CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

Under the Medicaid program, hospice care must not be of any less or greater duration, scope, or quality than that provided to individuals not receiving state and/or federal assistance.

Hospice is a coordinated program of home and inpatient care as defined in 12 VAC5-391 (Virginia Department of Health). The hospice provider employs an interdisciplinary team to assist in providing palliative care to meet the special needs of enrolled individuals. The hospice model of care utilizes volunteers and family members, training them to provide much of an individual's care. This unique combination of professional staff, volunteers, and family members ensures a greater magnitude of services can be provided to an individual within his or her home, allowing for the highest quality of life and avoiding unnecessary institutionalization.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness, if the terminal illness runs its normal course. The individual must be certified as being terminally ill and must elect hospice coverage. A plan of care must be established and services must be consistent with the plan of care.

FREEDOM OF CHOICE

Individuals eligible for Medicaid must be offered a choice of service provider(s) and this freedom of choice must be documented in the individual's file.

INDIVIDUALS ENROLLED IN CARDINAL CARE MANAGED CARE

Many individuals enrolled in the Medicaid program have their services furnished through contracted managed care organizations (MCOs) and their network of providers. All providers should check eligibility (refer to Chapter 3) prior to rendering services to confirm in which health plan the individual is enrolled. The MCO may require a referral or prior authorization in order for the individual to receive services. All MCO network hospice providers are responsible for adhering to their MCO provider contract, as well as state and federal regulations. Some providers may choose not to enroll in the MCO network; the individual's choice of provider is limited to those in the MCO network.

For those individuals enrolled in Medicaid receiving care under Medicaid fee-for-service, the provider is responsible for adhering to this manual, as well as state and federal regulations.

ADMISSION CRITERIA FOR COVERED HOSPICE SERVICES

The following applies to Fee-for-Service (FFS) and MCO determinations. In order to be eligible for hospice care under Medicaid, an individual must be certified as terminally ill. An individual is considered terminally ill if his or her life expectancy is six months or less, if the terminal illness runs its normal course. In addition, the individual or, in cases where a representative has signed the election statement, his or her representative, must have knowledge of the illness and life expectancy and must elect to receive hospice services, rather than active treatment for the illness. Both the attending physician and the hospice medical director, or physician member of the interdisciplinary team, must certify life expectancy. The hospice benefit period begins with the date of the

individual/representative signature on the hospice election statement. A representative is defined as a person who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care, or to terminate medical care on behalf of the individual who is enrolling hospice.

Hospice must obtain certification an individual is terminally ill in accordance with the following procedures:

For the initial 90-day benefit period of hospice coverage, a written certification documented on page 2 of the *Request for Hospice Benefits* form (DMAS 420) must be signed and dated by the attending physician and hospice medical director. *(NOTE: For directions on how to access the current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.")* This initial certification must be obtained prior to the request for authorization of enrollment. For individuals who are dually eligible (Medicare/Medicaid), Medicaid will accept the Medicare certification period(s) signed by both physicians (the attending physician and the hospice medical director) within the required Medicare time frames. This will apply even when the individual becomes Medicare eligible after a period when Medicaid was the primary payer for hospice services. Hospice services cannot begin prior to the individual's election of the hospice benefit. This certification must be maintained in the individual's medical record.

DMAS will accept the Medicare definition and regulations regarding the "Certification of Terminal Illness" as cited in the *Code of Federal Regulations* at 418.22(a)(2) and (3), which read as follows:

> "a) *Timing of certification* -- (1) *General rule*. The Hospice must obtain written certification of terminal illness for each of the periods listed in §418.21, even if a single election continues in effect for an unlimited number of periods, as provided in §418.24(c).
>
> (2) *Basic requirement*. Except as provided in paragraph (a)(3) of this section, the Hospice must obtain the written certification before it submits a claim for payment.
>
> (3) *Exceptions*. (i) If the Hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment."

For any subsequent 90-day or 60-day hospice period, *Section IV: Notice of Re-Election of Hospice Benefit* of the *Request for Hospice Benefits form* (DMAS 420) or a *Physician Recertification* form (DMAS 420A), must be signed and dated by the medical director of the hospice, or the physician member of the hospice interdisciplinary team, on or before the beginning day of the 90-day or 60-day period. *(NOTE: For directions on how to access the current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.")* This certification must include a statement that the individual's medical prognosis (his or her life expectancy) is six months or less, if the illness runs its normal course.

