SECTION 2
HOSPICE CARE SERVICES

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1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly noting the specific link that is not working and the page where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General Information.

Medicaid follows the federal guidelines for hospice care services as outlined in 42 CFR 418.

1-1 Hospice Care Services

Hospice care services are covered for eligible Traditional Medicaid members when determined to be medically necessary as outlined in this manual. Hospice care services come from recognizing that a member's terminal condition warrants a change in focus from curative care to palliative care. Hospice care services may be provided by an enrolled Medicaid hospice agency certified by Medicare in accordance with 42 CFR 418.

2 Health Plans

Information specific to Managed Care Entities (MCE) can be found in Section I: General Information, Chapter 2, *Health Plans.*

For more information about Prepaid Mental Health Plans (PMHP), refer to Section I: General Information Chapter 2-1.2, Prepaid Mental Health Plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

Refer to Section I: General Information Chapter 1-7, Fee for Service and Managed Care for information regarding Managed Care Entities (MCE) and how to verify if a Medicaid member is enrolled in an MCE.

A list of MCEs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

3 Provider Participation Requirements

To enroll as a Medicaid Provider refer to Section I: General Information Chapter 3, Provider Participation and Requirements.

3-1 Provider Credentials

A hospice agency must have a valid Medicaid enrollment in place prior to initiating hospice care for Medicaid members. The effective date will be the date a complete application has been submitted in PRISM, unless the hospice agency requests an earlier effective date to align with the date of Medicare hospice certification. Even if a provider requests retroactive enrollment, Medicaid will only approve retroactive enrollment up to 120 days earlier than the date when the complete Medicaid application is submitted.

At the time of a change of ownership, the previous owner's provider agreement terminates as of the effective date of the change of ownership. Medicaid accepts all waivers granted to hospice agencies by the Centers for Medicare and Medicaid Services as part of the Medicare certification process.

4 Record Keeping

Refer to Section I: General Information, Chapter 4, *Record Keeping.*

5 Provider Sanctions

Refer to Section I: General Information, Chapter 5 *Provider Sanctions.*

6 Member Eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to Section I: General Information Chapter 6, *Member Eligibility*.

Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

7 Member Responsibilities

For information on member responsibilities including establishing eligibility and co-payment requirements refer to Section I: General Information, Chapter 7, *Member Responsibilities.*

8 Programs and Coverage

For additional information regarding hospice care services, see Utah Administrative Code R414-14A-5. Hospice Care. Service Coverage. Specific coverage and reimbursement information by procedure code is found in the Coverage and Reimbursement Code Lookup.

Hospice agencies must provide the essential core services listed in this section. Frequency of services must be based upon an individualized assessment of need as determined by the attending physician and the treatment team, and as specified in the plan of care. A hospice agency may use contracted staff to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The

hospice agency remains responsible for the quality of services provided by contracted staff.

- nursing care provided by or under the supervision of a registered nurse,
- Medical social services provided by a qualified social worker under the direction of a physician,
- administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice agency,
- counseling services for the individual and family members or other persons caring for the person at home.

The following additional services must also be provided directly by, or made available by, the hospice agency whenever it is deemed appropriate and necessary by the treatment team and ordered by the attending physician.

Bereavement counseling consists of counseling services provided to the individual's family after a member's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

Special Modalities: Chemotherapy, radiation therapy, and other modalities may be used if it is determined, by the member's treatment team, that these services are needed for palliation. This determination is based on the member's condition and the hospice agency's care giving philosophy. No additional Medicaid payment will be made regardless of the cost of the services.

8-1 Definitions

Attending physician: means a physician who is a Doctor of Medicine or osteopathy, or

- a nurse practitioner or physician assistant who meets proper training, education, and experience requirements within their scope of licensing, and
- is identified by the member, when they elect to receive hospice care, as having the most significant role in determining and delivering the member's medical care.

Adult: means a member who is 21 years of age or older.

Cap period: means the twelve-month period, ending September 30, used in the application of the cap on overall hospice reimbursement specified in 42 CFR 418.309.

Concurrent care: means that a pediatric member, receiving hospice care, may also continue to receive curative treatment.

Consecutive months: means any number of months in a row wherein a hospice agency provides hospice care under the Medicaid benefit.

Continuous home care day: means a day in which a member, who has elected to receive hospice care at home, receives a minimum of eight aggregate hours of care from the hospice agency during a 24-hour day, which begins and ends at midnight. The eight hours of care must be predominately nursing care provided by either a registered nurse or a licensed practical nurse.

The Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT): means a federally mandated program that provides comprehensive and preventive health care services for children age birth through 20 years who are enrolled in Traditional Medicaid.

General inpatient care day: means a day when a member with elected hospice care receives general inpatient care for pain control or acute or chronic symptom management that is not manageable in their place of residence or another outpatient setting.

