NOE) form). For dual eligible beneficiaries, hospice care must be elected for both the Medicaid and Medicare programs simultaneously.

Reporting Election of Hospice Care

When a beneficiary elects Medicaid hospice, the provider must report initial hospice election to the hospice unit at Gainwell Technologies within 10 calendar days. Documentation to report beneficiary election of hospice must include the following completed forms:

1. Bureau of Health Services Financing (BHSF) Form Hospice-Notice of Election (NOE) with type bill 81A or 82A; and

2. BHSF Form Hospice-Certification of Terminal Illness (CTI). (See Appendix B).

A prior authorization packet, which includes the NOE, CTI and medical documentation is required upon the initial election of hospice or if the beneficiary is re-electing hospice during any hospice benefit period.

It is the responsibility of the hospice provider to make sure the NOE, CTI and any necessary attachments are properly completed prior to submitting to the hospice unit at Gainwell Technologies. The diagnosis code on the NOE and the diagnosis description on the CTI must match. The attending/referring physician's name on the NOE and CTI must match.

***All fields must be completed and submitted on the NOE and CTI within the 10 calendar day time frame. The top portion of the NOE form must be completed by the beneficiary or his/her legal representative only. The hospice provider cannot enter any information in the top section of the form.**

If these requirements are not met, reimbursement will not be available for the days prior to receipt. Reimbursement will be effective the date that BHSF receives the proper documentation.

Providers are advised to contact the hospice unit at Gainwell Technologies to confirm receipt of NOE/CTI and any documentation submitted if a letter is not received within 30 calendar days of the hospice election date.

Pending Medicaid Eligibles

The electronic prior authorization (e-PA) system will not allow a provider to enter a request until the Medicaid eligibility information is placed on the Medicaid Eligibility Verification Systems (MEVS) and Recipient Eligibility Verifications Systems (REVS) file. The hospice provider will not be able to request prior authorization until the beneficiary is deemed eligible for Medicaid. At the time a beneficiary is determined eligible for Medicaid, the request can be submitted for a retrospective review through the e-PA system. The begin date will be the hospice date of election or begin date of Medicaid eligibility whichever is the later date.

Attending Physician

The attending physician is the physician most involved with the beneficiary's care at the time of referral and prior to the election of hospice services. If the attending physician and the medical director of the hospice provider are one and the same, then a physician member of the interdisciplinary group (IDG) must also sign the BHSF Form Hospice-Certification of Terminal Illness (CTI). (See Section 24.5 – *Provider Requirements* for IDG requirements).

The attending physician is the physician identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice.

If a beneficiary (or legal representative) wants to change his or her designated attending physician during an elected benefit period the beneficiary (or legal representative) must file a signed statement, with the hospice provider, that identifies the new attending physician in enough detail so that it is with enough detail to clearly indicate which physician or nurse practitioner (NP) was designated as the new attending physician. The statement needs to include the following:

1. The effective date of the change;

2. The date that the statement is signed; and

3. The beneficiary's (or legal representative's) signature, along with an acknowledgement that this change in the attending physician is the patient's (or legal representative's) choice.

NOTE: There must be two different signatures on the BHSF Form Hospice-Certification of Terminal Illness (CTI) for beneficiaries electing hospice services. (See Section 24.5 – *Provider Requirements* for detailed information on the CTI).

Election Statement Requirements

The election statement must include the following:

1. Identification of the hospice provider that will provide care;

2. The beneficiary's or his/her legal representative's signature acknowledging that he/she has been informed and fully understands the palliative rather than curative nature of hospice care, as it relates to the beneficiary's terminal illness and related conditions. The legal representative must indicate the relationship to the beneficiary, date the form and list a daytime phone number;

3. Acknowledgment that certain Medicaid services are waived by the election; and

4. The effective date of the election. This date must not be earlier than the date of the election statement and the beneficiary's or legal representative's signature. The beneficiary or legal representative must enter the date of admission on the top portion of the form. Hospice providers cannot complete this section. Forms submitted that do not meet this requirement will be considered incomplete.