If hospice cannot obtain the written recertification within two (2) calendar days after the

recertification period begins, it must obtain an oral recertification within two (2) calendar days and the written recertification prior to submission of a claim for payment. Documentation must be in the chart that the provider received oral recertification and the date that recertification was received. This recertification must be maintained in the individual's medical record.

In cases of Medicaid retroactive eligibility, the requirements listed above still apply.

ELECTION OF HOSPICE CARE

The election of the hospice benefit is an individual, or his or her representative's choice. The hospice benefit is not designed to meet the needs of every individual with a terminal illness. The individual and his or her family representative must be fully informed of the services available and any limitation(s) on those services prior to electing the benefit. Some individuals' needs can be more effectively met by utilizing other state and/or local programs and services.

In addition to the provision of core services (physician, nursing, medical social services, and counseling), all other covered services must be available and provided to meet the needs of the individual. When an individual elects Medicaid hospice care, the individual waives rights to those services covered by Medicaid which are also covered by Medicare and relate to the treatment of his or her terminal illness. Hospice providers are responsible for the provision of all covered services through one of four per diem rates. Therefore, any covered services provided after the election of the hospice benefit becomes the financial responsibility of the hospice provider.

Note that, on April 1, 2011, Virginia's Medicaid State Plan Amendment incorporated the federal requirement that children under the age of 21 must be permitted to continue to receive curative medical services, even if they also elect to receive hospice services. This change was implemented in order to enforce Section 2302 of the Patient Protection and Affordable Care Act, termed the "Concurrent Care for Children" requirement. Concurrent curative care means receiving curative care to eradicate disease or normalize the underlying health condition, while simultaneously receiving hospice care for physical symptoms and psychosocial needs at end of life. See end of chapter for additional information.

The hospice benefit consists of two 90-day periods, followed by an unlimited number of 60-day periods (referred to as election periods). An individual must elect to receive hospice care in order to receive hospice services. A *Request for Hospice Benefits form* (DMAS 420) must be completed by the individual, or the individual's representative, who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care. *(NOTE: For directions on how to access the most current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.")* When an individual elects Medicaid hospice care, the individual waives rights to services covered by Medicaid which are also covered by Medicare. Therefore, after the hospice benefit is elected, Medicaid payment will continue for services covered under the Virginia State Plan for Medical Assistance if those services are not covered by Medicare and the individual meets the program criteria.

This does not mean a hospice provider may provide fewer services than specified in the *Code of Federal Regulations,* Title 42, Part 418, because the services could also be covered under another Medicaid benefit. For example, since payment to the hospice provider includes home health aide services, the provider cannot refuse to provide these services because similar services are available under another benefit. DMAS will reimburse the hospice provider only for services that are medically necessary. Services which are duplicative are considered unnecessary. An individual receiving hospice services may be considered appropriate for personal care services if the services cannot be provided under the law by home health aide or homemaker services.

Admission and Disenrollment Process for Individuals Enrolled in FFS, Effective January 1, 2020:

- When an individual enrolled in Medicaid fee-for-service elects the hospice benefit, the hospice provider must enter the hospice admission directly into the Automated Admission and Disenrollment (AE&D) portal;
- Hospice providers must enter all hospice disenrollments for FFS individuals directly into the AE&D portal;
- The hospice provider will no longer fax the DMAS 421A form to DMAS; and
- The hospice provider will maintain the DMAS 420, 420A, and 421A forms in the individual's record. *(Note: For directions on how to access the most current version of these forms, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms."*

Hospice Enrollment Process for Individuals Enrolled in a Cardinal Care Managed Care Organization**:**

- For hospice enrollment of an individual enrolled in a Cardinal Care Managed Care Organization, please refer to and follow the MCO's enrollment process.

Hospice care may not be provided by a hospice provider other than that designated by the individual, unless services are provided under arrangements made by the designated hospice provider. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected are waived, except for services provided by the individual's attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

An election period to receive hospice care will continue through the initial election period, as well as through the subsequent election periods, without a break in care, as long as the individual remains under the care of hospice and does not revoke the election in writing.

The election statement must include the following:

- Identification of the particular hospice provider that will provide care to the individual;
- The individual's (or representative's) acknowledgment that the individual has been given a full understanding of the palliative, rather than curative, nature of hospice care as it relates to his or her terminal illness;

- Acknowledgment that certain Medicaid services are waived by the election of hospice care;
- The effective date of the election; and
- The signature and date of the individual or representative.

