ELECTION OF HOSPICE CARE

An election statement for hospice care must be filed by the recipient or by a person authorized by law to consent to medical treatment for the recipient (see Appendix A for form). For dually eligible recipients, hospice care must be elected for both the Medicaid and Medicare programs simultaneously.

Reporting Election of Hospice Care

When a recipient elects Medicaid hospice, the provider must report initial hospice election to the hospice program manager within **10 calendar days.** Documentation to report recipient election of hospice must include the following *completed forms:

- Bureau of Health Services Financing (BHSF) Form Hospice-Notice of Election (NOE) (see Appendix A) with type bill 81A or 82A,
- BHSF Form Hospice-Certification of Terminal Illness (CTI) (see Appendix B), and
- NOE, CTI and a prior authorization packet if the recipient is re-electing hospice during a 60 day 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 program manager. 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. Please note: The top portion of the Notice of Election form must be completed by the recipient 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 to confirm receipt of NOE/CTI and any documentation submitted if a letter is not received within thirty days of the hospice election date.

Pending Medicaid Eligibles

The e-PA system required for prior authorization will not allow a provider to enter a request until the Medicaid eligibility information is placed on the MEDS and REVS file. The hospice provider will not be able to request PA until the recipient is deemed eligible for Medicaid. This can be checked in the MMIS system though MEDS and REVS. At the time a recipient 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 that physician most involved with the recipient's care **at the time of referral**. If the attending physician and the medical director of the hospice 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 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.

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

Election Statement Requirements

The election statement must include:

- Identification of the hospice that will provide care;

- The recipient'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 recipient's terminal illness and related conditions. The legal representative must indicate the relationship to the recipient, 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 recipient's or legal representative's signature. The recipient 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.

In cases where a recipient signs the Notice of Election form with an "X"; there must be two witnesses to sign next to his/her mark. The witnesses must also indicate relationship to the recipient and 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 (i.e. a medical power of attorney) to make medical decisions for recipients 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 recipient by virtue of blood, marriage, adoption, or legal guardians as court appointed.

Election Periods

Hospice services are covered on the basis of **periods**. A recipient 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 recipient's life span. The hospice IDG must help manage the recipient's hospice election periods by continually assessing the appropriateness for hospice care, especially before the recipient enters a new election period.

Hospice services will end when a recipient's Medicaid eligibility (including Medically Needy Spend Down, etc.) ends. A new Notice of Election form (see Appendix A) and Certificate of Terminal Illness form (see Appendix B) is required with updated signatures whenever the recipient is recertified for Medicaid. A prior authorization packet is also required for recipients whose eligibility ended in a subsequent period (60 day) which required prior approval. Providers must send in prior authorization requests for recipients whose eligibility has ended but are awaiting Medicaid approval. Completed election forms and prior authorization documentation must be submitted within 10 calendar days after a recipient's Medicaid eligibility ends in order to meet the timely filing guidelines and to prevent a break in hospice coverage.

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

NOTE: It is the responsibility of the provider to verify the recipient's Medicaid eligibility.

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 recipient remains in the care of a hospice.

A recipient who revokes or is discharged alive during an existing election period will lose the remaining days in the election period. The recipient 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

A recipient or his/her representative is allowed to change **once in each election period**, the designation of the particular hospice provider from which hospice care will be received. 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 recipient or his/her 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 recipient 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 two 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 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 recipient is transferring from the original hospice provider within two calendar days.

NOTE: The BHSF Form Hospice-NOE is also used to update changes in the recipient's condition and status (see Appendix A for details regarding this form.).

Waiver of Other Medicaid Covered Services

For the duration of an election of hospice care, a recipient waives all rights to the following Medicaid covered services:

- Hospice care provided by a hospice provider other than the hospice provider designated by the recipient;
- 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 recipient'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 Slots

Once a recipient elects hospice and a provider is chosen that hospice provider assumes all responsibility for the healthcare needs of the recipient 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 recipients 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 recipient to ensure that the recipient'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 recipients and Medicare/Medicaid hospice recipients. The hospice provider

must ensure a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid recipient 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).

Recipients 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 recipient'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 recipient, the recipient'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 recipient's daily needs are being met. This will involve coordinating services where the recipient may receive visits each day of the week.

The hospice provider must provide all hospice services as defined in 42CFR 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 recipient requires assistance. (See the *Medicaid Services Manual*, Chapter 30, Section 30.2 for a full description of LT-PCS covered services. http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf).

Community Choices Waiver

Community Choices Waiver recipients, who elect to receive hospice services, may only receive the companion care component of the waiver.

Program of All-Inclusive Care for the Elderly

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

Medicaid will not reimburse a hospice provider for services rendered to recipients 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.

Recipients under Age 21 Receiving Hospice and Concurrent Care

Recipients under age 21 may continue to receive curative treatments for their terminal illness. However, the hospice provider is responsible for coordinating ALL curative treatments related to the terminal illness and related conditions.

The hospice provider is responsible for making a **daily visit** to ALL recipients under the age of 21 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.

Curative is medical treatment and therapies provided with the intent to improve symptoms and cure. Its focus is on curing an underlying disease and the providing medical treatments to prolong or sustain life. Examples of curative treatments are antibiotics, chemotherapy, radiation, or a cast for a broken limb. Curative treatment does not include home health services, durable medical equipment, personal care services, extended home health or contracting with another provider for the performance of these services.

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 recipient is already receiving curative treatment(s).