KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Hospice Services				POLICY #: 3.43-P	
DEPARTMENT: Utilization Management					
Effective Date: 12/2005	Review/Revised Date: 11/18/2022	DMHC	X	PAC	X
		DHCS	X	QI/UM COMMITTEE	X
		BOD	X	FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Claims

_____ Date _____
Director of Utilization Management

POLICY:

Kern Health Systems (KHS) shall cover and facilitate the provision of hospice care services. KHS shall fully inform members and their families of the availability of hospice care as a covered service and the methods by which they may elect to receive these services.[1]

Hospice services will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- California Health and Safety Code[2] §§ 1368.1;1368.2; and 1746[3]
- California Code of Regulations Title 28 § CCR 28 §1300.68.2
- California Code of Regulations Title 22 §§51180; 51180.1; and 51349

- ❖ DHCS Contract Exhibit A-Attachment 5 (3)(I); Attachment 10 (7)(B) and Attachment 11 (17)(A)
- ❖ DHCS MMCD All Plan Letter 05003: Hospice Services and Medi-Cal Managed Care (March 25, 2005)
- ❖ California Code of Regulations Title 22 CCR, Section 51349**,**
- ❖ DHCS MMCD All Plan Letter 13-014: Hospice Services and Medi-Cal Manager Care (October 28, 2013)

Unless otherwise authorized by KHS, hospice services may only be provided by contracted hospice providers.

Members who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. [4] The hospice election may be revoked at any time.

The amount, duration, and scope of hospice services will be no less than the amount, duration, or scope of services that would be provided under the Medi-Cal fee-for-service program.[5] Hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.[6]

DEFINITIONS:

Palliative Care[7]	Interventions that focus primarily on reduction or abatement of pain and other disease-related symptoms, rather than interventions aimed at investigation and/or intervention for the purpose of cure or prolongation of life.
Period of Crisis[8]	A period in which the member requires continuous care to achieve palliation or management of acute medical symptoms.
Terminal Illness[9]	Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

PROCEDURES:

1.0 ACCESS

Hospice care is covered for a terminal illness if the services meet all of the following conditions:

- ➢ Ordered by the member's PCP or another authorized provider
- ➢ Performed by a contracted hospice provider or another authorized provider
- ➢ Approved, in the case of general inpatient care, by KHS

The only requirement for initiation of outpatient hospice services is physician certification[10] that a member has a terminal illness and member election of such services.[11] Only general inpatient care is subject to prior authorization if all other requirements regarding prior

authorization and associated clinical guidelines have been met.[12]

During regular business hours, providers may request verbal authorization for general inpatient hospice care by calling KHS Utilization Management staff at (661) 664-5083. During weekends, providers may request verbal authorization for hospice care by calling the Weekend on Call Nurse at 661-331-7656. KHS responds to requests for authorization for hospice services within 24 hours. [13]

Covered services are available on a 24-hour basis to the extent necessary to meet the needs of members for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions.[14] Hospice services may be initiated or continued in a home or clinical setting.[15]

1.1 Election of Hospice

The member or member's representative must file an election statement with the hospice providing the care. The member's election shall include all of the following elements on an appropriate hospice election form[16]:

A. The identification of the hospice
B. The patient's or representative's acknowledgement that:
    1. He or she has full understanding that the hospice care given as it related to the individual's terminal illness will be palliative rather than curative in nature.
    2. Certain specified Medi-Cal benefits are waived by the election.
C. The effective date of the election
D. The signature of the individual or representative

An individual may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.[17]

1.2 Special Considerations in Hospice Election

In the event that a member wishes to elect a hospice that is not contracted with KHS, considerations for the case of each member individually for such a choice is made. KHS has the option of immediately initiating a contract (one-time or ongoing) with the hospice provider or referring the patient to another provider for hospice care. On occasion, members receiving hospice at the time they become KHS members may not be able to change their hospice provider, if requested, due to limitations on the number of times there may be a change in the designation of a hospice provider during an election period. In addition, KHS may determine that such a change would be disruptive to the member's care or would not for some other reason be in the patient's best interest. In such instances, KHS should consider a one-time or ongoing contract with the established hospice provider until the new benefit period, or until the end of hospice services.

