MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hospice 03-05

Issued: December 1, 2003

Subject: Chapter III "Coverages and Limitations"
Revised Hospice Membership Notice Form (DCH-1074)

Effective: January 1, 2004

Programs Affected: Medicaid

This bulletin transmits a revised Hospice Chapter III (Coverages and Limitations). The Chapter incorporates policies previously issued in policy bulletins, as well as policy changes and clarifications. It also includes information previously contained in other areas of the manual. References and processes have been updated to reflect the current organization. This chapter becomes effective for dates of service on and after January 1, 2004.

Also attached to this bulletin is a revised Hospice Membership Notice (DCH-1074). The Notice has been modified to delete redundancies and to include information required for hospice residents living in a facility.

The format of the attached chapter is new. The Michigan Department of Community Health (MDCH) is in the process of updating all provider manuals with the goal of creating a single, all-inclusive manual that will be updated annually, distributed via compact disc, and will be available through the Internet. (MDCH will continue the current process of issuing paper copies of policy bulletins throughout the year as needed.) The new manual will allow the user to locate information through word searches and have internal links between related sections. The intent is to make this a user-friendly resource.

Manual Maintenance

Effective 1/1/04, discard Chapter III, Coverages and Limitations (bulletin Hospice 96-02) and insert the attached Chapter III. This bulletin may be discarded after manual maintenance is complete.

Questions

Any questions regarding this bulletin should be directed to Provider Support, Michigan Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

Paul Reinhart
Director
Medical Services Administration

HOSPICE MEMBERSHIP NOTICE

Michigan Department of Community Health

Fax to: (517) 373-1437

☐ **ENROLLMENT APPLICATION** ➔	1. Effective Date		
☐ **ENROLLMENT UPDATE** ➔	2. Effective Date		
☐ **DISENROLLMENT NOTICE** ➔	3. Effective Date	4. Reason Code	

SECTION I- PROVIDER INFORMATION:

5. Provider Name			6. Provider ID Number	7. Control Number
8. Attending Physician Name			10. Hospice Phone Number ( ) –	11. Hospice Fax Number ( ) –
9. Physician Address (Number & Street, Suite Number)			12. Physician Provider ID Number	13. Provider Type
City	State	ZIP Code	14. Is this Beneficiary a Waiver Participant? ☐ **YES** ☐ **NO**	

SECTION II- FACILITY INFORMATION:

Is beneficiary currently in Nursing Facility, Hospice Owned Nursing Facility or Hospital?

☐ **YES** (If Yes, complete this section.) ☐ **NO** (If No, proceed to Section III.)

15. Facility Name	16. Facility. Medicaid ID Number	17. Date Admitted to Facility	
18. Facility Address (Number & Street)	City	State	ZIP Code

SECTION III- BENEFICIARY INFORMATION:

19. Beneficiary Name (Last, First, Middle Initial)			21. Beneficiary ID Number	
20. Beneficiary Address (Street Address and Apt. No.)			22. Social Security Number	23. Birth Date
City	State	ZIP Code	24. Gender ☐ **Male** ☐ **Female**	25. Home Phone Number ( ) –
26. CSHCS Beneficiary? ☐ **YES** ☐ **NO**	27. Beneficiary LOC		28. Previous Hospice Enrollee? ☐ **YES** ☐ **NO**	29. Estimated Remaining Life Span Months
30. Legal Parent or Guardian Name (Last, First, Middle Initial)			31. Diagnosis Code(s)	

REMARKS:

32.

☐ By placing an "X" or a "✓" in this box, I certify that I have read (or they have been read to me) and understand the Conditions of Enrollment and Certification provisions on Page 2 of this form. Any questions I had about these provisions or my hospice care were answered by a hospice representative.

For ENROLLMENT Only		***For DISENROLLMENT Only***	
33. Beneficiary (or authorized representative) Signature	Date	35. Beneficiary (or authorized representative) Signature	Date
34. Witness Signature	Date	36. Witness Signature	Date

AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health is an equal opportunity employer, services and programs provider.

CONDITIONS OF ENROLLMENT:

Hospice services are an option of medical care that you may choose while you are in the terminal stages of your illness. Palliative at-home care is the basis for hospice care. If you do not have a family member or friend to care for you in your home, hospice care may be provided while you are a resident of an approved nursing facility (NF), home for the aged (HFA), adult foster care facility (AFC), licensed hospice long term care unit, boarding home, or hospice owned nursing facility. All Medicaid and any approved Children's Special Health Care Services (CSHCS) covered services for the terminal illness will be provided by the hospice. You must use your **mihealth card**, health plan card, or CSHCS Eligibility Letter to obtain care from your private physician or health plan for services not related to the terminal illness. You may elect to disenroll from the hospice at any time by signing the disenrollment form.