If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs. The hospice provider is responsible for completion of the DMAS required *Request for Hospice Benefits form*, pages 1 and 2 (DMAS 420). *(NOTE: For directions on how to access the most current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.")* If the provider bills Medicare for hospice services, Medicaid will accept the Medicare election of benefits forms with the Medicaid required physician signatures and dates.

Authorization to bill for Medicaid hospice services does not guarantee Medicaid payment for these services. The following conditions must be met for payment to be made:

- The individual must be eligible for Medicaid during the dates of service delivery;
- The individual must not have revoked the hospice election;
- The hospice provider must be enrolled with Medicaid during the dates of service delivery; and
- The hospice provider must pursue all other payment sources (e.g., Medicare and other insurance) prior to submitting a claim to DMAS.

DMAS reimbursement is subject to all DMAS and MCO quality management/utilization review activities.

ADVANCE DIRECTIVES

The hospice provider must provide written information to adult individuals at the time of the initial receipt of hospice care services regarding the individual's right to make medical care decisions. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will and/or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, the hospice provider must:

- Provide all adult individuals with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;

- Inform residents about the hospice provider's policy on implementing advance directives;
- Document in the individual's medical record whether the individual has signed an advance directive;
- Not discriminate against an individual based on whether the individual has executed an advance directive; and
- Provide staff and community education on advance directives.

AUTHORIZATION FOR SERVICES

Enrollment must be authorized by DMAS for reimbursement to be made for simultaneous provision of services under the hospice Medicare or Medicaid benefit. Hospice Providers must enter all hospice admissions and disenrollments directly into the AE&D portal for FFS individuals enrolled in Hospice Hospice providers will no longer FAX the DMAS 421A to DMAS. The Hospice provider must maintain the DMAS 420, 420A and 421A forms in the individual's record. Hospice enrollment cannot be completed without an active Medicaid number.

For individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for service authorizations.

The *Request for Hospice Benefits form* (DMAS 420), pages 1 and 2, must have all physician signatures and dates before the DMAS 421A can be submitted to DMAS. If there is no date for either physician's signature, it is the hospice provider's responsibility to obtain current dated signatures certifying the individual is eligible. Please note backdated signatures are not acceptable. Quality management/utilization reviews will be conducted to ensure services are appropriate and all documentation requirements are met.

A delay in enrollment shall place the hospice provider at risk of financial liability for covered services provided after the election statement is signed. Prompt enrollment limits the risk to the provider. The hospice provider cannot bill the individual for failure on the provider's part to obtain the required physician signatures and or failure to submit an enrollment to DMAS. Verification of documentation will be conducted upon post payment review.

In addition, the hospice provider must demonstrate respect for an individual's rights by ensuring an informed consent form, specifying the type of care and services that may be provided as hospice care during the course of the illness, has been obtained for every enrollee, either from the individual, or his or her representative. A representative is defined as a person who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or to terminate medical care on behalf of the individual.

A determination of the appropriateness of Medicaid payment will be made for the initial certification period, as well as each subsequent recertification period. With the exception of instances where the individual or representative revokes during a previous benefit

period, subsequent periods of care do not have to be authorized, but shall be certified by the physician, and the documentation of the physician's certification must be maintained by the hospice provider. The initial date of authorization of services will not be made retroactive prior to the date of the individual's election of hospice.

Hospice is responsible for providing or arranging for all services pertaining to the terminal illness. DMAS will perform quality management/utilization reviews to determine if the services were provided by the appropriate provider and to ensure services provided to individuals enrolled in Medicaid are medically necessary, appropriate, and that all certification and recertification requirements are met.

REVOCATION/TERMINATION OF HOSPICE SERVICES

An individual, or his or her representative, may revoke the election of hospice care at any time during an election period using the *Hospice Benefits Change/Revocation/Termination Statement*, (DMAS 421). *(NOTE: For directions on how to access the most current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.")* Upon revocation of the hospice benefit, the individual is no longer covered by Medicaid for hospice care; however, if eligible, the individual may resume Medicaid coverage under the regular scope of benefits. The individual may, at any time, elect to receive hospice coverage for any other benefit period(s) that the individual is still eligible to receive. For individuals enrolled under Medicaid fee-for-service, the hospice provider must enter the discharge date into the AE&D portal within five (5) calendar days of the revocation, using the *Hospice Enrollment/Disenrollment Authorization Request* form (DMAS 421A). For those enrolled in a managed care organization, please refer to and follow that particular MCO's hospice revocation/termination notification procedures. The DMAS 421 must be maintained in the individual's medical record.

