

COMPARISON OF MEDICAID HOSPICE BENEFIT AND
MEDICARE HOSPICE BENEFIT

Prepared by
The Maine Hospice Council

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COMPARISON OF MEDICAID HOSPICE BENEFIT AND MEDICARE HOSPICE BENEFIT

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| <p align="center"><u>Definitions (43.01)</u></p> <p>43.01-1 <u>Attending Physician</u> is a doctor of medicine or osteopathy licensed to practice in the State of Maine (or the state in which the services are provided) who provides services within the scope of practice of his or her profession as defined by Maine (or applicable state law), identified by the individual at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the individual’s medical care.</p> | <p><u>418.3 Definitions.</u> For purposes of this part –</p> <p>Attending physician means a physician who --</p> <p>(a) Is a doctor of medicine or osteopathy; and</p> <p>(b) Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual’s medical care.</p> | |
| <p>43.01-2 <u>Department</u> means the Maine Department of Human Services</p> | | |
| <p>43.01-4 <u>Hospice Services</u> are a range of interdisciplinary services provided twenty-four (24) hours a day, seven days a week to a person who is terminally ill and to that person’s family. These services are to be delivered in the least restrictive setting possible by volunteers and professionals who are trained to help the individual with physical, social, psychological, spiritual and emotional needs related to the terminal illness with the least amount of technology possible. Services are focused on pain relief and symptom management and are not curative in nature.</p> | | <p>Medicaid states that hospice services are to be delivered in the least restrictive setting possible.</p> |
| <p>43.01-5 <u>Interdisciplinary Team</u> is the team that manages the hospice services provided to the terminally ill individual and the individual’s family. The team includes at least the following individuals: a doctor of medicine or osteopathy, a registered nurse, a social worker and a counselor as outlined in Section 43.06-3. All individuals must be employees of the hospice, except the physician who may be a contractor of the hospice.</p> | <p><u>418.68 Condition of Participation – Interdisciplinary Group</u> The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice.</p> <p><u>418.68(a) Standard: Composition of Group.</u> The hospice must have an interdisciplinary group or groups that include at least the following individuals who are employees of the hospice:</p> <p>(1) A doctor of medicine or osteopathy.</p> <p>(2) A registered nurse.</p> <p>(3) A social worker.</p> <p>(4) A pastoral or other counselor.</p> | <p>Medicaid states social worker and a counselor must be included in the IDT.</p> <p>Medicare states social worker and a pastoral or other counselor must be included on the IDT.</p> |
| <p>43.01-6 <u>Medical Director</u> must be a hospice employee or contractor who is a doctor of medicine or osteopathy licensed in the State of Maine who has overall responsibility for the medical component of patient care at the hospice.</p> | <p><u>418.54 Condition of Participation—Medical Director</u> The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice’s patient care program.</p> | |

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| 43.01-7 <u>Representative</u> is an individual authorized under State law to end medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. | Representative means an individual who has been authorized under state law to terminate medical care to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. | |
| 43.01-8 <u>Terminal Illness</u> is a medical condition resulting in a prognosis that an individual has a life expectancy of six (6) months or less if the illness runs its normal course. | 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. | |
| <p style="text-align: center;"><u>Recipient Eligibility For Care (43.02)</u></p> <p><i>An individual is eligible for covered hospice services if he or she meets both the General Medicaid Eligibility Requirements and the Hospice Services Eligibility Requirements, with the exception of the following: those individuals deemed eligible for coverage under Medicare hospice benefits, however, shall not be eligible for services which would be duplicative under this Section.</i></p> | | Eligibility for Medicaid is based on having financial and or medical needs. |
| 43.02-1 <u>General Medicaid Eligibility Requirements</u> | | Eligibility for Medicare is based on being 65 or over and being disabled. |
| 43.02-2 <u>Hospice Services Eligibility Requirements</u> A. A recipient must be certified by a physician as having a terminal illness as set forth in Section 43.03-1, Certification of Terminal Illness; and B. The recipient or his or her Representative must elect hospice benefits in lieu of other Medicaid covered services as specified in Section 43.03-2 by completing an election statement as set forth in that section. | <u>201 Eligibility Requirements</u> In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified as being terminally ill. Obtain the certification that an individual is terminally ill in accordance with the following procedures. For the first 90-day period of hospice coverage, obtain, no later than two calendar days after hospice care is initiated (that is, by the end of the third day), written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician). These certification statements may be completed up to 2 weeks before hospice care is elected. If the written certification is not obtained within 2 calendar days following the initiation of hospice care, a verbal certification may be made within 2 days following the initiation of hospice care, with a written certification not later than 8 days after care is | |