CERTIFICATION:

By signing this form, I certify that I voluntarily apply for hospice enrollment for myself or the person indicated in item number 19. The enrollment is effective on the date entered on item number 1 and will continue as long as the hospice continues operation and eligibility continues under the Medicaid Program or CSHCS approval. If the Medicaid Eligibility Verification System indicates a patient-pay amount, I understand that I must pay that amount, **each month**, to the hospice for my care. Any applicable patient-pay amount, insurance payment, and Medicaid reimbursement represents payment-in-full to the hospice. I understand and accept the conditions of enrollment stated above. I authorize any physician or hospital to release medical information to the hospice. I authorize the hospice to release medical information to the Michigan Department of Community Health.

DCH-1074 (11-03) Obsoletes previous editions.

Hospice

Table of Contents

SECTION 1 - INTRODUCTION

Hospice is a health care program designed to meet the needs of terminally ill individuals when the individual decides that the physical and emotional toll of curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity and quality of life. Hospice is intended to address the full range of needs of the individual with a terminal illness, while also considering family needs. Care must be consistent with the individual's values, regardless of the location where care is provided.

The primary objective of the Medicaid Hospice Program is to ensure that essential medical/health services are available to those who would not otherwise have the financial resources to purchase them. Medicaid policies are designed to achieve this objective with fiscal responsibility. Hospice providers must verify Medicaid eligibility of beneficiaries prior to provision of services. Medicaid eligibility information may be obtained by calling the MDCH Eligibility Verification System (EVS). (Refer to the Beneficiary Eligibility chapter of this manual for more information regarding obtaining information from the EVS.)

SECTION 2 – PROVIDER REQUIREMENTS

Hospice providers are bound to all rules, regulations, and policies specified in this chapter for program participation/enrollment of Medicaid beneficiaries. Hospice providers must also comply with the Medicare Conditions of Participation (42 CFR§ 418.), which generally apply to non-Medicare beneficiaries as well as to Medicare beneficiaries. The exceptions are 42 CFR § 418.60 and 42 CFR § 418.98(c) conditions that apply ONLY to Medicare beneficiaries. (Additional information regarding federal Hospice requirements and guidelines is contained in the Center for Medicare & Medicaid Services (CMS) State Operations Manual 2083.)

2.1 PROVIDER ENROLLMENT

The Michigan Department of Community Health (MDCH) requires Hospice agencies to be licensed by the State Licensing Agency of the Department of Consumer & Industry Services (DCIS), certified by Medicare, and enrolled in the Medicaid Program. (Refer to the General Information for Providers chapter of this manual for more information.)

2.2 HOSPICE MARKETING

Hospice providers cannot engage in any of the following marketing-related practices:

- Provide cash, gift incentives, or rebates to prospective covered persons;
- Claim superior medical care or provider skills; or
- Make untruthful statements regarding the merits of the hospice.

The use of marketing practices that mislead, confuse, or defraud either the beneficiary or MDCH is considered grounds for terminating the hospice from participation in the Medicaid Program. Such actions may also result in investigation leading to possible prosecution under applicable State and Federal statutes.

SECTION 3 – BENEFICIARY ENROLLMENT

3.1 BENEFICIARY ENROLLMENT DETERMINATION

A terminally ill Medicaid beneficiary who lives in a hospice service area and whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director, has the option to enroll in a hospice program. A representative, such as a spouse, parent, legal guardian, or other authorized adult, may act on behalf of the beneficiary.

Medicaid will not cover Hospice services if the following conditions exist:

- The individual is not eligible for the Medicaid benefit.
- The beneficiary does not meet the hospice's enrollment criteria.
- The beneficiary is currently enrolled in a Medicaid Health Plan (MHP). (In this case, hospice services must be arranged and reimbursed by the MHP.)

All Hospice enrollment activities must be conducted according to MDCH policies and in such a manner as to maximize the beneficiary's ability to make a choice between enrollment in hospice or maintaining current active treatment with Medicaid coverage. Such activities must assure that the beneficiary fully understands how to use hospice services and that all care must be received from or through the hospice (except those services not related to the terminal illness or services provided by his attending physician).

It is imperative that the Hospice provider read the Conditions of Enrollment on the Hospice Membership Notice form (DCH-1074) to the beneficiary and answer any questions raised by the beneficiary. (Refer to the Forms Appendix for an example of the Hospice Membership Notice and instructions for its completion.)