CHANGE OF HOSPICE PROVIDER

An individual (or representative) may change the designation of the particular hospice provider, from which hospice care will be received, once in each election period by signing the *Hospice Benefits Change/Revocation/Termination Statement*, (DMAS 421) prior to provision of hospice services.

The change of the designated hospice provider is not a revocation of the election period for which it is made. The new provider must maintain the signed DMAS 421 in the individual's medical record. The new hospice provider must have a new *Request for Hospice Benefits* form (DMAS 420) signed by the individual or representative. The new provider must enter the admission in the AE&D portal for FFS individuals. For individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for a new provider.

RE-ELECTION OF HOSPICE BENEFITS

If an individual revokes the hospice benefit and subsequently re-elects the hospice benefit, the individual, or his or her representative, must sign and date a new *Request for Hospice Services* form (DMAS 420). The hospice medical director must sign and date the certification of the appropriate benefit period. This form must be maintained in the individual's medical record. Hospice must obtain written certification within two (2) calendar days of the beginning of the re-election benefit period and the provider must enter the admission ~~into~~ in the AE&D portal for FFS hospice individuals. For ~~those~~ individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for admission.

NOTIFICATION OF DEATH

The hospice provider must notify DMAS of the death of an individual no later than five (5) days following the death. The hospice provider should use the Hospice Enrollment/Disenrollment Authorization Request (DMAS 421A) as notification of death. *(NOTE: For directions on how to access the most current version of this form, please refer to the last section of this chapter, titled "How to Access DMAS Hospice Forms.")* The hospice provider must enter the discharge date in the AE&D portal for FFS hospice individuals. For ~~those~~ individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for discharge. The local Department of Social Services that has case responsibility for the individual must also be notified by the hospice provider, using the DMAS 225 process, if applicable. DMAS will reimburse the provider for the last day of service, which includes either discharge or death.

CATEGORIES OF CARE

As described for Medicare and applicable to Medicaid, hospice services entail the following four categories of daily care:

a. Routine home care is at-home daily care that is not continuous.

b. Continuous home care consists of a minimum of eight (8) hours of care a day. The care is predominantly nursing and is provided as short-term crisis care. A registered nurse or licensed practical nurse, with current licensure in the Commonwealth of Virginia, must provide care for more than half of the period of care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care.

c. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the individual. The hospice provider is responsible for all services related to the individual's terminal illness. These services may be provided under contract with the hospital or nursing facility, or by hospice direct staff. Medicaid reimbursement will be allowed for no more than five (5) consecutive days of hospice respite care.

d. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control, or acute/

chronic symptom management, which cannot be successfully treated in another setting. The hospice provider is responsible for all services related to the individual's terminal illness. These services may be provided under contract with the hospital or nursing facility, or by hospice direct staff.

GENERAL HOSPICE SERVICES

Hospice is responsible for the provision of all covered services through one of the above categories of care. Any covered services provided after the individual's election of the hospice benefit becomes the financial responsibility of hospice provider. Hospice must ensure that substantially all of the core services (physician, nursing care, social work, and counseling) are routinely provided directly by hospice employees to the individual. An individual or designated representative may refuse home health aides or homemaker services, social work, or counseling services, but the reason must be clearly documented in the medical record and identified in the plan of care. If appropriate, when due to a change in the individual's needs, the service should be re-introduced to the individual, or his or her responsible party, and the results of this discussion documented in the medical record.

Hospice may use contracted home health aides or homemaker services, if necessary, to supplement hospice employees to meet the needs of individuals during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice provider must maintain professional, financial, and administrative responsibility for the services and ensure the qualifications of staff and services provided meet all requirements. Documentation must be maintained by the provider to ensure the contracted aide has been fully trained in hospice philosophy and the provision of palliative care prior to any individual contact. Hospice maintains responsibility of nursing supervisory visits of any contracted aide.