Hospice care services may be initiated or continued in a home or clinical setting. KHS remains responsible for the provision of, and payment for, all Medi-Cal covered services not related to the terminal illness, including those of the member's primary care physician.

Members who move their legal residence out of the service area must disenroll from the MCP.

1.3 Change of Hospice Provider

A member or representative may change the designation of a hospice provider once each election period.[18]

On occasion, members receiving hospice care at the time of enrollment with KHS may not be able to change their hospice provider, due to limitations during an election period. In such instances, KHS will consider a one time or ongoing contract with the established hospice provider until the member can be transitioned to a contracting hospice provider during a new election period.[19]

[20]Members who move their legal residence out of the service area must disenroll from the associated Medi-Cal Managed Care Plan. Consequently, upon enrollment in a new plan, a "change in designated hospice" must be initiated. This may be done only once per election period.

1.4 Revocation of Hospice[21]

A member's voluntary election may be revoked or modified at any time during an election period. To revoke the election of hospice care, the member or representative must file a signed statement with KHS and the hospice revoking the individual election for the remainder of the election period. The effective date may not be retroactive. Revocation shall constitute a waiver of the right to hospice care during the remainder of the election period.

At any time after revocation, a member may execute a new election, thus restarting the 90/90/unlimited 60-day certification periods of care. An individual or representative may change the designation of a hospice provider once each benefit period.

If a member revokes the hospice benefit or is discharged by the hospice for cause and later elects hospice and is readmitted to the same or different hospice provider, then the 90/90/unlimited 60-day election periods are initiated as if hospice is starting anew. A member's change from one designated hospice to another is not considered a revocation of the hospice election.

2.0 COVERED SERVICES

Members who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. [22] The hospice election may be revoked at any time.

Upon member election of hospice services, KHS will facilitate the provision of and provide appropriate payment for covered hospice services provided by a hospice provider or by others under arrangements made by a hospice provider. Covered services include, but are not necessarily limited to, the following[23]:

A. Nursing services when provided by or under the supervision of a registered nurse.

B. Physical, occupational, or speech-therapy for purposes of symptom control, or to enable the member to maintain activities of daily living and basic functional skills.

C. Medical social services provided by a social worker with at least a bachelor's degree in Social Work, from a school approved or accredited by the council on Social Work Education, under the direction of a physician.

D. Certified home health aide and homemaker services under the supervision of a qualified registered nurse.[24] Services may include personal care services and such household services as may be necessary to maintain a safe and sanitary environment in the areas of the home used by the patient.

E. Medical supplies and appliances.

F. Drugs and biologicals when used primarily for the relief of pain and symptom control related to the member's terminal illness.

G. Physician services which include:

1. General supervisory services of the hospice medical director.
2. 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 hospice interdisciplinary team.

Physician services not described above shall be billed to the MCP separately and include services of the member's attending physician or consulting physician(s) if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Physician visits by a hospice-employed physician, medical director, or consultant are billable separately to the MCP.

H. Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling.

I. Continuous home nursing, home health aide, and/or homemaker services for as much as 24 hours a day during a period of crisis, and only as necessary to maintain the terminally ill member at home.[25] A crisis as the period in which a member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms.

J. Continuous home care for a minimum of 8 hours of care (aggregate) during a 24-hour day, which begins and ends at midnight.[26]

K. Respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.

L. Short term inpatient care for pain control or chronic symptom management which cannot be managed in the home setting.

M. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the hospice plan of care.

N. Interdisciplinary team care with development and maintenance of an appropriate plan of care.[27]

O. Volunteer services.[28]

2.1 Bereavement Services

Bereavement services include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs both prior to and following the death of the member. These services are available to the surviving family members for one year after the death of the member.[29]

2.2 Home Health Aide Services

Home health aide services include personal care and the performance of related tasks in the home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe healthy environment. These services are performed by a certified home health aide.[30]

2.3 Social Services and Counseling Services

Social service/counseling services are those counseling and spiritual services that assist the member and his/her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.[31]

2.4 Respite Care

Respite care is short-term inpatient care provided to a member only when necessary to relieve those caring for the member. Respite care is covered on an occasional basis for no more than 5 consecutive days at a time.[32]

3.0 SERVICES NOT COVERED BY HOSPICE PROVIDER

- Private pay room and board or residential care.
- Acute in-patient hospitalization unrelated to the terminal illness.
- Level A or Level B NF for unrelated issues.
- Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
- Other necessary services for conditions unrelated to the terminal illness.