3.2 BENEFICIARY ENROLLMENT PROCESS

Hospice providers are responsible for enrolling beneficiaries for hospice services. A Hospice Membership Notice form (DCH-1074) must be completed, including the signature of the beneficiary or his legally appointed representative. Fax the form to the MDCH Enrollment Services Section when completed. (Providers are not required to submit the form by US mail.) A copy of the form must be given to the beneficiary, and the original filed in the beneficiary's record.

Do not submit forms in batches. (Refer to the Forms Appendix for an example of the DCH-1074 form and instructions for its completion.)

A copy of the following information must be retained in the beneficiary's record:

- Hospice Membership Notice form (DCH-1074);
- Effective date of enrollment (If the date entered on the Hospice Membership Notice is changed, the hospice must contact the beneficiary to notify him of the new effective date.); and
- Hospice enrollment identification card (If the hospice chooses to issue one to their beneficiaries).

3.3 BENEFICIARY NOTIFICATION

Hospice providers must provide Medicaid beneficiaries with the following materials and written information within ten days of the effective date of enrollment in hospice:

- Conditions of enrollment, including:
  - Scope, content, and duration of coverage;
  - Enrollee grievance procedure; and
  - Beneficiary responsibility for reporting coverage by any other insurance.
- Procedures for obtaining health care, including:
  - Address, telephone number, and service hours of the health care providers;
  - Emergency medical care (other than for the treatment of the terminal illness); and
  - Health care provision outside of the hospice.

3.4 PLACE OF SERVICE

3.4.A. Beneficiary's Home

A beneficiary eligible for hospice may receive hospice services in their home. If the beneficiary is eligible for hospice services but does not have family or friends to provide the necessary home care, the beneficiary may live in a residential setting that may include an Adult Foster Care (AFC) facility, boarding home, Home for the Aged (HFA), or assisted living facility. The setting must be appropriate for the type of care required by the beneficiary. Medicaid does not pay room and board in these settings.

Beneficiaries may receive hospice services in these settings only if the hospice has a contract with the specific residential provider. These care settings are available for Medicare, Medicaid, and dually eligible beneficiaries**.**

3.4.B. Nursing Facility

When a dually enrolled Medicare/Medicaid beneficiary enters a nursing facility, the beneficiary can elect the Medicare hospice benefit if that nursing facility has hospice services available. In this case, the beneficiary revokes the 100 days of Medicare reimbursement for skilled Nursing Facility care.

Revocation of the 100-day nursing facility skilled care is a beneficiary's decision and should not be influenced by the nursing facility's funding source for the bed.

The Hospice Membership Notice form is used as the benefit election form for Medicaid eligible beneficiaries. This does not mean that the beneficiary has revoked the Medicare benefit for services not related to their terminal illness. The beneficiary remains eligible for Medicare, but has elected to use only the hospice portion of the Medicare benefit.

If the nursing facility contracts to make hospice services available, the hospice must provide Hospice Membership Notice forms to Medicaid, Medicare and dually eligible

beneficiaries. The facility must provide room and board for the beneficiary, and the hospice must provide its normal services.

When a hospice beneficiary resides in a nursing facility (NF) or in a hospice owned nursing facility with beds designated for hospice, Medicaid will reimburse the hospice for room and board. The hospice will then reimburse the nursing facility.

Per Medicare guidelines, the term "room and board" in a nursing facility includes the performance of personal care services that a family caregiver would provide if the individual were at home. This includes assistance in the activities of daily living such as bathing, grooming, toileting, dressing, meal service, socializing, companionship, hobbies, administration of medication, maintaining the cleanliness of the beneficiary's bed and room, and supervising/assisting in the use of durable medical equipment and prescribed therapies (e.g., range of motion, speech and language exercises). The nursing facility may not include hospice staff to meet its staffing requirements.

Hospice covered beneficiaries residing in the nursing facility must not experience any lack of nursing facility services or personal care due to their status as a hospice beneficiary. Nursing facilities must offer the same drugs, services, medical supplies and durable medical equipment to all residents who have elected the hospice benefit in the same manner that services are provided to other residents in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.

3.4.C. Hospital Inpatient Care

Medicaid hospice reimbursement includes payment for any hospitalizations related to the terminal illness. The hospice must contract with, and reimburse, a hospital for medically necessary inpatient services related to the beneficiary's terminal illness. Medicaid does not reimburse the hospital separately unless the hospitalization is not related to the terminal illness.

3.5 Duration of Coverage

Based on hospice eligibility criteria, the duration of hospice services is generally six months or less. There is no minimum period of hospice enrollment. A change in the beneficiary's prognosis could eliminate the need for hospice care. A beneficiary may cancel his/her enrollment in the hospice at any time and without cause. Beneficiaries who become ineligible for Medicaid while enrolled in a hospice also become ineligible for Medicaid reimbursement for hospice services.