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| | <p>initiated. If these requirements are not met, no payment is made for the days prior to the certification. Instead, payment begins with the day of certification. The attending physician is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in determination and delivery of the individual's medical care.</p> <p>For the subsequent periods, obtain, no later two calendar days after the first day of each period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include (1) the statement that the individual's medical prognosis is that his or her life expectancy is 6 months or less if the terminal illness runs its normal course and (2) the signature(s) of the physician(s). Retain the certification statements.</p> <p><u>Extending the Period For Physician Certification of an Individual's Terminal Illness</u></p> <p>BBA of 1997 amended §1879(a)(7)(A)(I) of the Act by removing specific written and verbal time frames for physician certifications (that an individual is terminally ill) for the initial 90-day benefit period and requiring only that certification be done "at the beginning of the period". Certification by physicians for hospice care at the beginning of the initial benefit period will remain as they are currently, i.e., "beginning of the period" continues to be not later than 2 days after hospice care begins, but written certification need only be on file in the patient's record prior to submission of a claim to the fiscal intermediary. An initial plan of care must be established at the start of care, prepared by the hospice physician or nurse, in consultation with the attending physician and one other member of the IDG.</p> | |
| <p style="text-align: center;"><u>Recipient Eligibility Procedure (43.03)</u></p> <p>43.03-1 <u>Certification of Terminal Illness</u></p> <p>A. No later than two (2) calendar days after the initiation of hospice care the hospice must get verbal certification of terminal illness from the medical director or the physician on the hospice's Interdisciplinary Team and the individual's attending physician, if the individual has an attending physician. The hospice must obtain written certification prepared by both the Medical Director or the physician on the hospice's Interdisciplinary Team and the individual's attending physician (if he/she has one) and submit a</p> | | |

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| <p>copy of the certification to: Bureau of Medical Services, Classification Review, 11 State House Station, Augusta, ME 04333-0011, before submitting the claim for payment.</p> | | |
| <p>B. With respect to any subsequent election of hospice benefits, the hospice must obtain written certification of the recipient's terminal illness from the Medical Director or the physician on the hospice's Interdisciplinary Team before submitting the claim for payment.</p> <p>C. The certification must include:</p> <ol style="list-style-type: none"> 1. The statement that the individual's life expectancy is six (6) months or less if the terminal illness runs its normal course; and 2. The signature(s) of the physician(s). <p>The hospice must keep the certification statement(s) in the recipient's record.</p> | <p><u>418.26 Elements of the Election Statement.</u> The election statement must include the following:</p> <ol style="list-style-type: none"> (a) Identification of the particular hospice that will provide care to the individual. (b) The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness. (c) Acknowledgement that certain Medicare services are waived by the election. (d) The effective date of the election. (e) The signature of the individual or representative. | |
| <p>43.03-2 <u>Election/Revocation of Hospice Benefits</u> A recipient or his/her Representative must choose hospice care by filing an election statement. An election will remain effective as long as the recipient remains in the care of the hospice and does not revoke the election. A new election statement must be filed if the recipient seeks to obtain hospice care after such benefits have been revoked. A recipient may designate the effective date for hospice benefits as the first or any subsequent day of hospice care, but the effective date may not be earlier than the date of election.</p> <p>A. <u>Contents of Election Statement</u> The election statement must include:</p> <ol style="list-style-type: none"> 1. Identification of the hospice that will provide care to the recipient; 2. The recipient's or Representative's acknowledgement that he or she fully understands the palliative rather than curative nature of the hospice care related to the terminal illness; 3. The recipient's or Representative's acknowledgement that he or she understands that the Medicaid services listed in Section 43.03-2(B) and Section 43.05-4 are waived (or subject to limitations) by the election and that the recipient may be held financially liable for obtaining said services; 4. The effective date of the election; and 5. The signature of the recipient or Representative. <p>The hospice must keep the election statement(s) in the recipient's</p> | <p><u>418.24 Election of Hospice Care</u></p> <ol style="list-style-type: none"> (a) <i>Election statement.</i> If an individual who meets the eligibility requirements for hospice care elects to receive that care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative as defined in 418.3. The election statement must include the elements specified in 418.26. (b) <i>Sequence of election periods.</i> The two 90-day election periods must be used before the 30-day period. (c) <i>Duration of election.</i> An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual – <ol style="list-style-type: none"> (1) Remains in the care of a hospice; and (2) Does not revoke the election under the provisions of 418.28. (d) <i>Effective date of election.</i> <ol style="list-style-type: none"> (1) An individual or representative may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care. (2) An individual or representative may not designate an effective date that is earlier than the date that the election is made. <p><u>Hospice Care Benefit Period</u> The BBA of 1997 restructured the hospice benefit periods</p> | <p>The Medicaid election statement must contain acknowledgement of Medicaid services listed in 43.03-2(B) and Section 43.05-4. (See 43.03-2-3)</p> |