The hospice election statement must include the patient's choice of attending physician after the election of hospice services. The beneficiary has the option to keep his or her current physician after hospice has been elected or designate a physician member of the hospice team to act as their attending physician once hospice services have been elected. The election form should include an acknowledgement by the beneficiary (or legal representative) that the designated attending physician or NP was the beneficiary's (or legal representative's) choice.

In cases where a beneficiary signs the NOE form with an "X"; there must be two witnesses to sign next to his/her mark. The witnesses must also indicate relationship to the beneficiary and list daytime phone numbers. Hospice provider representatives cannot sign as witnesses. Verbal elections are prohibited.

Legal Representatives

When known relatives exist but persons other than relatives sign the BHSF Form Hospice-Notice of Election, the non-relative must have legal rights (e.g. a medical power of attorney) to make medical decisions for beneficiaries who are physically or mentally incapacitated. Proof of these rights must be submitted at the time the election for hospice is made. Verbal elections are prohibited.

Definition of Relatives

For purposes of this section, a relative is defined as all persons related to the beneficiary by virtue of:

1. Blood;
2. Marriage;
3. Adoption; or
4. Court appointed legal guardians.

Election Periods

Hospice services are covered on the basis of periods and require prior authorization. A beneficiary may elect to receive hospice care during one or more of the following election periods:

1. An initial 90-day period;
2. A subsequent 90-day period; and
3. Subsequent periods of 60 days each (requires prior authorization).

The periods of care are available in the order listed and may be used consecutively or at different times during the beneficiary's life span. The hospice IDG must help manage the beneficiary's hospice election periods by continually assessing the appropriateness for hospice care, especially before the beneficiary enters a new election period.

Hospice services will end when a beneficiary's Medicaid eligibility (including Medically Needy Spend Down, etc.) ends. A new NOE form and CTI form is required with updated signatures whenever the beneficiary is recertified for Medicaid. A prior authorization packet is also required

for beneficiaries whose eligibility ended in a subsequent period. If the beneficiary's Medicaid eligibility ends during a benefit period (Spend Down, etc.) all required forms and documentation signed and dated within the day timeframe must be held by the provider in the beneficiary's records. Once eligibility is reestablished, a completed packet can then be submitted timely for retrospective authorization.

Providers are encouraged to communicate with family members regarding the beneficiary's Medicaid coverage.

NOTE: It is the responsibility of the provider to verify the beneficiary's Medicaid eligibility. A copy of the Medicaid eligibility approval letter should be included in request for prior authorization.

Duration of Election

An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the beneficiary remains in the care of a hospice provider.

A beneficiary who revokes or is discharged alive during an existing election period will lose the remaining days in the election period. The beneficiary may at any future time elect to receive hospice coverage for any other hospice periods for which he/she is eligible.

Change of Designated Hospice Provider

A beneficiary or his/her legal representative is allowed to change the designation of the particular hospice provider from which hospice care will be received once in each election period. The change of the designated hospice provider is not a revocation of the election for the period in which it is made. To change the designation of hospice providers, the beneficiary or his/her legal representative must file with the hospice provider from which care has been received and the newly designated hospice provider, a signed statement that includes the following:

1. The name of the hospice provider from which the beneficiary has received care and the name of the hospice provider from which he/she plans to receive care; and

2. The effective date of the change.

Within five (5) calendar days following receipt of the filed change form, the new hospice provider must submit a BHSF Notification of Election/Revocation/Discharge/Transfer (81C/82C) (See Appendix A) to the Prior Authorization Unit at Gainwell Technologies through e-PA.

A BHSF Notification of Election/Revocation/Discharge/Transfer (81C/82C) must be sent to the Prior Authorization Unit through e-PA when a beneficiary is transferring from the original hospice provider within five (5) calendar days.

NOTE: The BHSF Form Hospice-NOE is also used to update changes in the beneficiary's condition and status.

Medicaid Covered Services that are Waived

For the duration of an election of hospice care, a beneficiary who is 21 years of age or older waives all rights to the following Medicaid covered services:

1. Hospice care provided by a hospice agency other than the hospice agency designated by the beneficiary or a person authorized by law to consent to medical treatment for the beneficiary; and

2. If the beneficiary is 21 years or older, any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected services for a related condition, or services that are equivalent to hospice care, except for services provided by:

    a. The designated hospice provider;

    b. Another hospice provider under arrangements made by the designated hospice provider; and

    c. The beneficiary's attending physician if that physician is not an employee of the designated hospice provider or receiving compensation from the hospice provider for those services.