SECTION 4 - BENEFICIARY DISENROLLMENT

Disenrollments from hospice may be initiated for any of the reasons noted below. A Hospice Membership Notice (DCH-1074) indicating the reason for the disenrollment must be signed and dated by the beneficiary as proof of notification of disenrollment (unless the beneficiary has expired). The hospice must submit a copy of the disenrollment notice to the MDCH Enrollment Services Section. (Refer to the Directory Appendix for contact information.)

Terminations generated by the hospice are subject to the appeal procedures, as required by licensure requirements.

4.1 BENEFICIARY DIES

When a hospice-enrolled beneficiary dies, the hospice must complete the Hospice Membership Notice indicating the date the beneficiary expired and submit it to MDCH.

4.2 BENEFICIARY ELECTS TO DISENROLL

If the beneficiary elects to disenroll from the hospice, the hospice must give a copy of the disenrollment notice to the beneficiary when he signs it, and retain another copy in the beneficiary's record.

4.3 BENEFICIARY NO LONGER MEETS ENROLLMENT CRITERIA

An enrolled beneficiary may have a change in condition and would no longer qualify for hospice services. If the beneficiary is disenrolled for this reason, the hospice must send a copy of the Hospice Membership Notice (indicating the disenrollment) to the beneficiary along with a letter explaining the reason and effective date for the disenrollment.

4.4 BENEFICIARY BECOMES INELIGIBLE FOR MEDICAID

The hospice is responsible for verifying the beneficiary's continued Medicaid eligibility once he is enrolled. Hospice services rendered to a Medicaid ineligible beneficiary will not be reimbursed by Medicaid.

4.5 BENEFICIARY MOVES OUTSIDE THE HOSPICE SERVICE AREA

At the time of enrollment, beneficiaries must be told to notify the hospice and their local Family Independence Agency (FIA) worker if their place of residence changes. If the new residence is located in the hospice's normal service area, or if the hospice agrees to continue to provide services to the beneficiary, the move creates no changes except an address change. However, if the move is too far for the hospice to continue services for the beneficiary, the hospice must arrange a transfer of care for the beneficiary to another Medicaid enrolled hospice. The two hospices must work together to assure that no lapse occurs in services to the beneficiary.

The effective date of disenrollment for a beneficiary who has moved is the day that the beneficiary moves. It is preferable that the Hospice Membership Notice indicating the disenrollment from the first hospice, and the Notice indicating enrollment for the second hospice, be sent to MDCH together. If the

notices are sent separately, each hospice must place an explanation in the Remarks box on the Hospice Membership Notice form indicating the reason for the transition to the new hospice.

4.6 HOSPICE ELECTS TO TERMINATE THE BENEFICIARY'S ENROLLMENT

The hospice may disenroll a beneficiary if the beneficiary violates any of the conditions of membership in the hospice. MDCH must give approval for such a disenrollment. The decision to disenroll a beneficiary and the effective date of disenrollment are determined on an individual basis by the hospice medical director.

The hospice may request disenrollment of a beneficiary for any of the following reasons:

- Fraud;
- Abuse (including repeated instances of willfully and knowingly obtaining health care services for the terminal illness from non-hospice providers); or
- Misconduct (including violence that interferes with or interrupts the provider's proper delivery of health care to the patient or other patients).

SECTION 5 - HOSPICE SERVICES

5.1 CORE SERVICES

The hospice must provide all or "substantially all" of the "core services" applicable for the terminal illness in the beneficiary's home. (Home may include the beneficiary's private dwelling, apartment, boarding home, assisted living facility, AFC facility, HFA, nursing facility or hospice-owned nursing facility.)

These "core services" are:

- Physician care;
- Nursing care;
- Social work; and
- Counseling
  - Bereavement;
  - Spiritual; and
  - Dietary.

5.2 OTHER HOSPICE COVERED SERVICES

"Other" services that may be necessary due to the terminal illness and must be available but are not considered "core services" are:

- Home Health Aide services;
- Medical Supplies;
- Homemaker services;
- Occupational Therapy;
- Short-Term Inpatient care;
- Physical Therapy;
- Speech Therapy; and
- Drugs*/Biologicals.

***Although the drug AZT (Retrovir) is related to the terminal illness of AIDS, MDCH reimburses the pharmacy separately for a hospice beneficiary receiving AZT.**

These "other" services may be provided by contractual agreement or provided by the hospice directly and are not reimbursed separately.

