KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Hospice Services	Policy #	3.43-P
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Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The purpose of Kern Health Systems (KHS) hospice care policy is to ensure that hospice services are covered and facilitated for eligible Members, fully informing them and their families of hospice availability and the process for electing these services. Hospice services under KHS must be at least equivalent to the Medicare hospice benefit, as required by statutory, regulatory, and contractual obligations.

II. POLICY

A. 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 are covered under KHS contracts.
2. Hospice care must be equivalent to Medicare benefits.

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

1. California Health and Safety Code §§ 1368.1;1368.2; and 1746
2. California Code of Regulations Title 28 § CCR 28 §1300.68.2DHCS Contract Exhibit A-Attachment 5 (3)(I); Attachment 10 (7)(B) and Attachment 11 (17)(A)
3. DHCS MMCD All Plan Letter 05003: Hospice Services and Medi-Cal Managed Care (March 25, 2005)
4. California Code of Regulations Title 22 CCR, Section 51349,
5. DHCS MMCD All Plan Letter 13-014: Hospice Services and Medi-Cal Manager Care (October 28, 2013)

6. 42 CFR Part 418 Hospice Care

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

   Members who elect hospice care will remain enrolled in KHS and are entitled to curative treatment for conditions unrelated to their terminal illness. They are not entitled to any other benefits under the plan for terminal illness while the hospice election is in effect. Hospice is a voluntary option driven by Member or authorized representative preference. The hospice election may be revoked at any time.

D. 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. 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.

E. KHS recognizes that Centers for Medicare and Medicaid Services (CMS) hospice guidance is a tool and not solely determinative. Members may qualify for hospice care based on a physician's clinical judgment even if CMS guideline criteria are not fully met.

III. DEFINITIONS

TERMS	DEFINITIONS
Palliative Care	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	A period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.
Terminal Illness	Terminally illness is an incurable condition with a prognosis of six months or less that is expected to result in death.
Terminal Illness Certification for Hospice	The individual has a medical prognosis that his or her life expectancy is six (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 twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a new enrollee.
Authorized Representative	Defined as "Representative" in Title 42 CFR 418.3. Representative means an individual who as authority under State Law (whether by Statute or pursuant to an appointment by the Courts of the State) to terminate or authorize medical care or revoke the election of Hospice Care on behalf of a terminally ill patient who is mentally or physically incapacitated.

Palliative Care	It is defined in H&S Section 1339.31(b) means interventions that focus primarily on the reduction or abatement of pain and other disease related symptoms, rather than interventions aimed at investigation and /or interventions for the purposes of cure or prolongation of life.

IV. PROCEDURES

A. Certification of Terminal Illness and Necessary Documentation

1. Hospice care is covered for terminal illness if the services meet all the following conditions to initiate outpatient hospice services:

    a. Member or authorized Representative voluntarily files an election statement with the hospice Provider.

        i. The hospice provider must submit the appropriate election form to KHS within five (5) calendar days. If the form is submitted beyond five (5) days, the coverage/reimbursement will not be granted until the form is received, and coverage will begin at that date.
        ii. Payment and/or coverage for hospice services may be denied if documentation does not support medical necessity or terminal status. Liability for non-covered services rests with the hospice provider, and the Member shall not be billed.

    b. Written certification by the Member's Primary Care Physicians (PCP) and/or another authorized provider

    c. Performed by a contracted hospice provider or another authorized provider when medically necessary services are not available in-network.

2. The only requirement for initiation of outpatient hospice services which include routine home care, continuous home care and respite care, or hospice physician services is physician certification that a Member has a terminal illness and Member election of such services. Only general inpatient care is subject to prior authorization if all other requirements regarding prior authorization and associated clinical guidelines have been met.

3. 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 twenty-four (24) hours.

4. Covered services are available on a twenty- four (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. Hospice services may be initiated or continued in

a home or clinical setting.

5. Prior Authorization will be granted by KHS in the case of general inpatient care, regardless of if services are to be rendered by an in-network or out of network provided. The following itemized documents must be submitted for general inpatient prior authorization requests:

    a. A written prescription signed by the Member's attending physician

    b. Justification of the general inpatient care

    c. A copy of certification of the Member's terminal condition,

    d. A copy of the written initial plan of care, and a copy of the Member's signed election form.