Hospice agency: means an agency licensed under the provisions of Rule R432-750 and is primarily engaged in providing hospice care to terminally ill individuals.

Hospice care services: means an approach to caring for terminally ill members that stresses palliative care as opposed to curative care. In addition to meeting the member's medical needs, hospice care services address the physical, psychosocial, and spiritual needs of the member, as well as the psychosocial needs of the member's family/caregiver. The emphasis of hospice care services is on keeping the member at home with family and friends as long as possible.

Inpatient respite care day: means a day when a member with elected hospice care receives short-term inpatient care necessary to relieve family members or other persons caring for the member at their place of residence.

Palliative care: means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care addresses physical, intellectual, emotional, social, and spiritual needs while facilitating patient autonomy, access to information, and choice.

Pediatric: means a member who is under 21 years of age.

Pediatric hospice agency: means an enrolled hospice agency that has trained employees in providing hospice care to patients who are younger than 21 years of age.

Representative: means an individual who has been authorized under state law to make health care decisions on behalf of the member, including initiating, continuing, refusing, or terminating medical treatments for a member who cannot make the decisions for themselves.

Terminally ill: means a medical prognosis to live no more than six months if the illness runs its ordinary course.

8-2 Nursing Facilities or Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID)

When an individual residing in a nursing facility or ICF/ID elects hospice care, the hospice and the facility must enter into a written agreement which defines the roles and responsibilities of each entity. The hospice agency is responsible for professional management of the member's hospice care and the facility agrees to provide room and board. Room and board include all services typically administered in a nursing facility, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a member's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

An agreement between the hospice agency and the nursing facility must include the requirements found in 42 CFR 418.112.

For a member receiving hospice care, while residing in a nursing facility, it is the responsibility of the hospice agency to notify the nursing facility of a hospice revocation per 42 CFR 418.28. The notice must be in writing and the hospice agency must provide it to the nursing facility on or before the revocation date.

Hospice agencies are reimbursed in accordance with the following methodology for members residing in nursing facilities and ICF/ID:

- the hospice agency will receive its routine daily rate plus an allowance for the facility's room and board:
    - for adults, the room and board allowance is 95 percent of the facility's Medicaid per diem rate for each hospice member in that facility. If there is no per diem rate available for the facility, the room and board allowance is 95 percent of the statewide average.
    - for EPSDT members, reimbursement is 100 percent of the Medicaid per diem rate. If there is no per diem rate available for the facility, the room and board allowance is 100 percent of the statewide average.

The hospice agency receives Medicaid's payment and must, in turn, reimburse the facility for room and board. The facility cannot bill Medicaid separately.

8-2.1 Managed Care Entities

If a member is enrolled in a MCE and has elected hospice care before being admitted to a nursing facility or ICF/ID, the MCE is responsible to reimburse the hospice agency for both the hospice care and the room and board until the member is disenrolled from the MCE.

8-2.2 Member Cost-of-Care Contributions

When a hospice member in a nursing facility has a monetary obligation to contribute to their cost-of-care in the facility, the facility will continue to collect and retain the contribution the same as for a non-hospice nursing facility member.

The hospice agency will bill Medicaid for the room and board at the daily per diem rate of that long-term care facility.

8-3 General Inpatient Care

Short-term general inpatient (GIP) care in a participating hospice inpatient unit, hospital, skilled nursing facility, ICF/ID, or other long-term care facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be necessary for pain control, or acute, or chronic symptom management which cannot be provided in a home or other outpatient setting. A member's preference to die in a hospital or in another inpatient setting is not an allowable criterion for GIP care. GIP will not be authorized due to the breakdown of the primary caregiver's living arrangements or the collapse of other sources of support for the member.

8-4 Respite

Inpatient respite care is an option that may be furnished for up to five consecutive days at a time to provide short term relief for the family members or others that are caring for the member at home. Inpatient respite care is not available to members who are residents of nursing facilities, ICFs/ID, or freestanding hospice inpatient units. Clinical notes must reflect that this need clearly exists, and that inpatient respite care is not being used for any other purpose such as for work or schooling for the caregiver.

8-5 Medical Supplies and Durable Medical Equipment

Medical supplies and equipment, used primarily for the relief of pain and symptom control related to the terminal illness are covered under hospice care services. Medical supplies must be included in the written plan of care. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the member's terminal illness. Equipment is provided by the hospice for use in the patient's home while they are under hospice care.

8-6 Home health aide and homemaker services

Home health aide and homemaker services furnished by qualified aides; 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 member, such as changing the bed, or light cleaning and laundering essential to the comfort and cleanliness of the member. Aide services must be provided under the general supervision of a registered nurse.

8-7 Physical Therapy, Occupational Therapy, and Speech-Language Pathology

Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills are covered under hospice care services.