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| <p>record.</p> <p>The hospice must ensure that the recipient and/or Representative is adequately educated with regard to services waived by the hospice election and financial responsibility of the recipient for obtaining services that may duplicate services covered under this Section.</p> | <p>available to Medicare beneficiaries as provided for under §1812 of the Social Security Act (the Act). Effective upon the date of enactment, August 5, 1997, the hospice benefit has two initial 90-day periods followed by an unlimited number of subsequent 60-day periods. Each period requires a physician to certify at the beginning of the period that the individual has a terminal illness with a prognosis that the individual's life expectancy is 6 months or less. 42 CFR 418.22(b) clarifies that a physician's certification specifies that the prognosis is for a life expectancy of 6 months or less, but qualifies it with the words "if the terminal illness runs its normal course," recognizing that such a prognosis is not entirely predictable. This provision of the regulation remains unchanged.</p> | |
| <p>B. Waiver of Medicaid Benefits</p> <p>For the duration of the election of hospice care a recipient waives all rights to Medicaid payments for the following services only:</p> <ol style="list-style-type: none"> 1. Hospice care provided by a hospice other than the one designated by the recipient (unless provided under arrangements made by the designated hospice, or when transferring to another hospice program, see Section 43.03-03); 2. any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, or services that are determined to be related to the treatment of the recipient's condition (with respect to which a diagnosis of terminal illness has been made; and 3. any Medicaid services equivalent to hospice care, except for services: <ul style="list-style-type: none"> provided either directly or arranged by the designated hospice: provided by the recipient's attending physician if he or she is not employed by the designated hospice or does not receive payment from the hospice for those services; or Provided as room and board by a nursing facility if the recipient is a resident. <p>See Section 43.05 for additional provisions related to covered and non-covered services.</p> | <p><u>42 CFR Ch. IV (10-1-85 Edition)</u></p> <p>(e) <i>Waiver of other benefits.</i> An individual waives all rights to Medicare payments for the duration of the election of hospice care for the following services:</p> <ol style="list-style-type: none"> (1) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice). (2) Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services – <ol style="list-style-type: none"> (i) Provided by the designated hospice; (ii) Provided by another hospice under arrangements made by the designated hospice; and (iii) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. | |

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| <p data-bbox="226 170 674 196"><u>C. Revoking the Election of Hospice Care</u></p> <p data-bbox="226 232 974 532">A recipient or Representative may revoke the election of hospice care at any time by filing a revocation statement with the hospice which includes a signed statement that: a) the recipient revokes the election for Medicaid coverage of hospice care for the remainder of the election period and b) the effective date of the revocation. The effective date may not be earlier than the revocation date. Any days that are remaining in the benefit period are forfeited as of the effective date of the revocation. The recipient may re-elect hospice care at anytime. He/she does not have to wait until the previous benefit period would have been completed if the revocation had not occurred.</p> <p data-bbox="226 568 974 927">Upon revoking hospice care, the recipient resumes coverage of Medicaid benefits waived upon election of hospice care. A person may elect/revoke hospice care as many time as he she chooses as long as he/she continues to meet the eligibility standards in Section 43.02. The hospice must forward a copy of the complete revocation statement and Notice of Consumer Transfer/Death BMS/CS-34 to: Bureau of Medical Services, Classification Review, 11 State House Station, Augusta, ME 04333-0011. The hospice must keep the revocation statement(s) in the recipient's record. Even if a recipient has revoked hospice care one or more times, the recipient is only eligible for a lifetime total of two ninety (90)-day benefits (followed by an unlimited number of subsequent sixty (60)-day periods).</p> | <p data-bbox="1003 170 1497 196"><u>418.28 Revoking the Election of Hospice Care</u></p> <p data-bbox="1003 232 1680 894">(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period (b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information: (1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period. (2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made). (c) An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period- (1) Is no longer covered under Medicare for hospice care; (2) Resumes Medicare coverage of the benefits waived under 418.24(e)(2); and (3) May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.</p> | |
| <p data-bbox="92 966 663 992">43.03-3 <u>Changing From One Hospice to Another</u></p> <p data-bbox="226 1027 953 1112">A. A recipient may change hospice providers once in each benefit period. The change of hospice is not considered a revocation of the election of hospice services.</p> <p data-bbox="226 1148 953 1291">B. To change hospice providers, a recipient shall file a signed statement with the hospice where the recipient was initially enrolled and with the new hospice. If appropriate, the hospice shall assist the recipient with preparation of the statement. The statement shall include:</p> <ol data-bbox="279 1300 842 1505" style="list-style-type: none"> <li data-bbox="279 1300 842 1356">1. The hospice from which the recipient received hospice services. <li data-bbox="279 1391 842 1446">2. The hospice from which the recipient will receive services; and <li data-bbox="279 1482 842 1505">3. The date the change is effective. | <p data-bbox="1003 966 1455 992"><u>418.30 Change of the Designated Hospice</u></p> <p data-bbox="1003 1027 1680 1446">(a) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. (b) The change of the designated hospice is not a revocation of the election for the period in which it is made. (c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information: (1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care. (2) The date the change is to be effective.</p> | <p data-bbox="1707 966 2003 1170">Upon transfer to another Hospice, Medicaid requires notification on form Transfer/Death BMSKS-34, be sent to the department. Other transfer criteria are the same.</p> |