Hospice is required to have a legally binding, written agreement for the provision of arranged services such as x-rays, laboratory, and pharmaceutical services for individuals enrolled under their Medicaid hospice benefit. Hospice retains financial responsibility for these services. Although the services are provided to an individual enrolled in Medicaid, since the hospice provider retains financial responsibility, there is no obligation on the part of the service provider to accept the Medicaid-allowable payment on the basis of the individual's eligibility status. Provision of and payment for these services should be included in the contractual agreement between the hospice provider and the service provider.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

- ***Nursing Care*** - Nursing care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse, who is a graduate of an approved school of professional nursing. On January 1, 2005, Virginia joined the Nurse Licensure Compact. Under the *Code of Virginia*, the Nurse Licensure Compact authorizes licensed practical nurses and registered nurses licensed and residing in a compact state to practice in other compact states, without the necessity of obtaining an additional license. The Virginia Board of Nursing website (http://www.dhp.virginia.gov/nursing/) provides detailed information as to which states are considered compact states and an explanation

of "primary state of residence." Nursing services must be directed and staffed to ensure the nursing needs of individuals are met. Patient care responsibilities of nursing personnel must be specified. Services must be provided in accordance with recognized standards of practice.

- ***Homemaker/Home Health Aide Services*** **-** Home health aides must meet the federal and state qualifications specified for home health aides. Home health aide and homemaker services must be available and adequate to meet the needs of the individuals. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the individual, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the individual. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse. A registered nurse must visit the home site at least every two weeks when aide services are being provided and the visit must include an assessment of the aide services. Written instructions for the individual's care must be prepared by a registered nurse. Documentation of all services provided by the home health aide under the hospice benefit must be maintained in the individual's medical chart.

  An individual in the CCC Plus Waiver can receive personal care, respite care, adult day health care, and Personal Emergency Response System (PERS) services in conjunction with hospice services. This is applicable regardless of whether the hospice provider receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Waiver services are authorized and coordinated under Cardinal Care managed care organizations. For members enrolled in the Cardinal Care program, please refer to the CCC Plus Waiver Manual for specific requirements and enrollment information.

  If an individual is currently receiving services under the CCC Plus waiver and elects the hospice benefit, both the personal care provider and hospice provider must communicate to determine the most appropriate plan for aide services. The individual and/or caregiver must be included in the formation of the plan and informed of the hours permitted for personal and hospice care. Although each provider maintains their separate record documentation, it is required that this documentation reveal a collaboration of services provided by both providers.

  Once an individual elects the hospice benefit, the hospice provider becomes responsible for establishing an interdisciplinary plan of care designed to meet individual's needs. If, at the time of the hospice assessment, the individual's needs indicate waiver services might be appropriate to supplement those services provided by hospice and these hours cannot be met by hospice staff, volunteers, the family support system, or other community resources, the individual should be referred to a preadmission screening team (PAS) to evaluate whether the individual meets the criteria for the CCC Plus waiver.

  When waiver services are requested in addition to the services being provided under the hospice benefit, PAS teams must:

  - Authorize the waiver, based on existing preadmission screening criteria, as long as the individual will be safe in the home setting with the total amount of care available through waiver services, hospice, and informal supports.

Preadmission screening teams do not authorize services, but determine if criteria is met for LTSS waiver programs, which is a pre-determination of a need for the waiver service. The waiver provider determines the amount, duration, and scope of each waiver service and requests authorization from the appropriate entity.

Hospice must coordinate with the waiver provider to establish and agree upon one plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation. The individual and service providers must be involved in any and all decisions that affect the individual's care.

Hospice and the waiver provider must agree upon any collection of the patient pay from the individual each month. This is an agreement which should be established at the onset of care to determine which provider (whether it be the hospice or waiver provider) will be responsible for collection of the monthly patient pay. If the person is choosing to use consumer directed services through one of the waiver programs, the hospice provider will need to coordinate the collection of the patient pay with the individual directly.

After admission to hospice services, the individual may continue to receive community-based respite. The hospice benefit only provides coverage for facility-based respite and is limited to five (5) consecutive days. The decision to choose this option is the individual's. If the individual wants community-based respite services it must be coordinated in accordance with CCC Plus waiver policies.

- ***Medical Social Services*** - Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and who is working under the direction of a physician. The social worker must meet all qualifications as outlined by the Virginia Department of Licensure and Certification.

- ***Physician Services*** - Physician services must be performed by a professional who is legally authorized to practice, is acting within the scope of his or her license, and is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director, or the physician member of the interdisciplinary team, must be a licensed doctor of medicine or osteopathy.

