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 DXC Technology within 10 calendar days. Documentation to report beneficiary election of hospice must include the following *completed forms:

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

- 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 DXC Technology. 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 DXC Technology to confirm receipt of NOE/CTI and any documentation submitted if a letter is not received within 30 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 date the change is to be effective;
- The date that the statement is signed; and
- 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:

- Identification of the hospice provider that will provide care;
- 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;
- Acknowledgment that certain Medicaid services are waived by the election; and
- 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 not meeting 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:

- Blood;
- Marriage;
- Adoption; or
- Legal guardians as court appointed.

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:

- An initial 90-day period;
- A subsequent 90-day period; and
- 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 (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 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
- The date the change is to be effective.

Within five 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 DXC Technology 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 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 waives all rights to the following Medicaid covered services:

- Hospice care provided by a hospice provider other than the hospice provider designated by the beneficiary; and
- Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care, except for services provided by:
    - The designated hospice provider; either directly or under arrangements;
    - Another hospice provider under arrangements made by the designated hospice provider; and
    - 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) 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.

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 (ADL) and the instrumental activities of daily living (IADL).

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. http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf).

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:

- Pharmaceutical and biological services;
- Durable medical equipment; and
- 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.

Community Choices Waiver

Community Choices Waiver (CCW) beneficiaries who elect to receive hospice services, may only receive the companion care component of the waiver. 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 CCW Personal Assistance Services (PAS) can be utilized for those personal care tasks covered in the CCW program for which the beneficiary requires assistance. (See the *Medicaid Services Manual*, Chapter 7, Section 7.1 for a full description of CCW covered services. http://www.lamedicaid.com/provweb1/Providermanuals/manuals/CCW2/CCW.pdf.

Program of All-Inclusive Care for the Elderly

Individuals eligible for enrollment in the Program of All-Inclusive Care for the Elderly (PACE) are persons at least age 55 years or older and certified to need nursing facility level of care**.** The PACE interdisciplinary team performs an assessment and develops an individualized POC. PACE programs bear financial risk for all medical support services required for enrollees.

Medicaid will not reimburse a hospice provider for services rendered to beneficiaries participating in the PACE Program. Hospice providers must contact the PACE provider for direction before rendering services to a PACE participant. PACE must prior authorize all services. Unauthorized services provided will result in non-payment for services rendered.

Beneficiaries under Age 21 Receiving Hospice and Concurrent Care

Beneficiaries under 21 years of age may continue to receive curative treatments for their terminal illness. However, the hospice provider is responsible for and must coordinate ALL curative treatments related to the terminal illness and related conditions. No additional payment may be made regardless of cost of service for curative care treatment.

The hospice provider is responsible for making a daily visit to ALL beneficiaries under 21 years of age and to coordinate care to ensure there is no duplication of services. 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).

Curative Care/Treatments

Curative care consists of medical treatment and therapies provided to a patient with the intention to improve symptoms and cure the patient's medical problem. Antibiotics, chemotherapy, and a cast for a broken limb are examples of curative care.

Durable Medical Equipment

The hospice provider is responsible for providing durable medical equipment or contracts for the provision of durable medical equipment.

Other Services

Personal care services and extended home health must be coordinated with hospice services as outlined in the POC.

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

health services concurrently. The hospice provider and the PCS of home health provider must coordinate services and develop the patient's POC.