4.0 PLAN OF CARE[33]

A plan of care must be established by the hospice for each member before services are provided. Services must be consistent with the plan of care. The plan of care must conform to the standards specified in 42 Code of Federal Regulations, Part 418, Subpart C.

5.0 COORDINATION OF CARE

KHS provides coordination of care and joint case management with hospice care providers.[34]

Once a member has elected hospice, KHS contracted providers and case management staff work closely with hospice providers to facilitate the transfer of member services from those directed towards cure and/or prolongation of life to those directed towards palliation.[35] KHS arranges for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible.[36]

Ongoing care coordination is provided and services necessary to diagnose, treat, and follow-up on conditions not related to the terminal illness are provided or initiated as necessary.[37] KHS is responsible for the provision of and payment for all medically necessary services not related to the terminal illness, including those of the member's primary care physician.[38]

5.1 Provision of Hospice Services by Hospice Interdisciplinary Group

Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group(s) to plan, provide, and/or supervise the care and services offered by the hospice provider. A written plan of care must be established by the attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care. The plan of care is then reviewed and updated at intervals specified in the plan of care by the attending physician, the medical director or physician designee and interdisciplinary group of the hospice (Title 42, CFR, Section 418.56.)

KHS shall assure coordination of care between the member's health plan and hospice care providers and allow for the hospice interdisciplinary team to professionally manage the care of the patient as outlined in the law.

End of life care for children with a life-threatening condition may be substantially different than it is for adults. Hospice care options for children do not fit the traditional adult hospice model. Children can, and often do, live longer with a life-threatening condition because of aggressive treatment and their natural resilience.

Children and families may benefit from receiving palliative care services earlier in the course of a child's illness. In addition to hospice care services, a waiver program is available to children and families who may benefit from receiving palliative care services earlier in the course of a child's illness.
For additional information on this subject, please see CCS Numbered Letter (NL): 12-1119 regarding palliative/hospice options for CCS eligible children. This NL can be found on CCS's website at:
https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-12-1119.pdf

Policy guidelines and procedural direction on authorization of medically necessary services related to the child's CCS life-limiting condition for children who have elected hospice care can be found at:
http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf

5.2 Hospice Services for Children Served by California Children Services (CCS) for the Terminal Condition[39]

CCS does not offer the range of services provided through hospice for the terminally ill child. Members and their families are clearly advised of the differences between CCS and hospice services and of the potential change in caregivers, should hospice care be elected. KHS will work with CCS to facilitate continuity of medical care, including established patient provider relationships, to the greatest extent possible. Hospice care, if elected for children with terminal diseases, requires close consultation and coordination with CCS and/or other caregivers. Hospice services for CCS recipients are the responsibility of KHS and all hospice policies are applicable.

5.3 Concurrent Hospice Palliative and Curative Care for Children

Under Section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, Medicaid children who have elected to receive hospice services may continue receiving coverage of any payment for other services to treat their terminal illness. Additional information on concurrent care for children can be found at:

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-004.pdf

- Medi-Cal's Pediatric Palliative Care Benefit (the Benefit) is designed to assess and demonstrate the advantage of providing community-based palliative care concurrent with life-prolonging therapies. CCS NL 12-1119 defines the principles of palliative care, identifies palliative care services currently available under the state plan, and provides guidelines for timely authorization and payment for these services. This NL can be found at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-12-1119.pdf

Information on KHS palliative care benefits is referenced in *Policy and Procedure 3.77- Palliative Care.*

6.0 TRANSFER OF MEMBERS

Hospice providers shall provide transferring members with a transfer summary including essential information relative to the member's diagnosis; pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, which shall be signed by the physician (H&S Code, Section 1262.5). Consequently, upon enrollment in a new health plan, a "change in designated hospice" must be initiated (Title 42 CFR, Section 418.30). This may be done only once per election period.