  Attending physician means a physician who is a doctor of medicine or osteopathy and is identified by the individual or representative, at the time the individual elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

- ***Counseling Services*** - Counseling services are required to be provided as part of the "core services" of a hospice program. Medicaid will not provide direct reimbursement to the hospice, or any other provider, for counseling services. Counseling services must be provided to individuals enrolled in hospice and their family member(s), or other persons caring them. Counseling may be provided for the purpose of training the family or other caregivers to provide care and/or for the purpose of helping the individual and the individual's caregivers adjust to the approaching death. Hospice must give notice to the individual as to the availability of clergy to provide spiritual counseling.

- ***Dietary Counseling***- Dietary counseling, when required, must be provided by a qualified professional and described in the plan of care. Other counseling services may be provided by members of the interdisciplinary team, or other qualified professionals, as determined by the hospice provider.

- ***Bereavement Counseling* –** Bereavement counseling consists of services provided to the individual's family up to one year after the individual's death. "Family" means the individual's immediate kin, including spouse, brother, sister, child, parent, or any other relation or individual with significant personal ties to the individual who, by mutual agreement with the individual, family, and hospice, participated in care. The plan of care must reflect the following: family needs, services to be provided, frequency of service delivery, and a clear delineation of who is to provide the bereavement counseling.

- ***Short-Term Inpatient Care*** - Short-term inpatient care, which is also referred to as inpatient respite care, may be provided in a participating Medicaid hospice facility, in-patient unit, or a participating Medicaid hospital or nursing facility, to relieve the primary caregiver(s) providing at-home care for the individual enrolled in hospice. No more than five (5) consecutive days of respite care will be covered.

- ***General In-Patient Care* -** General in-patient care may be required for procedures necessary for pain control or acute/chronic symptom management which cannot be provided in other settings. It may be provided in an approved facility (freestanding hospice facility, hospital, or nursing facility).

  ***NOTE*:** Individuals enrolled in hospice care are exempt from the preadmission screening process for nursing facility requirements. For example: If an individual enrolled in hospice enters a nursing facility and remains under the hospice benefit, a preadmission screening is not required for the individual to enter the nursing facility. However, if the individual revokes the hospice benefit prior to entering the nursing facility, all of the preadmission screening requirements will apply. All preadmission screening requirements apply if the individual wants to enroll in the CCC Plus waiver. If the individual was not screened prior to entering the nursing facility, the preadmission screening team (PAS) may go into the nursing facility to complete the screening for CCC Plus waiver enrollment.

- ***Durable Medical Equipment (DME) and Supplies*** - Durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the individual's terminal illness, are covered. The written plan of care must include any supplies and equipment that are necessary to provide hospice care to the individual. Medical supplies and appliances must be provided as needed for the palliation and management of the terminal illness and related conditions. For additional information, refer to the Virginia Medicaid DME Manual.

- ***Drugs and Biologicals*** - Only drugs used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. All drugs and biologicals must be administered in accordance with accepted standards of practice. Hospice must have a policy for the disposal of controlled drugs maintained in the individual's home when those drugs are no longer needed by the individual. Drugs and biologicals must be provided as needed.

- ***Rehabilitation Services*** - Rehabilitation services include physical and occupational therapies and speech-language pathology services used for

purposes of symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Rehabilitative services must be available and, when provided, offered in a manner consistent with accepted standards of practice.

Rehabilitative services shall be specific and provide symptom management related to the individual's terminal diagnosis in accordance with accepted standards of medical practice. This includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

Physical therapy services can only be performed by a physical therapist licensed by the Board of Medicine in the state in which the hospice provider is located, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physical therapist licensed by the Board of Medicine.

Occupational therapy services are covered only when performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Board, under the direct supervision of an occupational therapist as defined above.

Speech-language therapy services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology in the state in which the hospice provider is located.

For additional information on rehabilitation services, refer to the *Rehabilitation* provider manual issued by DMAS.

INDIVIDUALS WHO RECEIVE HOSPICE CARE AND RESIDE IN NURSING FACILITIES (NFS) OR INTERMEDIATE CARE FACILITIES/INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICFS/IDD)

If an individual receiving hospice services is admitted to a nursing facility under the hospice benefit and remains, the preadmission screening evaluation is not required.