Waiver Beneficiaries

Once a beneficiary elects hospice and a provider is chosen that hospice provider assumes all responsibility for the healthcare needs of the beneficiary related to the hospice illness. The hospice

provider must coordinate all services to ensure there is no duplication of services. The Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), and hospice providers must ensure that all waiver beneficiaries considering hospice are counseled thoroughly enough to make an informed decision.

Service Coordination

Medicaid expects the hospice provider to interface with other non-hospice providers depending on the need of the beneficiary to ensure that the beneficiary's overall care is met and that non-hospice providers do not compromise or duplicate the hospice plan of care. This expectation applies to Medicaid hospice beneficiaries and Medicare/Medicaid (dual eligible) hospice beneficiaries. The hospice provider must ensure a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid beneficiary to identify all other Medicaid or other state and/or federally funded program providers of care.

Adult Day Health Care Waiver

The Adult Day Health Care (ADHC) Waiver is a Medicaid Home and Community-Based Services (HCBS) Waiver program that expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities.

ADHC Waiver beneficiaries who elect hospice services may choose to elect ADHC Waiver and hospice services concurrently. The hospice provider and the beneficiary's support coordination agency must coordinate ADHC Waiver and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with ADHC Waiver services. When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's caregiver and the support coordination agency. The POC must clearly and specifically detail the ADHC Waiver and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

The licensed hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies, and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, ADHC Waiver Services and LT-PCS (if applicable) can be utilized for those personal care tasks with which the beneficiary requires assistance. (See the *Medicaid Services Manual*, Chapter 9, Section 9.1 for a full description of ADHC Waiver covered services at https://www.lamedicaid.com/provweb1/providermanuals/manuals/ADHC/ADHC.pdf).

Community Choices Waiver

The Community Choices Waiver (CCW) is a Medicaid Home and Community-Based Services Waiver providing an array of alternative services to individuals to assist them to live in their own home or community instead of in a nursing facility or institution.

CCW beneficiaries who elect to receive hospice services, may only receive Personal Assistance Services (PAS) under this waiver program. PAS includes assistance and/or supervision with ADLs and IADLs that are necessary for the beneficiary with functional impairments to remain safely in the community.

CCW beneficiaries who elect hospice services may choose to elect CCW and hospice services concurrently. The hospice provider and the beneficiary's support coordination agency must coordinate CCW and hospice services when developing the beneficiary's plan of care (POC). All core hospice services must be provided in conjunction with CCW services. When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's care giver and the support coordination agency. The POC must clearly and specifically detail the CCW and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

The licensed hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, then CCW Personal Assistance Services (PAS) can be utilized for those personal care tasks with which the beneficiary requires assistance. (See the *Medicaid Services Manual*, Chapter 7, Section 7.1 for a full description of CCW covered services at http://www.lamedicaid.com/provweb1/Providermanuals/manuals/CCW2/CCW.pdf).

Program of All-Inclusive Care for the Elderly

Program of All-Inclusive Care for the Elderly (PACE) is an optional Home and Community-Based Service (HCBS) under the Medicaid State Plan. PACE is a capitated, managed care program for individuals age 55 or older and meet nursing facility level of care and program requirements**.** The PACE interdisciplinary team performs an assessment and develops an individualized POC. PACE programs bear financial risk for all medical support services required, including comprehensive care to beneficiaries who need end-of-life care, for PACE beneficiaries.

Medicaid will not reimburse a hospice provider for services rendered to hospice beneficiaries participating in the PACE Program. PACE beneficiaries must voluntarily disenroll from the PACE program if they would like to receive hospice services from a licensed hospice provider. Hospice providers must contact the PACE provider before rendering hospice services to ensure that the PACE beneficiary is no longer enrolled in the PACE program.

Long Term-Personal Care Services

Long Term-Personal Care Services (LT-PCS) are provided under the Medicaid State Plan and are not included as a waiver service. LT-PCS are services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs).