7.0 REIMBURSEMENT

Of the four levels of hospice care as described in Title 22, CCR, Section 51349 only general inpatient care is subject to prior authorization. Documents to be submitted for authorization include:

- Certification of physician orders for general inpatient care.
- Justification for this level of care.

KHS may not require prior authorization for routine home care, continuous home care and respite care or hospice physician services. Hospices shall notify the KHS of general inpatient care placement that occurs after normal business hours on the next business day. KHS may require documentation following the provision of general inpatient and continuous care for reasons of justification. If the documentation does not support these levels of care, or if the documentation included is inadequate, reimbursement may be reduced to the rate for routine home care. An appeal may be submitted for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care.

Visits made to a member by the hospice Medical Director, hospice physician, or consultant should be billed separately.[40]

7.1 Hospice Services Provided in a Long-Term Care Facility[41]

Hospice services are covered services and are not categorized as Long-Term Care (LTC) services regardless of the member's expected or actual length of stay in a nursing facility while also receiving hospice care.

KHS shall not require authorization for room and board as described in Title 42, CFR, 418.112 and Section 1902(a)(13)(B) of the SSA.

Section 1905(o)(1)(A) of the SSA allows for the provision of hospice care while an individual is a resident of a skilled nursing facility (SNF) or intermediate care facility. Payment from KHS will be provided to the hospice for hospice care (at the appropriate level of care).

In accordance with the Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Rev. 156, 06-01-12) 20.3 - Election by Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries (Rev. 1, 10-01-03) HO-204.2, payment for room and board shall be made directly to the hospice. The hospice shall then reimburse the NF for the room and board at the rate negotiated between the hospice and SNF. Payment for the room and board component must be equal to at least 95 percent of the reimbursement the NF/SNF would have been reimbursed by KHS. Payments by a hospice provider to a nursing home for room and board shall not exceed what would have been received directly from Medi-Cal or the MCP if the patient had not been enrolled in a hospice.

LTC residents who elect the Medi-Cal hospice benefit are not disenrolled from KHS. Hospices will bill the MCPs using the following revenue codes:

- Revenue code 658-Facility Code Type 25.
- Revenue code 658-Facility Code Type 26.

7.2 Medicare[42]

For beneficiaries with both Medicare and Medi-Cal coverage (dual-eligibles), the hospice bills Medicare for the hospice services. The room and board charge is billed to Medi-Cal only. Following payment from Medicare, the hospice then bills the MCP for the co-payment amount; however, the total reimbursed amount cannot exceed the Medicare rate (Title 22, CCR, Section 51544). For Medicare beneficiaries entitled to only Medicare Part B, benefits will be billed directly to the MCP. No Medicare denial will be required.

KHS cannot require authorization for the hospice to bill KHS for the room and board covered by Medi-Cal while the patient is receiving hospice services under Medicare.

The hospice shall notify KHS when a member elects the Medicare hospice benefit.

KHS will then pay the room and board payment to the hospice provider according to the rate outlined above, and the hospice shall be responsible for paying the nursing home. Eligibility for the Medi-Cal nursing home room and board payment continues
to be determined by the nursing home and KHS.

For beneficiaries enrolled in the Coordinated Care Initiate Demonstration Project (www.calduals.org), referred to as Cal Medi-Connect, DHCS will implement specific billing, claims, and payment procedures if hospice becomes part of Cal MediConnect. Currently, the benefit is covered by Medicare.

7.3 Hospice Rates

The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare. These rates are authorized by Section 1814(i)(1)(C)(ii) of the SSA, which also provides for an annual increase in payment rates for hospice care services. KHS must update their rates annually to coincide with changes to the Medicare rates.

KHS may pay more, but not less than, the Medicare rate for hospice services (Section 1902(a)(13)(B) of the SSA). The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register.

Inpatient rates (general or respite) shall be paid for the date of admission and all subsequent inpatient days except the day on which a patient is discharged. For the day of discharge, the appropriate home care rate shall be paid unless the patient dies as an inpatient. If the patient dies while an inpatient, the inpatient rate (general or respite) shall be paid for the discharge day.