8-8 Continuous Home Care

Continuous home care is provided only during a period in which a member requires at least eight aggregate hours of primarily nursing care in a 24-hour day to manage an acute medical crisis and to maintain the member at home (a 24-hour day begins and ends at midnight). The eight aggregate hours of care must be predominately (more than half) comprised of nursing care provided by either a registered nurse or licensed practical nurse. Homemaker and aide services may also be provided to supplement the nursing care.

Extended stay residents of nursing facilities are not eligible for continuous home care services.

8-9 Access Requirements

Hospice care services must meet the requirements relating to certification of terminal illness and the member's election of hospice care, as described in this chapter.

8-9.1 Certification of Terminal Illness

The hospice agency must obtain written certification by a physician that a member is terminally ill. The certification of a terminal condition must be based on a face-to-face assessment by a physician conducted no more than 90 days prior to the date of hospice enrollment. Hospice agencies are not reimbursed for hospice care until the physician's certification is complete.

Underlying conditions may not be used as qualifying terminal diagnoses for hospice care. Hospice agencies must use ICD-10-CM coding guidelines and code first the condition determined by the certifying physician to be the most contributory to a prognosis of six months or less. A diagnosis of debility or failure to thrive in adults does not meet eligibility criteria for the coverage of hospice care services. Underlying conditions can be reported as other diagnoses contributing to the prognosis of six months or less.

If written certification is not obtained within two calendar days following the initiation of hospice care, a verbal certification may be made within two days following the initiation of hospice care, with a written certification not later than eight days after care is initiated. Payment begins with the day of certification. An appropriate entry in the member's medical record must be made and filed as soon as the oral certification is obtained.

8-9.2 Election of Hospice

Election statements are designed and supplied to members by hospice agencies and must include the following elements:

- identification of the specific hospice that will provide the hospice care,
- the member's (or legal representative's) acknowledgment that they have been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the member's terminal illness,
- for adult members, acknowledgment that the member waives certain Medicaid services,
- acknowledgment that the member (or legal representative) may revoke the election of the hospice benefit at any time in the future. Adults must also acknowledge that revocation of hospice benefits will result in restoration of Medicaid benefits that were waived at the time of hospice election, and
- signature of the member or legal representative.

Pediatric hospice agencies must have distinct election statements designed specifically for members under 21 years of age. This election statement must inform pediatric members and their legal representatives that by electing hospice care, they do not forfeit any other benefit that would otherwise be available to them through the Medicaid State Plan; however, only services that are not part of the hospice rate can be billed separately. This election statement must also inform them that upon turning 21 years of age, they will no longer have concurrent care benefits and will be subject to the rules governing adults who have elected Medicaid hospice care.

If the member is not physically or mentally capable, or if the member is under 18 years of age, an election statement may also be filed by a representative authorized by state law to elect or revoke hospice care, or terminate medical care on behalf of a terminally ill individual.

Medicaid payment for hospice care is not available prior to the day that the election was filed. The effective date of the election may be the first day of hospice care or a later date but may be no earlier than the date of the election statement.

An election to receive hospice care remains effective through the initial election period and through the subsequent election periods without a break in care if the patient:

- remains in the care of a hospice,
- does not revoke the election, and
- is not discharged from the hospice.

A member 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, or
- an unlimited number of subsequent 60-day periods.

8-9.3 Dual Eligibility

A member dually enrolled in Medicare and Medicaid must elect the hospice benefit for both Medicare and Medicaid in accordance with 42 CFR 418.21 and 418.24. The member must receive hospice coverage under Medicare primarily. Election for the Medicaid hospice benefit provides the member coverage for Medicare coinsurance and room and board expenses while admitted to a Medicare-certified nursing facility, intermediate care facility for people with an intellectual disability (ICF/ID), or freestanding hospice facility.

8-9.4 Rights Waived to Some Medicaid Services for Adult Members

Medicaid does not separately cover modalities for palliative purposes as this is the responsibility of the hospice agency. For the duration of an election for hospice care services, an individual waives rights to Medicaid payments for the following services:

- Hospice care provided by a hospice agency other than the hospice agency designated by the individual (unless provided under arrangements made by the designated hospice agency)
- Coverage of services for illnesses or conditions unrelated to the member's terminal illness, is non-covered through the hospice benefit.
    - Such services are covered ancillary to hospice benefits when provided by an appropriate provider or facility.
- Any 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 agency,
    - another hospice agency under arrangements made by the designated hospice agency, and
    - the individual's attending physician if that physician is not an employee of the designated hospice agency or receiving compensation from the hospice agency for those services.

If an adult member seeks medical treatment for illnesses or conditions that are not related to the member's terminal illness, this type of treatment is covered by Medicaid when provided by the appropriate provider. Hospice agencies are not responsible to reimburse medical care providers for treatment that is unrelated to the member's terminal condition.

8-9.5 Concurrent Care for Members Under 21 Years of Age

For the duration of the election of hospice care, pediatric members may only receive hospice care that is:

- provided by the designated hospice agency, or
- provided under arrangements made by the designated hospice agency.