B. Election of Hospice

1. The Member or Member's representative must file an election statement with the hospice providing the care. The Member's election shall include all the following elements on an appropriate hospice election form:

2. The identification of the hospice Provider

    a. The patient's or representative's acknowledgement that:

        i. He or she has full understanding that the hospice care given as it is related to the individual's terminal illness will be palliative rather than curative in nature.

    b. Certain specified Medi-Cal benefits are waived by the election.

        i. The effective date of the election
        ii. The signature of the individual or representative
        iii. All Provides must complete the appropriate Department of Health Care Services (DHCS) Hospice Election Form and addendum and submit them within five (5) calendar days to KHS.
        iv. The Form can be located at: https://www.dhcs.ca.gov/services/medi-cal/Pages/Hospice-FAQ.aspx

    c. An individual may elect to receive hospice care during one or more of the following periods:

        i. An initial ninety (90)-day period.
        i. A subsequent ninety (90)-day period; or
        ii. An unlimited number of subsequent sixty (60)-day periods.

3. After the initial Hospice Period the hospice provider must obtain written certification of terminal illness for each benefit period. For the initial benefit period of ninety (90) days, the hospice provider must obtain written certification statements from the medical director of the hospice or the physician designee of the hospice interdisciplinary group, as well as the Members attending

such as primary care physician or referring physician.

4. A Member may elect to receive hospices care during one or more of the following periods: (1) an initial ninety (90)-day period, (2) a subsequent ninety (90)-day period, or (3) an unlimited number of sixty (60)-day periods.

5. For dual-eligible Members electing Medicare hospice, the DHCS election form shall be submitted to both DHCS and KHS.

C. Special Considerations in Hospice Election

1. If 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 be in the patient's best interest for some other reason. 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.

2. 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

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

4. Hospice providers must provide transferring Members with a transferring summary including essential information relative to the Member's diagnosis, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan which must be signed by the physician

5. When a Member upon enrollment enters into a new MCP a change in designated hospice must be initiated.

D. Change of Hospice Provider

1. A Member or representative may change the designation of a hospice provider once each election period.

2. 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.

3. 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.

E. Revocation of Hospice

1. A Member's voluntary election may be revoked or modified at any time during an election period. To revoke the hospice care election, 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.

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

3. If a Member revokes the hospice benefit or is discharged by the hospice for cause and later elect's hospice and is readmitted to the same or different hospice provider, then the 90/90/unlimited sixty (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.

    a. Upon Member re-election of hospice, the hospice Provider shall submit a new DHCS Hospice Election Form to KHS within five (5) calendar days

F. Transition to Hospice Services

1. General

    a. KHS will instruct Staff, Subcontractors, Downstream subcontractors, Network Providers, Out of Network Providers, and Other Programs of the importance of timely recognition of a Member's eligibility for hospice care services and their election of hospice care services. Once a Member has elected hospice care services, MCP Network Providers and case management staff must work closely with hospice Providers to facilitate the transfer of services for the Member from those directed toward cure and/or prolongation of life, to those directed toward palliation. Ongoing Care Coordination must be provided to ensure that services necessary to diagnose, treat, and follow-up on conditions unrelated to the terminal illness continue to be provided, or are initiated as necessary.

G. Services for Children with Life Threatening Conditions

1. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, children receiving hospice care services for a terminal illness and life expectancy of six months or less may receive additional services than are available for adults. Children can, and often do, live longer with a terminal illness because of aggressive treatment and their natural resilience.

2. In addition to hospice care services, children and families may benefit from receiving palliative

care services. Children are eligible for hospice care under the same criteria as adults (a physician certifies the Member as having a life expectancy of six months or less), although children under twenty-one (21) years of age also may elect to receive concurrent curative treatment of the hospice-related diagnosis and concurrent palliative care.

3. In addition, hospice and palliative care is available for California Children's Services (CCS) eligible children. KHS will work with CCS to facilitate Continuity of Care, including maintaining established patient provider relationships, to the greatest extent possible. Hospice care, if elected, for children with terminal illnesses requires close consultation and coordination between the KHS and the local CCS program (when applicable), and/or other caregivers. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition.

4. 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: 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

H. Concurrent Hospice and Curative Care for Children

1. Under section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, Medicaid children who have elected to receive hospice services, or for whom hospice services have been elected, may continue to receive services to treat their terminal illness.

I. Hospice Services for Children Served by California Children Services (CCS) for the Terminal Condition

1. 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.

J. Concurrent Hospice Palliative and Curative Care for Children

2. 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

3. 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

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

K. Covered Services

1. 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. The hospice election may be revoked at any time.

2. 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.