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| <p>C. In order to change providers, notification must be sent to the Department on the Notice of Consumer Transfer/Death BMS/CS-34 by the hospice to which the recipient is transferring.</p> | | |
| <p>43.04 <u>DURATION OF CARE</u></p> <p>The hospice benefit has two (2) ninety (90)-day periods, followed by an unlimited number of subsequent sixty (60)-day periods. At the beginning of each period the hospice must obtain a Certification of Terminal Illness.</p> | | |
| <p>43.05 <u>COVERED SERVICES</u></p> <p>43.05-1 <u>Covered Services</u></p> <p>Covered hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. To be covered, all services must be in accordance with the plan of care and approved by the Interdisciplinary Team. Services unrelated to the terminal illness which affect the plan of care must be reflected in the plan in order to assure coordination and non-duplication of services.</p> <p>The following are considered covered hospice services. Unless noted otherwise, reimbursement shall be based on a per diem or hourly rate, and in accordance with the provisions described in section 43-07.</p> <p>A. <u>Physician Services</u> (see Section 43.07.3 for further details.)</p> <p>B. <u>Nursing Services</u> provided by or under the supervision of a registered nurse.</p> <p>C. <u>Medical Social Services</u> provided by a medical social worker working under the supervision of a physician.</p> <p>D. <u>Counseling Services</u> must be available to the recipient and family members or others caring for the recipient at home, including dietary, spiritual and other counseling. Counseling may be given both for the</p> | <p><u>418.80 Furnishing of Core Services</u> Except as permitted in 5418.83, a hospice must ensure that substantially all the core services described in this subpart are routinely provided directly by hospice employees.</p> <p>A hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must assure that the qualifications of staff and services provided meet the requirements specified in this subpart. (418.80-418.88)</p> <p><u>418.82 Nursing Services.</u> The hospice must provide nursing care and services by or under the supervision of a registered nurse.</p> <p>(a) Nursing services must be directed and staffed to assure that the nursing needs of patients are met.</p> <p>(b) Patient care responsibilities of nursing personnel must be specified.</p> <p>(c) Services must be provided in accordance with recognized standards of practice.</p> <p><u>418.84 Medical Social Services.</u> Medical social services must be provided by a qualified social worker, under the direction of a physician.</p> <p><u>418.86 Physician Services.</u> In addition to palliation and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary</p> | <p>Medicare says spiritual counseling must include notice as to the availability of clergy.</p> <p>Medicaid allows home health aide services to be provided by Home Health Aides and Certified Nursing Assistants, per 43.05-1E.</p> <p>Medicaid denotes chemotherapy and radiation as being potential palliative treatments, and that no extra payment would be made for the services. This is referenced in 43.05-1I.</p> |

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| <p>purpose of training caregivers to provide care, and for the purpose of helping the recipient and those caring for him or her to adjust to the recipient's approaching death.</p> <p>E. <u>Home Health Aide Services</u> furnished by certified home health aides and certified nursing assistants. Home health aides may provide personal care and household services essential to the comfort and cleanliness of the patient and maintaining a safe and healthy environment to allow implementation of the plan of care. Aides services must be provided under the general supervision of a registered nurse.</p> <p>Home health aide services can include the provision of homemaker services. Homemaker services include maintenance of a safe and healthy environment and services that enable the recipient to carry out the plan of care.</p> <p>F. <u>Medical Supplies, Drugs and Biologicals.</u> Only drugs used for primarily for the relief of pain and symptom control related to the recipient's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to relief or management of the illness. Equipment is provided by the hospice for use in the patient's home while under hospice care. Medical supplies include those that are part of the written plan of care.</p> <p>G. <u>Short-term Inpatient Care</u> provided in a participating hospice inpatient unit or a participating hospital or nursing facility which meets the special hospice standards regarding staffing and patient areas. Participating facilities are defined as those with which the hospice has a contract that provides for all requirements contained within in the Medicare Hospice conditions of participation. Inpatient services must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for individuals caring for the recipient at home.</p> <p>H. <u>Physical, Occupational and Speech/Language Therapy</u> provided for symptom control or to allow the recipient to perform daily living activities and basic functional skills.</p> <p>I. <u>Special Modalities.</u> Chemotherapy, radiation therapy, and other modalities may be used for palliative purposes if it is determined that</p> | <p>group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.</p> <p><u>418.88 Counseling Services.</u> Counseling services must be available to both the individual and the family. Counseling includes bereavement counseling, provided after the patient's death, as well as dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice.</p> <p><u>418.88 Spiritual Counseling.</u> Spiritual counseling must include notice to patients as to the availability of clergy as provided in 418.70(f)</p> <p><u>418.88 Additional Counseling.</u> Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.</p> <p><u>418.90 Furnishings of Other Services.</u> A hospice must ensure that the services described in this subpart are provided directly by hospice employees or under arrangements made by the hospice as specified in 418.56.</p> <p><u>418.92 Physical Therapy, Occupational Therapy, and Speech-Language Pathology.</u></p> <p>(a) Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.</p> <p>(b) (1) If the hospice engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the FDA, such testing must be in compliance with all applicable requirements of part 493 of this chapter. (2) If the hospice chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.</p> <p><u>418.94 Home Health Aide and Homemaker Services.</u> Home health aide and homemaker services must be available and adequate in frequency to meet the needs of the patients. A home health aide is a person, who meets the training, attitude and skill requirements specified in 484.36 of this chapter.</p> <p><u>418.96 Medical Supplies.</u> Medical supplies and appliances including drugs and</p> | |