Pediatric members who elect to receive hospice care services may also receive concurrent Medicaid State Plan services for the terminal illness and other related conditions.

Medicaid does not separately cover any modalities for palliative purposes as this is the responsibility of the hospice agency.

- services provided outside of the hospice benefit shall be reported directly to Medicaid for coverage.
- hospice agencies are not responsible for reimbursing other providers or facilities for life-prolonging services rendered to pediatric members.

Hospice agencies performing pediatric care shall develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide hospice care services. Staff members and volunteers who provide pediatric hospice care services shall receive training before providing hospice services and at least annually thereafter.

- The training shall include the following pediatric-specific elements:
  - growth and development
  - pediatric pain and symptom management
  - loss, grief, and bereavement for pediatric families and the child,
  - communication with family, community, and interdisciplinary team,
  - psycho-social and spiritual care of children,
  - coordination of care with the child's community
  - Medicaid adopts the National Hospice and Palliative Care Organization's (NHPCO) standards for pediatric hospice services.

A plan of care must be established by the interdisciplinary group. At least one of the persons involved in development of the initial plan must be an appropriately licensed practitioner acting within their scope of practice. The plan of care must be consistent with the hospice philosophy of care. This plan must be established on the same day as the face-to-face assessment and certification if the day of assessment and certification is to be a covered day of hospice care.

8-9.6 Revocation of Hospice Benefits

The member (or legal representative) may revoke the election of hospice care at any time. To revoke the election of hospice care, the member or representative must give the hospice a signed statement revoking the election of hospice care for the remainder of that election period with the date revocation is to be effective. The individual forfeits the remainder of the election period. Signed statements must include the following information:

- a signed statement that the member or representative revokes the member's election for Medicaid coverage of hospice care,
- the date that the revocation is to be effective, which may not be earlier than the date that the revocation is made, and

- an acknowledgment signed by the patient or the patient's representative that the patient will forfeit Medicaid hospice coverage for any remaining days in that election period.

Upon revocation of the election of Medicaid coverage of hospice care for a particular election period, a member:

- is no longer covered under Medicaid for hospice care,
- resumes Medicaid coverage for the benefits waived (for adult members), and
- may at any time elect to receive hospice coverage for any other hospice election periods that they are eligible to receive.

Hospice agencies may not encourage adult members to temporarily revoke hospice care services solely for the purpose of avoiding financial responsibility for Medicaid services that have been waived at the time of hospice election.

8-9.7 Change in Hospice agency

A member or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not a revocation of the election for the period in which it is made. To change the designation of a hospice agency, the member must file a statement with the hospice agency from which care has been received and with the newly designated hospice agency on or before the effective date of the change. The statement must include the following information:

- the name of the hospice agency from which the member has received care,
- the name of the hospice agency from which the member plans to receive care, and
- the date the change is to be effective.

8-9.8 Provider Initiated Discharge from Hospice Care

Hospice agencies may not initiate discharge of a patient from hospice care except in the following circumstances:

- the member moves out of the hospice agency's geographic service area or transfers to another hospice agency by choice
- the hospice agency determines that the patient no longer meets the eligibility criteria for hospice
- the hospice agency determines that the member's behavior (or the behavior of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the member or the ability of the hospice to operate effectively is seriously impaired. This type of discharge is called "for cause." When it becomes necessary to discharge for cause, the following steps must be taken prior to discharge:
    - advise the member that a discharge for cause is being considered,
    - make a diligent effort to resolve the problem(s) that the patient's behavior or situation presents,

- ascertain that the discharge is not due to the member's use of necessary hospice care services, and
- document the problem and efforts to resolve the problem in the member's medical record.

Before discharging a patient for any reason, the hospice agency must obtain a physician's written discharge order from the hospice agency's medical director. If a patient also has an attending physician, the hospice agency must consult the physician before discharge and the attending physician must include the review and decision in the discharge documentation.

A member, upon discharge from the hospice during a particular election period, for reasons other than immediate transfer to another hospice:

- is no longer covered under Medicaid for hospice care,
- resumes Medicaid coverage of the benefits waived during the hospice coverage period (for adult members), and
- may at any time elect to receive hospice care if the member is again eligible to receive the benefit in the future.

The hospice agency must have in place a discharge planning process that considers the prospect that a patient's condition might stabilize or otherwise change if that patient cannot continue to be certified as terminally ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because the patient is no longer terminally ill.

If the hospice agency or Medicaid determines that a member is not terminally ill while receiving hospice care under this manual, the member is not responsible to reimburse Medicaid. If Medicaid denies reimbursement to the hospice agency, the hospice agency may not seek reimbursement from the member.