5.3 TRANSPORTATION

Routine, non-emergency transportation to obtain Medicaid covered services is available through the local FIA for beneficiaries who do not reside in a nursing facility. The beneficiary should contact his FIA worker to determine the appropriate mode of non-emergency transportation and make the necessary arrangements. The transportation provider, not the hospice, bills the local FIA office for the transportation provided.

Non-emergency transportation for nursing facility beneficiaries is provided by the facility as part of their per diem.

Non-emergency ambulance transportation requires a physician's order and is reimbursed directly to the ambulance provider regardless of where the beneficiary resides.

5.4 HOSPICE SERVICE LOG

The hospice must complete a monthly service log that indicates, on a daily basis, the services provided to the beneficiary and whether an employee or a volunteer provided them.

The log must be retained as part of the beneficiary's medical record. However, if the hospice maintains this information electronically in a secure, yet readily understood format, it is not necessary to maintain a paper copy of the log.

5.5 CATEGORIES OF CARE

There are four categories of hospice care:

5.5.A. Routine Home Care

Routine Home Care is defined as Hospice home care that is not continuous.

5.5.B. Continuous Home Care

Continuous Home Care is defined as short-term in-home care that is reflective of at least half of the hours predominantly being nursing care, provided by either a registered nurse or licensed practical nurse in a crisis situation. 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 hospice care. Payment is made for the hours of continuous care provided, up to 24 hours in one day.

5.5.C. Inpatient Respite Care

Inpatient Respite Care is defined as short-term inpatient care to relieve the primary caregiver(s) providing at-home hospice care for the beneficiary. Hospice care may be provided in a hospice owned nursing facility, hospital, or nursing facility meeting hospice

standards for staffing and patient areas. The length of stay may not exceed five consecutive days.

5.5.D. General Inpatient Care

General Inpatient Care may be provided in a hospice inpatient unit, hospital, or nursing facility meeting hospice standards for staffing and patient areas. This care is usually for pain control, or acute or chronic symptom management that cannot be successfully treated in another setting.

Guidelines for "core" and "other" services (as detailed above) apply to all categories of care.

5.6 PLAN OF CARE (POC)

After enrollment in the hospice, a Plan of Care (POC) must be developed before the beneficiary can receive services. The hospice Medical Director (or physician designee), the beneficiary and/or family or involved support system, and the Interdisciplinary Group (IDG) as defined by federal regulations, must participate in the development of the plan. The beneficiary's attending physician should be encouraged to attend as well. The hospice is responsible for implementing the POC for hospice services.

5.6.A. Adult Foster Care Facility/Home for the Aged (AFC/HFA)

The AFC/HFA is responsible for care related to the non-terminal needs of the beneficiary who resides in their facility. There is to be no duplication of services by either staff.

5.6.B. Assisted Living Facility

The hospice is responsible for implementation of the POC for hospice services provided in this setting.

5.6.C. Nursing Facilities

The Nursing Facility and hospice are responsible for performing their respective functions, which have been agreed upon and included in the jointly developed POC. The joint POC must include directives for managing pain and other uncomfortable symptoms, and be revised and updated as necessary to reflect the beneficiary's current status. The hospice retains overall professional management and responsibility for directing the implementation of the POC.

The joint POC should reflect the participation of the hospice, nursing facility, and the beneficiary to the extent possible. The hospice and nursing facility must communicate with each other when any changes to the POC are indicated, and each provider must be aware of the other's responsibilities in implementing the POC. There must be evidence of this coordination of care in the clinical records of both providers. All aspects of the

joint POC must reflect the hospice philosophy. Nursing Facility services must be consistent with the POC developed in coordination with the hospice.

5.6.D. Adult Home and Community Based Waiver Beneficiaries (MIChoice)

If the hospice finds that the beneficiary is enrolled in the waiver program, the hospice should contact the beneficiary's waiver coordinator/agent. A joint POC must be retained in the beneficiary's record by both the hospice and the waiver coordinator. The waiver coordinator must understand the hospice philosophy so that the two agencies work for a common goal and eliminate duplicate services. Ongoing communication and coordination must occur regularly between the two providers during the time they are serving the same beneficiary. Written documentation of this ongoing communication and coordination must be kept in the beneficiary's record at each agency.

The hospice is not required to submit a Hospice Membership Notice form (DCH-1074) to MDCH for each waiver participant it serves.

Beneficiaries may receive services from both types of providers concurrently as long as the services are not duplicative. Level of Care 22 identifies the beneficiary as receiving services through the Home and Community Based Waiver for the Elderly and Disabled (MIChoice Waiver) and remains on the MDCH eligibility file for the beneficiary. The hospice should not complete enrollment for a beneficiary whose eligibility verification indicates a Level of Care 22 until the hospice contacts the waiver coordinator to discuss and coordinate the services required.