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| <p>these services are needed for palliation. This determination is based on the patient's condition and philosophy of care giving of the hospice. No additional Medicaid reimbursement shall be provided, regardless of the cost of services.</p> <p>J. <u>Other Items and Services</u> specified in the plan of care for which payment may otherwise be made. This item reflects the hospice's responsibility for providing any and all services in the plan of care necessary for the relief and management of the terminal illness and related conditions.</p> | <p>biologicals must be provided as needed for the palliation and management of the terminal illness and related conditions.</p> <p><u>418.98 Inpatient Care for Respite Purposes.</u> Inpatient care for respite purposes must be provided by one of the following:</p> <ol style="list-style-type: none"> (1) A provider specified in paragraph (a) of this section. (2) An ICF that also meets the standards specified in 418.100(a) and (e) regarding the 24-hour nursing service and patient areas. <p><u>418.98 Inpatient Care for Symptom Control</u> Inpatient care for pain control and symptom management must be provided in one of the following:</p> <ol style="list-style-type: none"> (1) A hospice that meets the condition of participation for providing inpatient care directly as specified in 418.100. (2) A hospital or a SNF also meets the standards specified in 418.100(a) and (e) regarding 24-hour nursing service and patient areas. | |
| <p>43.05-2</p> <p>Special Coverage Requirements</p> <p>Bereavement counseling consists of counseling services provided to the recipient's family up to one (1) year after the recipient's death. It is a required hospice service but is not separately billable.</p> | <p><u>418.88 Bereavement Services.</u> There must be an organized program for the provision of bereavement services under the supervision of a qualified professional.</p> <p>The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient). A special coverage provision for bereavement counseling is specified 418.204(c).</p> | |

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| <p>43.05-3</p> <p>Room and Board Services for Nursing Facility Residents</p> <p>The following services shall be included as room and board services and shall be provided by the nursing facility for those Medicaid recipients who elect to receive hospice while residing in the nursing facility:</p> <p>Performance of personal care services; Assistance in activities of daily living; Administration of medication; Maintaining cleanliness of resident’s room; and Supervising and assisting the use of durable medical equipment and prescribed therapies.</p> | | <p>Medicaid delineates services to be provided by Nursing facilities as part of room and board.</p> |
| <p>43.05-4</p> <p><u>Coverage Restrictions During Hospice Election</u></p> <p>A. <u>Medically Necessary/Non-Duplicative Services</u></p> <p>Medically necessary services (as defined by the Department) which are not duplicative of hospice services or unrelated to an individual’s terminal illness may be obtained by a hospice recipient. The services provided must be appropriately documented in the patient record, in accordance with Department specifications. These services are subject to the same coverage provisions, limitations, prior authorization requirements and conditions applied to services available to non-hospice Medicaid recipients. (All services, related to and unrelated to the terminal illness, must be consistent with the plan of care). These services are reimbursable by Medicaid outside of the hospice rate.</p> <p>The services include:</p> <p>Ambulance Services- Chapter 11, Section 5 Audiology Services- Chapter 11, Section 10 Consumer Directed Attendant Services-Chapter 11, Section 12, subject to additional restrictions that may be outlined in that Section. Chiropractic Services-Chapter 11, Section 15. Family Planning Agency Services-Chapter 11, Section 30. Hearing Aids & Services-Chapter 11, Section 35. Home Health Services-Chapter 11, Section 40 subject to additional</p> | | <p>In this section (43.05-4) Medicaid lists services that can be billed separately, in addition to the hospice benefit.</p> |

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| <p>restrictions that may be outlined in that section Optional PHP/Non-traditional PHP Treatment Services-Chapter V, Section 4. Transportation Services_Chapter 11, Section 113. Pediatric Services- Chapter 11, Section 95. Private Duty Nursing and Personal Care Services- Chapter 11, Section 96, subject to additional restrictions that may be outlined in that Section. Licensed Clinical Social Worker Services-Chapter 11, Section 58 Medical Supplies and Durable Medical Equipment Chapter 11, Section 60 Psychological Services-Chapter 11, Section 100 Genetic Testing and Clinical Genetic Services- Chapter 11, Section 62. Medical Imaging Services-Chapter 11 Section 101 Occupational Therapy Services- Chapter 11, Section 68 Physical Therapy Services- Chapter 11, Section 85 Speech Pathology Services- Chapter 11 Section 110 Speech and Hearing Agencies-Chapter 11, Section 105</p> | | |
| <p>B. <u>Continuation of Services</u></p> <p>In order to maintain activities of normal life for as long as possible, certain Medicaid services may be continued after the hospice election for those recipients who have been receiving these services for a substantial period of time prior to the hospice election.</p> <p>These services include:</p> <p>Case Management Services- Chapter 11, Section 13 Community Support Services- Chapter 11, Section 17 Developmental & Behavioral Evaluation Clinical Services- Chapter 11 Section 23 Day Habilitation Services for Persons with Mental Retardation-Chapter 11, Section 24 Day Health Services- Chapter 11 Section 26 Early Intervention Services-Chapter 11, Section 27. Day Treatment Services- Chapter 11, Section 41 Rehabilitative Services- Chapter 11, Section 102 Home Based Mental Health Services-Chapter 11, Section 37 Mental Health Clinic Services- Chapter 11, Section 65. Psychiatric Facility Services-Outpatient services only, Chapter 11, Section 46 Private Non-Medical Institution Services-Chapter 11, Section 97</p> | | |