7.4 Physician Services

Hospice providers must use current Medi-Cal billing code when billing for physician services for pain and symptom management related to a patient's terminal condition and provided by a physician employed by, or under arrangements made by the hospice. KHS is required to reimburse one visit-per-day, per-patient.

Consulting/special physician services code may be billed only for physician services to manage symptoms that cannot be remedied by the patient's attending physician because of one of the following:

- Immediate need.
- The attending physician does not have the required special skills.

8.0 UTILIZATION REVIEW

KHS may not restrict access to hospice care services any more than the MCAL Fee-For – Service (FFS) program may restrict the same services (Title 42 CFR, §438.210(a)). The FFS program does not require prior authorization of hospice services except for inpatient admissions; therefore, KHS shall adjust their utilization review standards, if necessary, to meet those of the FFS program. Authorizations are entered for tracking purposes only to assist validation of the appropriate documentation requirements are met, i.e., initial physician certification and member election forms. Additional certifications for illness periods (90-day period, subsequent 90-day period, or unlimited 60-day period) will be required for tracking purposes and coordination of services.

Per Chapter 9 of the Medicare Claims Processing Manual, Medicare Hospice Benefit Section 40.1.5 - Short-Term Inpatient Care, general inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Skilled nursing care may be needed by a patient whose home

support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting. General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit.

8.1 Denials to Terminally Ill Members

KHS is required to provide members and providers with notification of denial for a prior authorization request for services within 5 business days or less referenced in *Policy and Procedure 3.22-P, Referral and Authorization Process* for additional information. The notification to the member will provide all of the following information:

a. A statement setting forth the specific medical and scientific reasons for denying coverage.
b. A description of alternative treatment, services, or supplies covered by the Plan, if any.
c. Information regarding member's rights, including appeal and grievance options and forms.
d. Copies of KHS grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of KHS grievance system provided under Section 1368(a)(3). See *KHS Policy and Procedure #5.01-P: Grievance Process* for additional information.

9.0 PROVIDER REQUIREMENTS[43]

KHS only contracts with entities licensed pursuant to the California Hospice Licensure Act of 1990[44] or licensed home health agencies with federal Medicare certification[45] for the provision of hospice services. Contracted hospice providers may arrange to provide hospice services with appropriately licensed individuals or entities.

A hospice physician or nurse practitioner (NP) is required to have a *face-to-face encounter with every hospice patient* to determine the continued eligibility of that patient. The face-to-face encounter requirement is satisfied when the following criteria are met:

1. Timeframe of the encounter:
   The encounter must occur no more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter (refer to item four below for an exception to this timeframe).

2. Attestation requirements
   A hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.
   The attestation, its accompanying signature and the date signed must be on a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.
   Where an NP performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course.

3. Practitioners who can perform the encounter
   A hospice physician or a hospice NP can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A

hospice NP must be employed by the hospice. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.

4. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period
   In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period.

   For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face-to-face encounter that occurs within two days after admission will be considered timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as complete.

   The hospice must retain the certification statements and have them available for audit purposes.

10.0 DELEGATED OVERSIGHT

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including applicable APLs, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

REFERENCE:

Policy Reviewed 2021-11: Policy reviewed by UM Director**.** Approved by QI/UM Committee on 11/2021. Approved by PAC on 2/2022. **Revision 2021-08:** Policy approved by DHCS 8/30/2021; Policy approved by DMHC on 11/01/2021, filing no. 20214084. Director of Utilization Management to definition of Terminal Illness based on feedback from DHCS. **Revision 05/2021:** Minor revision by Director of Utilization Management to section 3.0 language. **Revision 07/2020:** Definition of Terminal Illness revised to comply with 2019 DMHC Medical Audit deficiency #6. **Revision 02-2020:** Updated Utilization Review per DMHC comments 1/14/2020. Revisions to section 5.1 and 5.2 with updates to CCS NL reference. Section 10.0 added language for Delegated Oversight. **Revision 03-2015:** New requirements effective February 1, 2015 for face-to-face encounters for every hospice patient. Language added in Section 9.0 Provider Requirements. Revision **2014-12**: Revisions to Section 5.2 to facilitate continuity of care with CCS. Utilization Review added new language for tracking purposes and certification for illness periods. **Revision 2014-06:** Major revisions throughout policy to comply with All Plan Letter (APL) 13-014. Review and revision provided by Director of Health Services. Board of Directors approved at 7/17/2014 meeting.