8-9.9 Notifications

The hospice agency is responsible for notifying Medicaid whenever a member is enrolled in hospice care, whenever a member is discharged from hospice care, whenever a member moves into a nursing facility, intermediate care facility for people with intellectual disabilities (ICF/ID), or freestanding inpatient hospice facility, or whenever there has been a change in hospice agencies. When any of these events occurs, the hospice agency must submit the following applicable documents to Medicaid within ten (10) calendar days:

- a completed Hospice Prior Authorization Request Form, a copy of the signed election statement, and a copy of the physician's certification statement whenever a member is enrolled in hospice care and for each election period thereafter,
- a completed Hospice Prior Authorization Request Form and a copy of the initial plan of care when a member becomes retroactively eligible for Medicaid and hospice care,

- a copy of the completed Hospice Prior Authorization Request Form and revocation statement whenever a member chooses to revoke hospice benefits,
- a copy of the member's written statement at the time of a change to a different hospice agency, and
- a copy of the completed Hospice Prior Authorization Request Form indicating the effective date of the discharge. If the discharge is "for cause," providers must attach a copy of the written discharge order signed by the hospice agency's medical director. Providers must also send to DMHF a written summary describing the "for cause" reason of discharge and any supporting documentation to show that the provider satisfied the required steps prior to discharging the member from hospice care.

9 Non-Covered Services and Limitations

Coverage of services for illnesses or conditions unrelated to the member's terminal illness, is non-covered through the hospice benefit, rather, such services are covered ancillary to hospice benefits when provided by an appropriate provider or facility.

Hospice agencies are not permitted to engage in unsolicited direct marketing to prospective members. Hospice agencies are free and welcome to engage in marketing strategies such as mass outreach and advertisements but are not permitted to approach a prospective member or legal representative unless the member or legal representative explicitly requests information from a particular hospice agency. Hospice agencies must refrain from offering incentives or other enticements to persuade a prospective member to choose that provider for hospice care.

10 Prior Authorization

All enrollments into hospice care services, excluding room and board, must be prior authorized.

Prior authorization can only be approved for the duration of defined election periods. The hospice agency shall maintain documentation to support the requirement that the service provided was medically necessary and complied with an established plan of care.

To request prior authorization, the Medicaid hospice agency must complete and submit the Hospice Prior Authorization Request Form. Along with the Hospice Prior Authorization Request Form, providers must also submit a copy of the election statement which has been signed and dated by the member or the member's legal representative and a copy of the physician's certification statement.

When an adult patient (21 years of age or older) reaches 18 consecutive months in hospice care, an independent face to face physician review, by a physician not affiliated with the hospice agency, is required. Dually eligible members receiving hospice care services through Medicare are excluded from this requirement. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care. Eighteen consecutive months means 18 months in a row wherein Medicaid hospice care was provided during any portion of each of the 18 months.

Medicaid will not accept independent physician reviews that were performed more than 30 days earlier than the date the prior authorization is submitted for the applicable election period. Hospice agencies must advise patients of this requirement and provide the "Independent Physician Review for Extended Care" form to take with them to each independent review. Prior authorization requests for extended hospice care beyond 18 months will be denied if the "Independent Physician Review for Extended Care" form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements. Medicaid members receiving hospice care through Medicare Part A are excluded from the requirement of independent physician reviews.

- Prior authorization grace period
    - A hospice agency may begin service for a new Medicaid hospice member for a grace period up to 10 (ten) calendar days before submitting the Hospice Prior Authorization Request Form to Medicaid. Hospice requests may be approved no more than the 10 days prior to the date a complete hospice request is received.
- Post-payment for hospice care services while a member is in Medicaid pending status
    - If a provider admits a member to hospice care under a non-Medicaid funding source and the member becomes Medicaid eligible at a later date, the provider must submit the Hospice Prior Authorization Request Form to Medicaid along with a copy of the signed election statement and the initial plan of care immediately upon learning that the member is Medicaid eligible. (Providers should not send any information to Medicaid until the member's Medicaid eligibility has been established.) Medicaid will review the documents and reimburse a hospice agency retroactively to allow the hospice eligibility date to coincide with the member's Medicaid eligibility date when the following requirements are met:
        - The member met Medicaid eligibility requirements at the time the service was provided,
        - The hospice care met the prior authorization criteria at the time of delivery.
    - The hospice provider must provide a copy of the initial care plan and any other documentation to Medicaid adequate to demonstrate the hospice care met prior authorization criteria at the time of delivery.
- Post-authorization for service intensity add-on (SIA) payments
    - In order to claim SIA payments for direct face-to-face services rendered by a registered nurse or social worker during the last seven (7) days of a patient's life, hospice agencies must submit the Post-Authorization Request for Service Intensity Add-On Form to Medicaid before the end of 180 calendar days following the patient's death.

- Along with the required form, hospice agencies must also submit copies of nursing and social worker notes for the dates of service listed and any other records that document the amount of time requested. Each face-to-face encounter must be reported with start and end times, which may require listing multiple service lines for each of the possible seven (7) dates of service.