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| <p>Substance Abuse Treatment Services-Chapter 11, Section 111</p> <p>There may be instances where it is appropriate to allow individual hospice recipients to receive these services even if they did not receive them prior to electing the hospice benefit. However, the provider must show that services are medically necessary given the patients terminal condition, and are coordinated with the hospice plan of care. These services are reimbursable by Medicaid outside of the hospice rate.</p> | | |
| <p>C. Waiver Services</p> <p>Eligibility for and limits on home and community-based waiver services for recipients of hospice care are in the relevant section of Chapter II of the MMAM.</p> | | <p>Medicaid allows waiver services to be provided in addition to hospice services.</p> |
| <p>43.06</p> <p><u>POLICIES AND PROCEDURES</u></p> | | |
| <p>43.06-1</p> <p>Recipient Service Provision Rights</p> <p>Recipient of hospice services in no way affects the rights afforded to residents of a nursing facility under Chapter II, Section 67, including those relating to transfer and discharge, status change notification and hearings and appeals.</p> <p>The election of hospice by a recipient, however, in no way diminishes the responsibility of the recipient or nursing facility to obtain required prior authorization, or to comply with eligibility requirements for nursing facility placement.</p> | <p><u>204.2 Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries.</u></p> <p>A Medicare beneficiary who resides in an SNF and NF may elect the hospice benefit if:</p> <ol style="list-style-type: none"> (1) The residential care is paid for by the beneficiary; or (2) The beneficiary is eligible for Medicaid and the facility is being reimbursed for the beneficiary’s care by Medicaid, and (3) The hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the individual’s hospice care and the facility agrees to provide room and board to the individual. <p>The state Medicaid agency pays the hospice the daily amount allowed by the State for room and board while the patient is receiving hospice care, and the hospice pays the facility. Room and board services include the performance of personal care services, administration of medicine, maintaining the cleanliness of a resident’s room and supervising and assisting in the use of durable medical equipment and prescribed</p> | |

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| | <p>therapies. Whenever Medicaid is involved, send a copy of the election from the State Medicaid agency at the time of election, and also notify this agency when the patient is no longer receiving hospice care. In States that office the hospice benefit under the Medicaid program, dually eligible beneficiaries must elect the benefit under both programs at once.</p> | |
| <p>43.06-2</p> <p>Recipient Status Change</p> <p>A. Notification of the following changes in consumer status must be provided to the Department.</p> <ul style="list-style-type: none"> ? Admissions to or discharge from a nursing facility. ? Transfer from one nursing facility to another. ? Entry into or exit from hospice status. ? Transfer from one hospice to another. ? Recipient death. <p>B. As applicable, the following forms must be used:</p> <ul style="list-style-type: none"> ? Notice of Consumer Transfer/Death BMS/CS-34 ? Election/Revocation of Hospice. ? Certification of Terminal Illness. <p>C. Hospice Enrollee in a nursing facility This section delineates who is responsible for submitting notification for hospice recipients who are in a NF.</p> <p>1. When the change of status involves only the nursing facility, the NF must submit information as outlined in Chapter II, Section 67, of the MMAM</p> <p>2. When the change of status involves only the hospice (including, but not limited to, election/revocation) the hospice must submit the appropriate election or revocation form.</p> <p>3. When the change of status is a transfer from one hospice to another, the hospice to which the recipient is moving must submit the BMS43 form.</p> | | |

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| <p>4. When the change of status involves both the hospice and the nursing facility (e.g. patient death) the NF is responsible for submitting the BMS-34 form.</p> <p>D. Recipients who are hospice only.</p> <p>When the change of status is a transfer from one hospice to another, the hospice to which the recipient is moving must submit the BMS-34 form.</p> | | |
| <p>43.06-3</p> <p>Professional and Other Qualified Staff</p> <p>The hospice is responsible for the verification of appropriate licensure, certification or other qualifications of hospice state and for monitoring service providers. The hospice must maintain documentation of qualifications of service providers</p> <p>Staff must meet orientation and training requirements outlined in hospice licensing regulations.</p> <p>A. The following professionals, employed directly or by contact with a hospice , by virtue of possession of a current license to which practice their discipline in the State of Maine or state or province in which the service is provided, may provide hospice services within the scope of their license</p> <ol style="list-style-type: none"> 1. Physician 2. Registered Nurse 3. Practical Nurse 4. Clinical, Dietary and Pastoral Counselors. 5. Physical Therapist 6. Physical Therapist Assistant 7. Occupational Therapist Registered.(OTR) 8. Certified Occupational Therapy Assistant. (COTA) 9. Medical Social Worker 10. Speech-Language Pathologist 11. Speech-Language Pathologist Assistant <p>B. The following staff, employed directly or by contact with a hospice, may provide hospice services within a scope of their</p> | <p><u>418.72 Licensure</u></p> <p>The hospice and all hospice employees must be licensed in accordance with applicable Federal, State and local laws and regulations.</p> <p>(a) <i>Standard Licensure of program.</i> If State or local law provides for licensing of hospices, the hospice must be licensed.</p> <p>(b) <i>Standard: Licensure of employees.</i> Employees who provide services must be licensed, certified or registered in accordance with applicable Federal or State laws.</p> | |