3. Services include:

   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. Services may include personal care services, and such household services 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 include general supervisory duties of the hospice medical director, interdisciplinary plan participation, and policy establishment. Palliative items under the hospice benefit are distinct from Medi-Cal Palliative Care (APL 18-020)

   h. 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.

i. Physician visits by hospice-employed physicians, medical directors, or consultants are billed to KHS separately.

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

j. Continuous home nursing, home health aide, and/or homemaker services for as much as twenty-four (24) hours a day during a period of crisis, and only as necessary to maintain the terminally ill Member at home.

k. A crisis as the period in which a Member requires continuous care for as much as twenty-four (24) hours to achieve palliation or management of acute medical symptoms.

l. Continuous home care for a minimum of eight (8) hours of care (aggregate) during a twenty-four (24)-hour day, which begins and ends at midnight.

m. Inpatient 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.

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

o. 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.

p. Interdisciplinary team care with development and maintenance of an appropriate plan of care.

q. Volunteer services.

4. Face to Face Encounter - A hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice Member to determine the continued eligibility of that Member starting with the third benefit period. The face-to-face encounter requirement is satisfied when the following criteria are met:

   a. The timeframe of the face-to-face encounter occurred no more than thirty (30) calendar days prior to the start of the third benefit period, and no more than thirty (30) calendar days prior to every subsequent benefit period thereafter. However, in cases where a hospice newly admits (i.e. transfer/admission to a licensed hospice facility type) a Member in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. Under documented exceptional circumstances, a face-to-face encounter within two calendar days after admission will be considered timely.

   b. The hospice physician or NP must attest in writing that they had a face-to-face encounter

with the Member.

5. 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.

6. 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.

7. 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.

8. 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 five (5) consecutive days at a time.

L. Provision of Hospice Services by Hospice Interdisciplinary Group

1. Due to the highly specialized services provided by hospices, federal law mandates that the hospice designates 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).

2. KHS shall ensure 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.

M. Plan of Care

1. 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.

N. Coordination of Care

1. KHS provides coordination of care and joint case management with hospice care providers.

2. 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. KHS arranges for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible.

3. 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. 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.

O. Reimbursement

1. If hospice services are covered by the Member's Other Health Coverage (OHC), the hospice Provider shall bill the OHC first and submit the Explanation of Benefits or denial with the Medi-Cal claim.

2. Medi-Cal program payments for hospice services are based upon the level of care provided so that hospice Providers may group services into the following revenue codes as outlined in the Medi-Cal Provider Manual. The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare.

3. KHS may pay more, but not less than the Medicare rate for hospice services. Forty-eight (48) The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register:

    a. Routine home care (service intensity add-on rate), Revenue Code 0552.

    b. Routine home care (high rate), Revenue Code 0650.

    c. Continuous home care, Revenue Code 0652.

    d. Inpatient respite care, Revenue Code 0655.

    e. General inpatient care (no respite)/hospice general care, Revenue Code 0656.

    f. Physician services, Revenue Code 0657.

    g. Routine home care (low rate), Revenue Code 0659

4. Routine home care is reimbursed at the high rate for days 1-60 and the low rate starting day 61. Routine home care days during the last seven (7) days of a hospice election ending in death qualify for the Service Intensity Add-On (SIA) payment.

5. Inpatient hospice rates (general or respite) shall be paid for the date of admission and all subsequent inpatient days, except the discharge day, which is paid at the home care rate unless the Member dies as an inpatient.

6. 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:

a. Certification of physician orders for general inpatient care.

b. Justification for this level of care.

7. Per the Medicare Benefit Policy Manual (Chapter 9) 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 appropriately be provided in other settings. Skilled nursing care may be needed by a Member whose home support has broken down, making it no longer appropriate 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. For example, a brief period of general inpatient care may be needed in some cases when a Member elects the hospice benefit at the end of a covered hospital stay. In this circumstance, if a Member continues to need pain control or symptom management, which cannot be appropriately provided in other settings while the Member prepares to receive hospice home care, general inpatient care is appropriate. Other examples of appropriate general inpatient care include a Member in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring, or a Member whose family is unwilling to permit needed care to be furnished in the home.

8. 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.

9. Visits made to a Member by the hospice Medical Director, hospice physician, or consultant should be billed separately.

P. Services Not Covered by Hospice Provider

1. The following services are not covered through Hospice:

a. Private pay room and board or residential care.

b. Acute in-patient hospitalization is unrelated to terminal illness.

c. Level A or Level B NF for unrelated issues.

d. Physician and/or consulting physician services are not related to terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.

e. Other necessary services for conditions unrelated to the terminal illness.