11 Billing

For general information related to billing Medicaid refer to chapter 11 *Billing Medicaid* of the *Section I: General Information* provider manual for additional billing instructions.

Billing Instructions

Hospice agencies will bill the room and board for NFs or ICFs/ID in the same manner as for other hospice care services (CMS 1500 or UB-04). Hospice providers are also required to report the location of where services are rendered to ensure appropriate payment.

- For electronic billing of the 837 professional claim, complete the service facility location name, 2310C loop.
- For claims submitted on a paper CMS 1500 form, report the service facility location information in boxes 32, 32a, and 32b.

12 Coding

Hospice providers should use the following codes when reporting hospice care services:

- T2042 Routine home care - daily (The same code applies to the higher base rate and the lower base rate.)
- T2043 Continuous home care – hourly (minimum of 8 hours)
- T2044 Inpatient respite care - daily
- T2045 General inpatient care - daily
- T2046 Long-term care facility room and board - daily
- G0155 Service Intensity Add-on – per quarter hour (maximum of 4 hours per day)

13 Reimbursement

Medicaid must provide payment for hospice care in accordance with the methodology set forth in the Utah Medicaid State Plan.

13-1 Hospice Care Rates

Hospice care services (including room and board) are reimbursable to the hospice agency. Medicaid payments for hospice care services are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. However, Medicaid will not apply the aggregate caps used by Medicare. The

rates will be based on the Medicare rates for Utah which are unique to each geographic region in the state. Providers should bill the rate that applies to the geographic region where the member resides, not the geographic region of the provider's address.

Medicaid establishes reimbursement rates for the following categories:

- Routine home care,
- Continuous home care,
- Inpatient respite care,
- General inpatient care.

Reimbursement is made for only one of the categories of hospice care listed above for any day. Room and board is reimbursed separately from the routine home care rate when a member resides in a nursing facility, ICF/ID, or freestanding hospice inpatient units. Service intensity add-on is also reimbursed separately from the routine home care rate.

Reimbursement for inpatient care is limited as follows:

- The total reimbursement rate paid to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid members do not exceed 20% of the total days for which these members had elected hospice care. Members with an AIDS diagnosis are excluded from this payment methodology when calculating inpatient days.
- At the end of a cap period, Medicaid calculates a limitation on payment for inpatient care for each hospice agency to ensure that Medicaid payment is not made for days of inpatient care in excess of 20% of the total number of days of hospice care furnished to Medicaid members by the hospice agency.
- No adjustment is necessary if the number of inpatient care days received by Medicaid members is equal to or less than 20% of the total number of days.
- If the number of days of inpatient care furnished to Medicaid members exceed 20% of the total days of hospice care to Medicaid members, the total payment for inpatient care is determined in accordance with the procedures specified. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice.

If a hospice exceeds the number of inpatient care days, the total payment for inpatient care is determined as follows:

1. Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicaid members.
2. Multiply this ratio by the total reimbursement for inpatient care made by Medicaid.
3. Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate.
4. Sum the amounts calculated.

The hospice agency may request an exception to the inpatient care payment limitation if the hospice agency demonstrates the volume of Medicaid enrollees during the cap period was insufficient to reasonably achieve the required 20% ratio.

- Routine home care
    - "Routine home care day" is a day in which a member who has elected to receive hospice care is at home and is not receiving continuous home care during a period of crisis. For purposes of routine home care day, extended stay residents of nursing facilities are considered at home and are eligible to receive routine home care and SIA payments. The rate is paid (1) without regard to the volume or intensity of routine home care services, and (2) even when the patient is receiving hospital care for a condition that is unrelated to the terminal illness.

Effective January 1, 2016, routine home care will be paid using a tiered payment system as described below:

- For the first 60 days of hospice episode, a higher base payment rate will be paid in recognition that service intensity is often greater during the first two months of hospice care.
- Beginning with day 61 through the remainder of hospice episode, a lower base payment rate will be paid in recognition that service intensity is often lower after the first 60 days.

For the purposes of the tiered payment rates, a hospice “episode” is an election period or a series of election periods where there are no breaks in stay longer than 60 days. If there is a break in stay and the patient returns to hospice care before the end of 60 days, the count continues from where it left off at discharge. If the break in stay is longer than 60 days, the count begins anew upon re-election of hospice care.

Service intensity add-on (SIA) payments are permitted during the last seven days of a patient’s life even if hospice election is short term (less than seven days). SIA payments are available in 15-minute increments for up to four hours each day. SIA payments are equal to the continuous home care hourly rate for each hour of direct service and is paid in addition to the routine home care daily rate.

Certain criteria must be met for SIA payments as follows:

- The service day is a routine home care level of care day, and
- The day occurs during the last seven days of hospice care and the patient is discharged due to “death,” and
- SIA payments are limited to direct patient care (face to face) which is provided by a registered nurse or social worker.
    - Encounters performed by licensed practical nurses (LPNs), hospice aides, therapists, clerical staff, or others are not eligible for SIA payments.