Responsibilities of the Hospice Provider for Individuals in NFs or ICFs/IDD:

Once an individual, or his or her representative, has elected the hospice benefit, the hospice provider becomes responsible for providing:

- Skilled services, including but not limited to, the administration and monitoring of narcotics therapy, wound care, total parenteral nutrition, physical therapy, occupational therapy, and speech/language pathology services for treatment and related conditions;
- Care coordination, including, but not limited to, arranging routine appointments and transportation to those appointments, ordering and ensuring receipt of specialized equipment and supplies necessary to carry out the established care of the individual, and ensuring timely physician visits and pharmacy reviews;
- Assessments and care planning by individual disciplines and timely updates;

- Interdisciplinary team care planning and timely updates;
- Quality management/utilization review and maintenance of medical records; and
- Submitting claims to DMAS for routine home care for fee-for-service, Medicaid-only individuals. Revenue code 0658 must be billed by the hospice provider in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), for FFS members.

  Effective July 1, 2015, hospice providers furnishing services to nursing facility residents must submit Resource Utilization Group (RUG) codes on the revenue code 0022 line. Revenue code 0022 must be billed with revenue code 0658.

  For Mediacid members enrolled in the Cardinal Care program, nursing facilities shall directly bill hospice related nursing facility services to the Cardinal Care health plans. Providers should bill using the existing revenue code structure for Medicaid nursing famility services, ie., using revenue code 190. These claims will not differ from other Medicaid NF Resource Utiliztion Groups IV (RUG-IV) Grouper 48 claims billed to CCC Plus health plans; NFs should not bill managed care plans using hospice revenue codes.

  Effective with dates of service 07/01/2019 and after, DMAS and Cardinal Care plans will reimburse Hospice 100% of the Medicaid per diem rate for the nursing facility, in addition to reimbursement for either routine or continuous home care. The calculation of the per diem rate will be determined based on the nursing facility rate associated with the dates of service.

Responsibilities of the Nursing Facility and the ICF/IDD:

"Room and board" furnished to the individual enrolled in hospice by a nursing facility or intermediate care facility for those with intellectual disabilities (ICF/IDD) is defined as follows:

- Performance of personal care services, including assistance in activities of daily living and in socializing activities;
- Administration of medications;
- Maintaining the cleanliness of a resident's room; and
- Supervising and assisting in the use of durable medical equipment and prescribed therapies.

The nursing facility or ICF/IDD must bill the hospice provider, not DMAS, for reimbursement that would normally be paid to the facility by DMAS. Individuals receiving hospice services in nursing facilities or ICFs/IDD have the same responsibility to apply their income to their cost of care as other nursing facility residents. Local Departments of Social Services will send the facility the DMAS-225 form as with any other resident, for FFS members. The facility bills the hospice provider instead of DMAS, but the facility must deduct the patient-pay amount from the bill it submits to the hospice provider. The nursing facility and ICF/IDD must account for the patient pay for these individuals and

provide the hospice with a copy of the current DMAS-225. Hospice must adjust its total charges for revenue code 658 (percentage of nursing facility per diem). Any patient pay amount cannot be included in the nursing facility charges. Hospice must submit a copy of the current DMAS-225 identifying the patient-pay amount with its invoice when billing for revenue code 658.

For individuals eligible for hospice benefits under Medicare and Medicaid, the hospice provider must bill Medicare. Unless specifically prohibited by statute, Medicaid is the payer of last resort. In these instances (for example, because Medicare only reimburses for nursing facility care when it is provided in a skilled nursing bed), the routine or continuous home care charges would be billed to Medicare and the hospice provider would bill Medicaid for nursing facility charges for FFS members. For dates of service July 1, 2019 and after, Hospice providers do not bill Cardinal Care MCOs for nursing facility room and board charges. The nursing facility must bill the MCO directly for these charges and not the hospice provider.

In addition, Medicaid does not make bed-hold payments to any nursing facility when an individual is in an acute care setting. Any arrangement to hold a bed for an individual enrolled in hospice would be made between the hospice provider and the nursing facility. The individual and/or his or her family may elect to pay to reserve the bed while the individual is hospitalized, but they cannot be required to do so. All residents and their families must be informed the resident has the right to be admitted at the time of the next available vacancy following discharge from the hospital.

Individuals who are dual eligible and qualify for and are admitted to a Medicare skilled bed must dually elect their Medicare/Medicaid hospice benefit. Therefore, Medicaid cannot become the primary payer for dually eligible individuals who elect skilled nursing facility placement.