Q. Hospice Services Provided in a Long-Term Care Facility

1. 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.

2. 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.

3. 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).

4. 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 ninety-five (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.

5. LTC residents who elect the Medi-Cal hospice benefit are not disenrolled from KHS.

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

   a. Revenue Code 0658-Facility Type Code 25.

   b. Revenue Code 0658-Facility Type Code 26.

   c. Revenue Code 0658-Facility Type Code 28.

   d. Revenue Code 0658-Facility Type Code 65.

   e. Revenue Code 0658-Facility Type Code 81.

   f. Revenue Code 0658-Facility Type Code 86.C. Dually Eligible Medicare and Medi-Cal

for all Members with both Medicare and Medi-Cal coverage (dual eligibles).

7. Medicare remains the primary payor for the hospice care services. KHS shall cover cost sharing for contracted services. For dually eligible SNF residents, in accordance with the Medicare Benefit Policy Manual (Chapter 9) section 20.3 - Election by Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries, payment for room and board must be made directly to the hospice Provider. The room and board charge billed to KHS as the hospice benefit under Medicare does not cover room and board.

8. Following payment from Medicare, the hospice Provider then bills the MCP for the Medicare co-payment amount; however, the total reimbursed amount cannot exceed the Medicare rate (Title 22 CCR section 51544).

9. For Medicare Members entitled to only Medicare Part B, benefits will be billed directly to the KHS.

10. KHS will not require authorization for the hospice Provider to bill the KHS for the room and board covered by Medi-Cal while the patient is receiving hospice under Medicare. Additionally, KHS will not require a copy of explanation of benefits, Remittance Advice, or denial Letter from Medicare to accompany room and board claims.

R. Hospice Rates

1. 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.

2. 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.

3. 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 in-patient. If the patient dies while an inpatient, the inpatient rate (general or respite) shall be paid for the discharge day.

S. Physician Services

1. 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.

2. 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:

a. Immediate need.

b. The attending physician does not have the required special skills.

T. Utilization Review Procedures

1. Utilization Management

a. Procedures are in place to ensure KHS does 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).

b. 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 ninety (90)-day period, subsequent ninety (90)-day period, or unlimited sixty (60)-day period) will be required for tracking purposes and coordination of services.

c. 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.

2. Denials to Terminally Ill Members

a. KHS is required to provide Members and providers with notification of denial for a prior authorization request for services within 7 calendar days or less referenced in Policy and Procedure 3.22-P, Referral and Authorization Process for additional information. The notification to the Members will provide all of the following information:

i. A statement setting forth specific medical and scientific reasons for denying coverage.
ii. A description of alternative treatment, services, or supplies covered by the Plan, if any.
iii. Information regarding Member's rights, including appeal and grievance options and forms.
iv. 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.

b. KHS will not deny hospice care services to Members certified as terminally ill by a qualified physician, consistent with APL 25-008 requirements.

U. Provider Requirements

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

2. 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:

   a. Timeframe of the encounter:

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

3. Attestation requirements

   a. 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.

4. Practitioners who can perform the encounter

   a. 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.

   b. A Hospice NP must be employed by the hospice.

   c. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.

5. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period.

    a. 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.

    b. 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 complete.

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

V. Delegated Oversight

1. 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.

W. Fraud, Waste, and Abuse

1. Compliance with Protocols and Procedures

    a. KHS remains proactive and vigilant in program integrity efforts, with ongoing monitoring for fraud, waste, and abuse in hospice claims and elections.

    b. KHS implements procedures to facilitate timely hospice election, avoid unnecessary delays, and incorporate safeguards to validate Member elections and prevent fraud, waste, and abuse.
    c. KHS will follow appropriate compliance review protocols and procedures regarding claim processing and Utilization Management systems upon receipt of a hospice election form and/or hospice claim to identify a Member as receiving hospice.

    d. Protocols and procedures will include informing the Member's PCP to notify them of the Member's election to hospice and adding any other system indicators to flag Members receiving hospice services.

        i. KHS shall initiate system updates to designate hospice Members consistent with DHCS Medi-Cal Eligibility Data System (MEDS) 900-restricted services coding to ensure accurate tracking and claims processing.

e. KHS will examine documentation received from the hospice provider to determine the qualification of the Member to receive hospice.

f. When appropriate, KHS will request additional documentation for such a determination, to confirm proper and appropriate claim payments and service authorizations are made, and not based on fraudulent submissions.