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| <p>license or certification when they meet the following requirements:</p> <ol style="list-style-type: none"> 1. <u>Certified Home Health Aide and Certified Nurse's Assistant (CNA)</u> <p>A CNA or home health aide must be listed on the Maine Registry of Certified Nursing Assistants. A CNA or home health aide must be supervised as required by licensing required by licensing regulations.</p> <ol style="list-style-type: none"> 2. <u>Other Qualified Staff</u> <p>Other qualified staff are members, other than those defined above, who have been determined competent by a health care professional and documented by the hospice to have appropriate education, training, and experience for the task in the plan of care for which they have been hired.</p> | | |
| <p>43.06-4</p> <p style="text-align: center;">Written Plan of Care</p> <p>A plan of care must be established before services are provided. The plan of care must established by the attending physician, the hospice physician, and the Interdisciplinary Team. Services must be consistent with the plan of care to be reimbursed. The plan must be established on the same day as the assessment if the day of the assessment is to be a covered day of hospice care.</p> | <p><u>418.58 Plan of Care</u></p> <p>A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.</p> <ol style="list-style-type: none"> (a) <i>Standard: Establishment of Plan.</i> The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care. (b) <i>Standard: Review of Plan.</i> The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented. (c) <i>Standard: Content of plan.</i> The plan must include assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs. | |
| <p>43.06-5</p> <p style="text-align: center;">Recipient Record</p> <p>All hospices must maintain a clinical record for each recipient receiving care and services. The clinical record must include the</p> | <p><u>418.74 Central Clinical Records.</u></p> <p>In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.</p> | |

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| <p>following information:</p> <p>A. The plan of care;</p> <p>B. The recipient’s name, Medicaid ID, address, sex, age, and next of kin;</p> <p>C. Election/revocation forms;</p> <p>D. Pertinent history medical forms;</p> <p>E. Certification of terminal illness; and</p> <p>F. Complete documentation of all services and events, including: assessments progress notes and reviews of the plan of care. Progress notes must be maintained in conformance with Medicare conditions or participation.</p> | <p>(a) <i>Standard: Content.</i> Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services whether furnished directly or under arrangements made by the hospice. Each individual’s record contains –</p> <ol style="list-style-type: none"> (1) The initial and subsequent assessments; (2) The plan of care; (3) Identification data; (4) Consent and authorization and election forms; (5) Pertinent medical history; and (6) Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.). <p>(b) <i>Standard: Protection of Information.</i> The hospice must safeguard the clinical record against loss, destruction and unauthorized use.</p> | |
| <p>43.06-6</p> <p>Surveillance and Utilization Review</p> <p>The Department’s Bureau of Medical Services shall perform the Surveillance and Utilization Review activities set forth in Chapter I, General Administrative Policies and Procedures, of the MMAM.</p> <p>Upon request, the provider will furnish to the Department, with no additional charge, the clinical records, or copies thereof, corresponding to and substantiating services billed by that provider.</p> | | |
| <p>43.07</p> <p><u>REIMBURSEMENT</u></p> | | |
| <p>43.07-1</p> <p>Levels of Care</p> <p>There are four levels of care into which each day of care is classified:</p> <ul style="list-style-type: none"> ? Routine Home Care ? Continuous Home Care ? Inpatient Respite Care ? General Inpatient Care | <p><u>402 Levels of Care</u></p> <p>There are four levels of care into which each day of care is classified:</p> <ol style="list-style-type: none"> A. Routine Home Care B. Continuous Home Care C. Inpatient Respite Care D. General Inpatient Care <p>For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary</p> | <p>Medicaid states in 43.07-1C that respite care may not be provided when the patient is in a NF or other residential facility.</p> |

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| <p>For each day a recipient receives hospice care, the hospice will be reimbursed an amount applicable to the type and intensity of the services provided to the recipient for that day. For continuous home care, payment is determined based on the number of hours of continuous care furnished that day. A description of each level of care follows.</p> <p>A. <u>Routine Home Care</u> rate is billed for each day the recipient is under care of the hospice and not receiving one of the other categories of hospice care. This rate is paid regardless of the volume and intensity of routine home care services provided on any given day and is also paid when the patient is receiving hospital care for a condition unrelated to the terminal condition.</p> <p>B. <u>Continuous Home Care</u> is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or licensed practical nurse, and a nurse must be providing care for more than half of the period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day beginning at midnight. This care need not be continuous. For example, four (4) hours could be provided in the morning and another four (4) hours that evening. Homemaker and home health aide services may also be provided to supplement the nursing care. Continuous care is covered when it is provided to maintain an individual at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.</p> <p>C. <u>Inpatient Respite Care</u> is a day of care in which the eligible recipient receives care in an approved facility for short-term respite only when necessary to relieve the family members or others caring for the recipient at home. Respite care may be provided only occasionally and may not be reimbursed at the inpatient respite rate for more than five (5) consecutive days at a time. Payment for the sixth (6) and any subsequent day is at the routine home care rate. Respite care may not be provided when the patient is in a nursing home or any other residential facility.</p> | <p>for that day. For levels A, C, and D only one rate is applicable for each day. For level B, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows.</p> <p><u>402.1 Routine Home Care</u> The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving hospital care for a condition unrelated to the terminal condition.</p> <p><u>402.2 Continuous Home Care</u> The hospice is paid the continuous home care rate when continuous home care is provided. (See 230.2A.) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.</p> <p><u>402.3 Inpatient Respite Care</u> The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. (See 230.2B.) Payment for respite care may be made for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.</p> <p><u>402.4 General Inpatient Care</u> Payment at the inpatient rate is made when general inpatient care is provided. (See 230.1E.) None of the other fixed payment rates (i.e., routine home care) are applicable for a day on which the patient receives hospice inpatient care except as described in 402.5.</p> | |