[1] DHS Contract Exhibit A - Attachment 10 (8)(C)
[2] Includes HSC sections as added/amended by AB892 (1999)
[3] Definitions
[4] CCR Title 22 §51349(f)
[5] MMCD All Plan Letter 05003 III B (page 4) references 42 CFR Section 438.210(a)(2)
[6] HSC 1368.2(b)
[7] HSC 1339.31(b)
[8] CCR28 §1300.68.2(d)(1)
[9] Title 42 CFR § 418.3 used; HSC 1368.1 also referenced with definition being less strict (12 months); similar definitions found in title 28 Section 1300.68.2 (a)(11), and 1376.96.(c).

[10] Certification as outlined in Title 42, CFR 418 Subpart B
[11] MMCD All Plan Letter 05003 I (page 2)
[12] Title 22 Section 51349 (b); MMCD All Plan Letter 05003 I (page 2)
[13] 2004 DHS Contract Exhibit A-Attachment 5(3)(I); MMCD All Plan Letter 05003 I (page 2)
[14] CCR 28 §1300.68.2(c)
[15] MMCD All Plan Letter 05003 III D (page 5)
[16] CCR Title 22 Section 51349 (d); MMCD All Plan Letter 05003 III A (page 3)
[17] MMCD All Plan Letter 05003 III A (page 3). The MMCD letter contradicts Title 22 Section 51349 (e). Per D. Chin (9/26/05) KHS was instructed to follow to MMCD letter.
[18] MMCD All Plan Letter 05003 III C (page 4)
[19] MMCD All Plan Letter 05003 III D (page 5)
[20] MMCD All Plan Letter 05003 III D (page 5) references 42 CFR Section 418.30
[21] CCR Title 22 Section 51349 (e); MMCD All Plan Letter 05003 III C (page 4)
[22] CCR Title 22 §51349(f)
[23] CCR Title 28 Section 1300.68.2 (b); CCR Title 22 Section 51349 (h); MMCD All Plan Letter 05003 III B (page 3)
[24] Addition of "certified" and "under the supervision of…" per Title 28 Section 1300.68.2 (b)(2)(B)
[25] 42 CFR Section 418.204 CCR28; §1300.68.2(d)(1)
[26] Per MMCD All Plan Letter 05003: Section 230.3 of the Medicare Hospice Manual and CMS Transmittal A-03-016
[27] CCR Title 28 Section 1300.68.2 (b)(2)(A)
[28] CCR Title 28 Section 1300.68.2 (b)(2)(F)
[29] Definition included in Member Handbook by DMHC request 04/15/02. CCR28 §1300.68.2(a)(1)
[30] Definition included in Member Handbook by DMHC request 04/15/02. CCR28 §1300.68.2(a)(4)
[31] Definition added to Member Handbook by DMHC request 04/15/02. CCR28 §1300.68.2(a)(10)
[32] CCR Title 28 §1300.68.2(d)(2)
[33] CCR Title 22 Section 51349 (g)
[34] MMDC All Plan Letter 05003 IV C (page 6)
[35] MMCD All Plan Letter 05003 IV (page 5)
[36]DHS Contract Exhibit A - Attachment 10 (7)(B)
[37] MMCD All Plan Letter 05003 IV (page 5) references 42 CFR Section 438.208
[38] MMCD All Plan Letter 05003 III D (page 5)
[39] MMCD All Plan Letter 05003 IV B (page 5)
[40] MMCD All Plan Letter 05003 III B (page 3)
[41] DHS Contract Exhibit A – Attachment 11 (17)(A); DHS Contract Exhibit A - Attachment 10 (7)(B); MMCD All Plan Letter 05003 V A (page 6)
[42] MMCD All Plan Letter 05003 V B (page 6) references Title 22 Section 51544
[43] CCR Title 28 Section 1300.68.2 (b)(1)
[44] HSC Section 1745, et seq
[45] HSC Sections 1726 and 1747.1