    i. At any time, DHCS may inspect and audit KHS records, documents, and electronic systems to ensure compliance with service delivery and/or claim payments.

g. KHS will report complete, accurate, reasonable, and timely submission of Encounter Data. Reported data will include:

    i. Data for the referring Provider (attending physician), rendering Provider (Hospice Provider), and the starting day of service data.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type	Specific Reference
All Plan Letter(s) (APL)	DHCS APL 25-008
All Plan Letter(s) (APL)	DHCS APL 18-020
All Plan Letter(s) (APL)	MMCD All Plan Letter 05003 III B (page 4) references 42 CFR Section 438.210(a)(2
All Plan Letter(s) (APL)	MMDC All Plan Letter 05003 IV C (page 5, 6)
All Plan Letter(s) (APL)	MMCD All Plan Letter 05003 IV (page 5) references 42 CFR Section 438.208
All Plan Letter(s) (APL)	MMCD All Plan Letter 05003 III D (page 5)
All Plan Letter(s) (APL)	MMCD All Plan Letter 05003 IV B (page 5)
All Plan Letter(s) (APL)	MMCD All Plan Letter 05003 III B (page 3)
Regulatory	DHS Contract Exhibit A - Attachment 10 (8)(C)
Regulatory	CCR Title 22 §51349(f), § 51349 (g), §51544
Regulatory	HSC 1368.2(b), HSC 1339.31(b), HSC 1368(a)(3)
Regulatory	CCR 28 §1300.68.2(a)(1), §1300.68.2(a)(4), §1300.68.2(a)(10),

	§1300.68.2(d)(1), §1300.68.2(d)(2) § 1300.68.2 (b). §1300.68.2(c)
Regulatory	Title 42 CFR § 418.3 used; 418.112, 418.56, 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).
Regulatory	Certification as outlined in Title 42, CFR 418 Subpart B
Regulatory	MMCD All Plan Letter 05003 I (page 2,3,4 5)
Regulatory	CCR Title 28 Section CCR Title 22 Section 51349 (h); MMCD All Plan Letter 05003 III B (page 3)
Regulatory	DHS Contract Exhibit A – Attachment 11 (17)(A); DHS Contract Exhibit A - Attachment 10 (7)(B); DHCS Contract Exhibit A-Attachment 5 (3)(I); MMCD All Plan Letter 05003 V A (page 6)
Regulatory	MMCD All Plan Letter 05003 V B (page 6) references Title 22 Section 51544
Regulatory	CCR Title 28 Section 1300.68.2 (b)(1)
Regulatory	HSC Section 1745, 1746 et seq
Regulatory	HSC Sections 1726 and 1747.1
All Plan Letter(s) (APL)	DHCS MMCD All Plan Letter 13-014: Hospice Services and Medi-Cal Manager Care (October 28, 2013)
Regulatory	42 CFR Part 418 Hospice Care, Subpart C
Regulatory	Section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010
Other KHS Policies	KHS Policy and Procedure #5.01-P: Grievance Process
Other KHS Policies	KHS Policy and Procedure 3.22-P, Referral and Authorization Process
Other KHS Policies	KHS Policy and Procedure 3.77- Palliative Care.

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2025-09	The policy was revised to align with DHCS APL 25-008, AIR 1. Approved 09/29/2025	UM
Revised	2025-05	Updated to comply with DHCS All Plan Letter 25-008 Dated May 05, 2025 Supersedes APL 13-014. Titled Hospice Services and Medi-Cal Managed Care	UM
Revised	2021-11	Policy reviewed by UM Director. Approved by QI/UM Committee on 11/2021. Approved by PAC on 2/2022.	UM
	2021-08	Policy approved by DHCS 8/30/2021; Policy approved by DMHC on 11/01/2021, filing	UM

Revised		no. 20214084. Director of Utilization Management to definition of Terminal Illness based on feedback from DHCS.	
Revised	2021-05	Minor revision by Director of Utilization Management to section 3.0 language.	UM
Revised	2020-07	Definition of Terminal Illness revised to comply with 2019 DMHC Medical Audit deficiency #6.	-
Revised	2020-02	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.	-
Revised	2015-03	New requirements effective February 1, 2015 for face-to-face encounters for every hospice patient. Language added in Section 9.0 Provider Requirements. Revision	-
Revised	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.	-
Revised	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.	-

VIII. APPROVALS

Committees | Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		
Choose an item.		