- Remote encounters such as telephone contact performed by a registered nurse or social worker are not eligible for SIA payments.

- Continuous home care
  - “Continuous home care day" is a day in which a member who has elected to receive hospice care receives a minimum of eight aggregate hours of care from the hospice agency during a 24-hour day, which begins and ends at midnight. The eight aggregate hours of care must be predominately nursing care provided by either a registered nurse or licensed practical nurse. Continuous home care is only furnished during brief periods of crisis in which a patient requires continuous care that is primarily nursing care to achieve palliation or management of acute medical symptoms.
  - The hospice agency will maintain documentation to support the requirement that the services provided were reasonable and necessary and followed an established plan of care to meet a particular crisis situation. Continuous home care is a covered benefit only as necessary to maintain the terminally ill member at home.
  - The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The number of hours of continuous care provided during a continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight hours of licensed nursing care must be furnished on a particular day to qualify for the continuous home care rate. Continuous home care is a covered benefit only as necessary to maintain the terminally ill member at home. Extended stay residents of nursing facilities, ICFs/ID, or freestanding hospice inpatient units are not eligible for continuous home care.

- Inpatient respite care
  - "Inpatient respite care day" is a day in which the member who has elected hospice care receives short-term inpatient care when necessary to relieve family members or other persons caring for the member at home. The hospice will be paid at the inpatient respite care rate for each day on which the member is in an approved inpatient facility and is receiving respite care. Payment for inpatient respite care will include the date of admission but not the date of discharge. Respite care will not be reimbursed for more than five consecutive days at a time.
  - Inpatient respite care is a covered benefit only as necessary to provide relief to family members or others who are providing care in the home setting and is intended as a measure to preserve the primary care giving living arrangement. Extended stay residents of nursing facilities, ICFs/ID, or freestanding hospice inpatient units are not eligible for inpatient respite care.

- General inpatient care (GIP)

- "General inpatient care day" is a day in which a member who has elected hospice care receives general inpatient care for pain control or acute or chronic symptom management that cannot be managed in a home or other outpatient setting. General inpatient care may be provided in a hospice inpatient unit, a hospital, or a nursing facility.

During the 12-month period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. The inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

A hospice may not arrange to provide inpatient services (including general inpatient care and inpatient respite care) in a Veteran's Administration Hospital or a military hospital because Medicaid cannot pay for services which have already been paid by another governmental entity.

General inpatient care may only be utilized on a short-term basis for pain control or acute or chronic symptom management that cannot be managed in a home or other outpatient setting. A member's preference to die in a hospital setting is not an acceptable criterion for GIP services. GIP may not be authorized due to the breakdown of the primary care giving living arrangements or the collapse of other sources of support for the member.

- Room and Board
  - "Room and Board" is medication administration, performance of personal care, social activities, routine and therapeutic dietary services, meal service including direct feeding assistance, maintaining the cleanliness of the member's room, assistance with activities of daily living, durable equipment, prescribed therapies, and all other services unrelated to care associated with the terminal illness that would be covered under the Medicaid State Plan long-term care facility benefit.

For all members residing in a long-term care facility, ICF/ID, or a freestanding hospice inpatient unit who elect to receive hospice care (including members under 21 years of age), Medicaid will pay the hospice agency an additional per diem for routine home care services to cover the cost of room and board in the facility. For nursing facilities and ICFs/ID, the room and board rate is 95 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider for that member if the member had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 95 percent of the statewide average paid by Medicaid for nursing facility services. In the event a Medicare-certified facility provides hospice care services and is not Medicaid-certified, the room and board rate will be 95 percent of the statewide average Medicaid reimbursement rate for nursing facilities.

For members under 21 years of age, the hospice room and board rate is 100% of the amount that Medicaid would have paid to the nursing facility, ICF/ID, or freestanding hospice inpatient unit for that member if the member had not elected to receive hospice care.

13-2 Date of Discharge

Medicaid reimbursement for GIP or Inpatient Respite Care is available for the day of admission to the inpatient setting, but not for the day of discharge. The only exception is if the member dies while in the inpatient setting, the date of death is the date of discharge and is reimbursable at the GIP or Inpatient Respite Care rate. If the member is still living at the time of discharge from the inpatient setting, the appropriate home care rate will be paid to the hospice agency for the date of discharge.

For hospice care that is provided in a member's home, in a long-term care facility, ICF/ID, or any other setting that is not an inpatient setting, Medicaid reimbursement is available at the appropriate home care rate for the date of admission but not for the day of discharge. The only exception is if the member dies, the date of death is the date of discharge and is paid at the appropriate home care rate.

13-3 Physician Services

Costs for administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

Direct patient care related to the terminal illness, or a related condition(s) provided by the medical director, hospice-employed physician, or consulting physician are reimbursed and should be billed in accordance with the usual Medicaid reimbursement policy for physician services. This reimbursement is in addition to the daily rates. Services furnished voluntarily by physicians are not covered.