When an individual residing in a nursing facility elects the hospice benefit, the nursing facility is not required to submit a patient intensity rating system (DMAS 80) form to DMAS on admission, or any subsequent nursing facility stays, as long as the individual remains in hospice care. The hospice provider must submit the current version of the DMAS 421A to the DMAS Division of Aging and Disability Services to request authorization of enrollment for individuals under Medicaid fee-for-service. Nursing facilities must continue to complete a Minimum Data Set (MDS) on individuals receiving hospice care, as required for all nursing facility residents.

If a resident is in a nursing facility under the DMAS specialized care program, no payment for hospice services will be made to the hospice provider by DMAS. The nursing facility specialized care provider is responsible for providing and billing for all services needed by the resident.

INDIVIDUALS RECEIVING HOSPICE SERVICES WHILE RESIDING IN DEDICATED HOSPICE FACILITIES

If an individual is admitted to a dedicated hospice facility under the hospice benefit, preadmission screening is not required. The facility shall provide 24-hour nursing services sufficient to meet the total nursing needs of those its care. This includes treatment, medication, and diet, as prescribed, as well as keeping individuals comfortable, well-groomed, and protected from accident, injury, and infection.

Individuals residing in dedicated hospice facilities are not eligible to receive CCC Plus

waiver services, as facility staff are required to meet the needs of persons residing in the facility.

PEDIATRIC CONCURRENT CARE

Under Federal requirements DMAS must cover concurrent care for children under the age of 21. Concurrent curative care is covered outside of the hospice benefit when the child is enrolled in Medicaid FFS, or a Cardinal Care plan (FAMIS only). Those children who are enrolled in a Cardinal Care plan (that is a non-FAMIS plan) and elect hospice will be moved out of the Cardinal Care plan and moved into Medicaid FFS the day before the hospice benefit is elected.

Those receiving pediatric concurrent care do not have to be discharged from hospice to receive concurrent curative care. Concurrent care would be covered under the regular Medicaid benefit or waiver services. Coordination of care is an important piece in the management of these cases. The hospice provider, care coordinator (for MCO plans) and the treating providers should work together as much as possible to make sure everyone one involved in the childs care has accurate information.

Normal procedures for curative care shold be followed even though the child in enrolled in hospice. Providers will need to seek service authorization for concurrent care if it required. For Medicaid FFS members see the published manuals on our website for guidelines and service authorization requirements. Provider should refer to the individual Cardinal Care plan guidelines for members enrolled in one of the MCO plans. It is important for those enrolled in an MCO plan to work with the care coordinator for the Medicaid member to coordinate care.

Some examples of pediatric concurrent care include (but are not limited) to the following:

- A child who has elected hospice care at home and needs 24 hour mechanical ventilation and also needs a speciality wheelchair to accommodate the ventilator and their functional limitations in order for the child to be mobile for doctor's visits, movement around the home and community.
- A child with a diagnosis of cancer whose family has elected hospice but is actively still seeking treatment for cancer. The cancer treatment may include specialty doctor's visits and inpatient or outpatient treatments.
- A child who is on the waiting list for a lung transplant, whose family elected the hospice benefit. The child is actively seeking curative treatment and is seeing several specialist for care.

HOW TO ACCESS DMAS HOSPICE FORMS

There are four hospice DMAS forms, including: (1) the *Request for Hospice Benefits* (DMAS 420); (2) the *Physician Recertification* (DMAS 420A); (3) the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421); and (4) the *Hospice Enrollment/Disenrollment Authorization Request* (DMAS 421A). The current versions of these forms are available on the Virginia Medicaid Portal located online at: www.virginiamedicaid.dmas.virginia.gov. To access the forms, visit the portal and click on the "Provider Services" tab highlighted in blue on the right side of the page. Once on the Provider Services page, click on "Provider Forms Search" in the center of the page.

On the page that generates, select “Long Term Care Facility and Home Based Services” in the “Type” dropdown box, while selecting “Hospice” in the “Category” dropdown box. Finally, click the “Search” button at the bottom. The current versions of all DMAS hospice forms will populate on the next page.

The provider must not alter any DMAS forms, though the forms may be duplicated. Forms may also be obtained through Commonwealth Martin at 804-780-0076.

***NOTE*:** These forms and processes may be different for providers who participate in the Cardinal Care network. Refer to your provider contract or guidance from the MCO for compliance audit specifications.