The fact that the beneficiary has a Level of Care 22 on the Department's computerized eligibility system must also be noted prominently on the claim form in order to allow correct claims processing.

Hospice services must be used to the fullest extent before additional waiver services of the same type are initiated. Post-payment review may be employed to monitor services. If inappropriate (i.e., duplicative) services were authorized, MDCH seeks recovery of Medicaid funds paid for those services from the waiver coordinator.

The MDCH maintains a list of MIChoice waiver coordinators and contact information on the MDCH website. (Refer to the Directory Appendix for website information.) Habilitation Supports waiver coordinators may be contacted through the local Community Mental Health Services Provider.

5.7 Special Programs

5.7.A. Children's Home and Community Based Waiver Beneficiaries (Children's Waiver, Habilitation Supports Waiver)

If waiver services are not related to the terminal illness, the hospice should send the MDCH waiver program coordinator an explanation of the situation when enrolling the

beneficiary. The hospice agency should contact the waiver case manager or supports coordinator at the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) to coordinate care and to develop a combined POC.

5.7.B. Children's Special Health Care Services (CSHCS)

To be eligible and authorized for the CSHCS hospice benefit, the beneficiary must be determined by MDCH to have:

- CSHCS coverage; and
- Reached the terminal phase of illness where the physician treatment plan deems palliative measures necessary and appropriate, versus the ongoing aggressive treatment typically engaged for curative measures; and
- Documentation from the treating specialty physician, indicating the need to pursue the palliative measures; and
- Limited life expectancy of approximately six months or less; and
- Need for services that are clinically and developmentally appropriate to the beneficiary's needs and abilities; and
- Need for services that are consistent with the philosophy/intent of hospice.

Requests for hospice must be made in writing to CSHCS. (Refer to the Directory Appendix for contact information.)

5.8 HOME HELP / PERSONAL CARE

Home Help/personal care may be available to the hospice beneficiary living at home (e.g., not residing in a hospice residence, nursing facility, AFC, etc.). It is important that hospice services be utilized first, prior to Home Help services. Home Help services may be in addition to hospice care and must not duplicate hospice services. Home Help/personal care services are assistance with eating, toileting, bathing, grooming, dressing, transferring, self-administered medication, meal preparation, shopping/errands, laundry and light housekeeping. Some examples of when these services are appropriate are:

- The caregiver is too frail or otherwise unable to provide all of the needed personal care.
- There is no unpaid caregiver available and the beneficiary wishes to remain at home.
- The beneficiary is new to hospice but has been receiving personal care services through Home Help.

If hospice services duplicate or replace personal care services, payment is not approved for Home Help/personal care.

The hospice must contact the beneficiary's FIA adult services worker or ask for the assignment of an adult services worker if the beneficiary does not already have one. The adult services worker determines which personal care services may be provided in addition to hospice care. This determination may require the hospice to submit a POC for the worker's review.

SECTION 6 - BILLING AND REIMBURSEMENT

6.1 INTERACTION WITH OTHER RESOURCES

6.1.A. Medicare/Medicaid Beneficiaries

If a beneficiary is dually enrolled in Medicare and Medicaid, he must receive hospice coverage under the Medicare benefit. (Medicaid is the payer of last resort.) If the beneficiary resides in a nursing facility, Medicare may pay hospice services, with nursing home room and board paid for by Medicaid. When a beneficiary is receiving services through the Medicare hospice benefit, Medicaid will not pay for curative or duplicative services. The hospice provider must complete the Hospice Membership Notice whenever Medicaid is billed (i.e., co-insurance, deductibles, and room and board in the Nursing Facility or Hospice owned nursing facility).

If the hospice benefit is revoked under Medicare, the beneficiary cannot use the Medicaid hospice benefit as a replacement. Hospices should carefully explain this situation to the dually eligible beneficiary, especially during the fourth Medicare benefit period.* However, if the dually eligible beneficiary is no longer appropriate for hospice care and is disenrolled as a hospice beneficiary, that beneficiary is able to re-enroll with the hospice for the Medicaid benefit period if he becomes eligible for hospice again.

6.1.B. Medicaid Health Plan (MHP) Enrollees

Hospice services are included in the MHP covered services package for Medicaid enrollees. If the terminally ill enrollee requests and meets the criteria for hospice services, the MHP must cover the requested hospice services. If the terminally ill enrollee does not request hospice services, the MHP may provide its own array of services for the terminally ill. If MHP enrollment is indicated when verifying a Medicaid beneficiary's eligibility (a level of care 07 will be noted on the EVS), the hospice must contact the MHP immediately to receive prior authorization from the MHP before furnishing services. The MHP may require it's enrollees to receive hospice services through a contracted hospice with which they have made arrangements. MHPs are responsible for arrangement of, and payment for, the enrollee's hospice care. The enrollee's Level of Care code does not change; the appropriate managed care code remains throughout the hospice care.