Reimbursement to an independent attending physician will be made in accordance with the usual Medicaid reimbursement methodology for physician services and is not based on whether the services are for the terminal illness or an unrelated condition.

Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

The hospice should notify Medicaid of the election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee.

In-home physician visits by the attending physician are permitted only if the attending physician determines that direct management of the member in the home setting is

necessary to achieve the goals associated with a hospice approach to care. Residents of nursing facilities, ICFs/ID, or freestanding inpatient hospice units are not eligible to receive in-home physician services.

13-4 Services Not Related to Terminal Illness

If a member seeks medical treatment for illnesses or conditions that are not related to the member's terminal illness, this type of treatment is covered by Medicaid in the usual and customary manner when rendered by an appropriate Medicaid provider (not the hospice agency).

For coordination of care purposes, hospice agencies should be notified whenever a member or a member's representative wishes to seek any medical treatment beyond that which is included in the hospice plan of care.

13-5 Medicaid Managed Care Entities and Hospice

If a Medicaid-only member is enrolled in a Medicaid Managed Care Entity (MCE), the hospice selected by the member must have a contract with the MCE. The MCE is responsible to reimburse the hospice for hospice care. Medicaid will not directly reimburse a hospice agency for a Medicaid-only member covered by an MCE.

If a Medicaid-only member enrolled in an MCE elects hospice care before being admitted to a long-term care facility, ICF/ID, or a freestanding hospice inpatient unit, the MCE is responsible to reimburse the hospice agency for both the hospice care and the room and board until the member is disenrolled from the MCE by Medicaid. At the point the MCE determines that the enrollee will require care in the nursing facility for greater than 30 days, the MCE will notify Medicaid of the prognosis of extended nursing facility services. Medicaid will schedule disenrollment from the health plan to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities.

If a hospice enrollee is covered by Medicare for hospice care, the Medicaid MCE is responsible for the health plan's payment rate less any amount paid by Medicare and other payors. The MCE is responsible for payment even if the Medicare covered service is rendered by an out-of-plan provider or was not authorized by the MCE.

The health plan is responsible for room and board expenses of a hospice enrollee receiving Medicare hospice care while the member is a resident of a Medicare-certified nursing facility, ICF/ID, or freestanding hospice facility until the member is disenrolled from the MCE by Medicaid. At the point Medicaid determines that the enrollee will require care in the nursing facility for greater than 30 days, Medicaid will schedule

disenrollment from the MCE to occur in accordance with the terms of the health plan contract for care provided in skilled nursing facilities.

The hospice agency is responsible for determining if an applicant for hospice care is covered by a Medicaid MCE prior to enrolling the member, for coordinating services and reimbursement with the MCE during the period the member is receiving the hospice benefit, and for providing notification when the member will be admitted to a nursing facility for a period greater than 30 days.

Resource Table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

For information regarding:	
Administrative Rules	Utah Administrative Code Table of Contents Utah Administrative Code, Title R414-1, Utah Medicaid Program Utah Administrative Code, Title R432-750, Hospice Rule Utah Administrative Code, Title R414-14A-5. Hospice Care. Service Coverage.
General information including: Billing Fee for Service and Managed Care Member Eligibility Prior Authorization Provider Participation	Section I: General Information Claims Managed Care: Accountable Care Organizations Utah Medicaid Prior Authorization Administrative Rules: Eligibility Requirements. R414-302. Medicaid General Provisions. R414-301. Program Benefits and Date of Eligibility. R414-306. Utah Medicaid Program. R414-1.
Information including policy and rule updates: Medicaid Information Bulletins (Issued Quarterly in January, April, July, and October) Medicaid Provider Manuals Utah State Bulletin (Issued on the 1st and 15th of each month)	Utah Medicaid Official Publications Utah State Bulletin
Medicaid forms including:	Utah Medicaid Forms

Hospice Independent Physician Review for Extended Care Form Hospice Post-Authorization Form Service Intensity Add-On (SIA) Form Hospice Prior Authorization Request Form	
Medical Supplies and DME	Medical Supplies And Durable Medical Equipment Provider Manual Medical Supplies, Durable Medical Equipment, and Prosthetic Devices. R414-70.
Modifiers	Section I: General Information
Patient (Member) Eligibility Lookup Tool	Eligibility Lookup Tool
Prior Authorization	Utah Medicaid Prior Authorization Hospice Prior Authorization Request Form
Provider Portal Access	Provider Portal Access
Provider Training	Utah Medicaid Provider Training
References including: Social Security Act Code of Federal Regulations Utah Code	Social Security Act 1905(a) Social Security Act 1861 42 CFR 418.309 Hospice Aggregate Cap 42 CFR 418.112 Condition of Participation Utah Annotated Code Title 58