Beneficiaries who elect hospice services may choose to elect LT-PCS and hospice services concurrently. The hospice provider and the long-term care access services contractor must coordinate LT-PCS and hospice services when developing the beneficiary's plan of care (POC). All core hospice services must be provided in conjunction with LT-PCS.

When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's care giver and the LT-PCS provider. The POC must clearly and specifically detail the LT-PCS and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive visits each day of the week.

The hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling. Once the hospice program requirements are met, then LT-PCS can be utilized for those personal care tasks covered in the LT-PCS program for which the beneficiary requires assistance. (See the *Medicaid*

Services Manual, Chapter 30 *Personal Care Services*, Section 30.2 for a full description of LT-PCS covered services at http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf).

Additional Personal Care Services

Beneficiaries who are 21 years of age and older may be eligible for additional personal care services as defined in the Medicaid State Plan. Services furnished under the personal care services benefit may be used to the extent that the hospice provider would routinely use the services of the hospice beneficiary's family in implementing the beneficiary's POC.

The hospice provider must provide services to the beneficiary that are comparable to the services they received through Medicaid prior to their election of hospice. These services include, but are not limited to the following:

1. Pharmaceutical and biological services;
2. Durable medical equipment; and
3. Any other services required by federal law.

NOTE: The above services are for illustrative purposes only. The hospice provider is not exempt from providing care if an item or category is not listed.

Beneficiaries under Age 21 Receiving Concurrent Care Hospice

Beneficiaries under 21 years of age who elect hospice shall be eligible for the concurrent care model of hospice. Concurrent care allows the beneficiary to elect to receive life-prolonging therapies. Life-prolonging therapies consist of any aspects of the beneficiary's medical plan of care that are focused on treating, modifying, or curing a medical condition so that the beneficiary may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. When the beneficiary turns 21 years of age, the concurrent care benefit is no longer available. Beneficiaries and families may change their election between standard and concurrent care anytime with the hospice during the hospice benefit period.

The hospice provider is responsible for making a daily visit available and optional to all beneficiaries under 21 years of age and for coordinating care to ensure there is no duplication of

services. If a daily visit is declined by the beneficiary, or their family, then the hospice provider must maintain documentation of the date and reason for not making a visit. The daily visit is not required if the person is not in the home due to hospitalization or inpatient respite stays.

All questionable services and/or treatments will be sent for medical review. All treatments and therapies must be included in the POC. Documentation of therapies and treatment as well as progress notes are required upon each request for a continuation of hospice care and upon the initial request for hospice care if the beneficiary is already receiving curative treatment(s).

Durable Medical Equipment

The hospice provider is responsible for providing durable medical equipment or contracts for the provision of durable medical equipment for hospice care. Durable medical equipment necessary for life-prolonging therapy shall be reimbursed separately to the appropriate provider.

Other Services

Beneficiaries who elect hospice services may also receive early and periodic screening, diagnosis and treatment (EPSDT), pediatric day health care (PDHC), personal care services (PCS), and intermittent or extended home health services concurrently.

Beneficiaries who elect hospice services may also receive Office for Citizens with Developmental Disabilities (OCDD) waivers services (New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver (SW), and Children's Choice Waiver (ChCW)) concurrently as long as the developmental disabilities diagnosis is not related to the terminal hospice condition and are not duplicative of hospice care. The hospice provider must coordinate services with the waiver support coordinator and waiver services provider to ensure there is no duplication of services.

Coordination of Care

The hospice provider for a beneficiary receiving concurrent care is responsible for facilitating communication and coordinating services with the beneficiary, beneficiary's caregiver (if applicable) and beneficiary's non-hospice providers to ensure that the beneficiary's overall care is met and that services are non-duplicative.

A beneficiary with a serious illness may have multiple subspecialists, along with a pediatrician, and can continue to receive care from the subspecialist/pediatrician as necessitated by the beneficiary's goals of care. The subspecialist/pediatrician shall assist with care coordination for

life-prolonging therapies. The hospice providers and subspecialist/pediatrician shall work together to ensure a collaborative approach when concurrent care model is being utilized.