If a fee-for-service Medicaid beneficiary is automatically enrolled in a MHP while receiving hospice care, the beneficiary or his representative should contact the MDCH Hospice Enrollment Coordinator if he wishes to continue receiving services from his current hospice provider. The hospice enrollment coordinator will initiate the process of disenrollment from the MHP. It is not the intent of MDCH to disrupt a hospice beneficiary's care through automatic enrollment in a MHP. If the beneficiary subsequently disenrolls, or is discharged, from hospice care, the beneficiary may be offered the opportunity to join a MHP.

* The fourth Medicare benefit period is the subsequent extension period during the beneficiary's lifetime that occurs after the first two 90-day periods, and subsequent 60-day period, have been utilized.

Refer to the Directory Appendix for MDCH Hospice Enrollment Coordinator contact information.

If the MHP enrollee requires hospice services in a nursing facility or hospice owned nursing facility, the MHP pays a negotiated rate for room and board in addition to the payment for the hospice services. The hospice must contact the MHP prior to enrolling the beneficiary to request authorization by the MHP.

6.2 REIMBURSEMENT

MDCH employs the following standards when reimbursing for hospice care:

- **Rate Methodology.** MDCH uses the Medicaid rates established by CMS and applies the appropriate local wage adjustors for the categories of care provided. Medicaid will publish and implement rate updates when new rates are released and CMS approval for publication has been received by the Department.
- **Co-payments.** When a Medicaid beneficiary is receiving hospice services under Medicare, the hospice may bill Medicaid for the coinsurance, as well as room and board if the beneficiary resides in a nursing facility or hospice owned nursing facility. Coinsurance and/or room and board cannot be billed to a Medicaid beneficiary, his family, or his representative.
- **Physician Services**. Reimbursement for administrative duties performed by the Medical Director is included in normal hospice rates. Direct patient care provided by the Medical Director, hospice-employed physician or consulting physician may be billed by the hospice and is separately reimbursable based on the lesser of Medicaid's maximum allowable amount for the service or the charge. Claims must reflect the Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes for the physician's direct patient care.
- **Patient-Pay Amount.** If the Medicaid beneficiary residing in a nursing facility has a patient-pay amount, the hospice must collect that amount each month and apply it toward the beneficiary's medical care. While the hospice is responsible for collecting the patient-pay amount, this duty may be delegated to the Nursing Facility (via contract with the hospice) as long as the amount is applied to the room and board bill. The patient-pay amount must be exhausted each month (even if services do not span the entire month) before any Medicaid payment can be made. Whenever the hospice collects a patient-pay amount, a receipt must be given to the beneficiary (or family).
- **Payment for Non-Covered Services.** For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to access their patient-pay amount to pay for these services. If Medicare covers the beneficiary's need for medical services, then Medicaid will continue to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.
- **Spenddown.** Prior to provision of hospice services to the beneficiary in a home setting, the hospice should utilize the MDCH Eligibility Verification System to determine if the beneficiary has a spenddown or not. If the spenddown is identified as "yes" on the Eligibility Verification System, the hospice should ask the beneficiary or their responsible person for a copy of the FIA letter sent the first of each month which indicates the dollar amount the beneficiary must spend before

becoming Medicaid eligible for services. Medicaid may not be billed until the spenddown obligation is met.

- **Room and Board to Nursing Facilities.** When Medicaid reimburses the hospice for room and board in a nursing facility, the beneficiary must be placed in a bed certified by Medicaid (i.e., a Medicare/Medicaid certified bed or one certified Medicaid-only). If the beneficiary is not placed in a bed certified for Medicaid, MDCH will not pay for any services. MDCH pays the hospice 95 percent of the individual or specific facility's Medicaid rate for room and board. Hospice reimbursement to the nursing facility for room and board must be outlined in the contract established between the hospice and the nursing facility.

  - **Holding a Bed (Hospital Leave and Therapeutic Leave).** For nursing facility beneficiaries on hospice, Medicaid will reimburse the hospice for holding a nursing facility bed as indicated below.

    Hospice reimbursement to the nursing facility for bed holds must be outlined in the contract between the nursing facility and the hospice.

    Family members/responsible parties for the hospice/nursing facility beneficiary must be informed of the bed hold and readmission policy of the nursing facility. If the beneficiary refuses to have a family member/responsible party notified, this must be documented in the beneficiary's medical record.

  - **Hospital Leave Days**. Medicaid reimburses during a beneficiary's temporary absence (up to 10 days) from the nursing facility for admission to the hospital for emergency medical treatment, as documented by the attending physician in the beneficiary's medical record. The facility must hold the bed, and the hospice may bill Medicaid, if the attending physician documents a reasonable expectation at the point of admission to the hospital that the beneficiary will return to the nursing facility by the end of the 10th day.

    The beneficiary must return to the nursing facility within 10 days for the hospice to bill for hospital leave days. If the beneficiary is in the hospital for more than 10 days, the nursing facility is released from its obligation to hold the bed and the hospice cannot bill Medicaid for any leave days. Reimbursement to the hospice will be at 100 percent of the classwide nursing facility hospital leave day rate. This rate, determined annually by MDCH, is available on the MDCH website at www.michigan.gov/mdch, click on Providers, click on Information for Medicaid Providers, click on Long Term Care Provider Forms, click on Rate Setting Reimbursement Limits.

    - If the beneficiary is expected to be in the hospital for 10 days or fewer, and dies while in the hospital, the hospice may bill Medicaid for the hospital leave days up to the day before the beneficiary died.
    - If the resident returns to the nursing facility under Medicare coverage and still elects hospice care, the hospice may bill Medicaid for the hospital leave days if the emergency hospitalization was for no more than 10 consecutive days.

    Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The hospice/nursing facility should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. The

Medicaid claims processing system automatically deducts the patient-pay amount and reimburses the provider for the balance. If the hospice bills Medicaid for hospital leave days that occur at the beginning of the month, then the hospice should collect the patient-pay amount as usual. The hospice should charge the amount against the patient-pay that Medicaid will pay for that day. For example, if a beneficiary has a patient-pay of $200 and is in the hospital for an emergency condition for the first five days of the month (the stay totals no more than 10 consecutive days), the hospice should collect the patient-pay amount from the beneficiary, then submit a Medicaid claim. Medicaid would reimburse the hospice for the hospital leave day per diem rate, minus the patient-pay amount. The hospice reimbursement, based on 2003 rates, would be $132.80 [($66.56 x 5) - $200].

There is no annual limit to the number of hospital leave days, per beneficiary, that may be billed to Medicaid as long as there are no more than 10 consecutive leave days per hospital stay.

- **Therapeutic Leave Days.** If the beneficiary has a temporary absence from the Nursing Facility for therapeutic reasons approved by the attending physician, the hospice may be reimbursed by Medicaid to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for non-medical reasons such as overnight stays with friends/relatives, Make-a-Wish Foundation trips, etc. The beneficiary's POC must provide for such absences. There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period. If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date he left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

  Reimbursement will be at 95 percent of the individual or specific nursing facility's daily per diem rate, just as the customary room and board rate is reimbursed.

- **Hospice Owned Nursing Facility.** When the Medicaid or Medicare/Medicaid beneficiary resides in an inpatient hospice facility (Hospice owned NF with hospice-designated beds), the reimbursement for room and board by Medicaid follows the policy for reimbursement for nursing facilities as noted above. Medicaid, as provider of last resort, covers the beneficiary's room and board.
- **Adult Foster Care Facilities/Home for the Aged Facilities (AFC/HFA).** Medicaid does not reimburse for room and board in these settings. Reimbursement is made directly to the facility provider in the normal manner (i.e., Supplemental Security Income, Personal Care/Supplemental Payment). This payment is made in full. The AFC or HFA cannot seek additional restitution from the beneficiary or the hospice provider.
- **Boarding Homes.** Medicaid does not reimburse for room and board in these settings.
- **Assisting Living Facility.** Medicaid does not reimburse for room and board in these settings.

6.3 Reimbursement Limits

Medicaid must apply the aggregate inpatient (80/20) payment cap, and follow the guidelines established for the Medicare beneficiary. The 80/20 cap requirement means no more than 20 percent of all days of care provided by a hospice can be paid as inpatient hospice days. Inpatient days that exceed the 20 percent cap must be paid as routine care. Beneficiaries with AIDS are exempt from the 80/20 cap.

Medicaid does not apply an aggregate dollar cap. (The Medicare program establishes the maximum total dollar amount per year that Medicare pays for hospice services. The Medicaid program does not apply this policy to beneficiaries receiving hospice care.)

Medicaid applies the same number of inpatient respite days as Medicare (i.e., no more than five consecutive days are allowed). If more than five consecutive days are billed, the number is reduced to five days, and the excess days must be billed as routine care by the hospice.

Reimbursement for routine, non-emergent transportation is included in the per diem (room and board amount) negotiated between the hospice and the nursing facility.