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| <p>D. General Inpatient Care is a day of care when an eligible hospice patient receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.</p> | | |
| <p>43.07-2</p> <p>Reimbursement Policy</p> <p>Reimbursement for covered services shall be made on the basis of a per diem or hourly rate and shall be the lowest of:</p> <p>A. The amount established by the Department and listed in Chapter III, Section 43 of the Maine Medical Assistance Manual; or</p> <p>B. The lowest amount allowed under the Medicare Hospice benefit for covered services.</p> <p>In accordance with Chapter I of the Maine Medical Assistance Manual, the provider must seek payment from any other available sources before billing the Maine Medical Assistance Program. The Maine Medical Assistance Program shall not provide differential payments to hospices that have entered into reimbursement agreements with other payers.</p> | | <p>Medicaid states that Medicaid be the pay source of last resort in 43.07-2B.</p> |
| <p>43.07-3</p> <p>Payment For Physician Services</p> <p>The basic payment rates for hospice care, listed in Chapter III, Section 43 of the Maine Medical Assistance Manual, are designed to reimburse the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements with the hospice. These activities would generally be performed by the Medical Director and the physician on the Interdisciplinary Team.</p> | <p><u>406 Payment for Physician Services</u></p> <p>A. Administrative Activities – Payment of physicians' administrative and general supervisory activities is included in the payment rates listed in 403. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group.</p> <p>B. Patient Care Services – Payment for physicians' direct patient care services furnished by hospice employees or</p> | |

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| <p>Team activities would include, participation in developing plans of care, supervision of care and services, periodic review and update of plans of care and establishing governing policies. The cost for these services are included in the reimbursement rates for routine home care, continuous home care and inpatient respite care.</p> <p>Payment will be made to the hospice, when also enrolled in the Medicaid Program for Physician Services, for other physician's services not included in the reimbursement rates for routine home care, continuous home care and inpatient respite care. These include direct patient care services, furnished to individual patients by hospice employees and under arrangements made by the hospice, unless the patient care services were furnished on a volunteer basis. The hospice will be reimbursed in accordance with the usual Medicaid reimbursement policy for Physician Services in Chapter III, Section 90 of the Maine Medical Assistance Manual. This reimbursement is in addition to the daily rates.</p> | <p>under arrangement with the hospice is made in the following manner.</p> <ol style="list-style-type: none"> (1) Formulate a charge and bill the intermediary for these services. (2) The intermediary pays you at the lesser of the actual charge or 100 percent of the Medicare reasonable charge for these services. This payment is in addition to the daily rates. (3) Payment for physicians' services is counted with the payments made at the daily payment rates to determine whether the hospice cap amount has been exceeded. (4) No Payment is made for physician services furnished voluntarily. However, some physicians may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if you are obligated to reimburse the physician for the services. A physician must treat Medicare patients on the same basis as other patients in the hospice; a physician may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients. <p>C. Attending Physician Services – Payment for patient care services rendered by a physician designated by the hospice patient as the attending physician is made in the following manner:</p> <ol style="list-style-type: none"> (1) Patient care services rendered by an attending physician who volunteers services to the hospice is made in accordance with subsection B. (This is because physicians who volunteer services to the hospice are, as a result of this volunteer status, considered employees of the hospice in accordance with 42 CFR 418.3). (2) Patient care services rendered by an independent attending physician (a physician who is not considered employed or under contract with the hospice) are not part of the hospice benefit. These physicians bill the Medicare carrier directly. Payment for services to hospice patients is made directly by the carrier to the independent attending physician at 80 percent of the Medicare reasonable charge. <p>Only the independent attending physician's personal professional services to the patient may be billed; the costs for services such as lab or x-rays are not to be included in the bill.</p> | |

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| | <p>The hospice must notify the Medicare carrier of the hospice election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee. This reimbursement is not counted in determining whether the hospice cap amount has been exceeded because services provided by an independent attending physician are not part of the hospice's care. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.</p> | |
| <p>43.07-4</p> <p>Payment for Inpatient Care</p> <p>Payment for inpatient care is limited. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of reimbursable inpatient days (both for inpatient general care and respite care) shall be capped. The aggregate number of reimbursable inpatient days may not exceed twenty (20) percent of the aggregate days of hospice care provided to all Medicaid recipients during that twelve (12) month period by the hospice provider. Days on inpatient care provided to recipients with AIDS (acquired Immunodeficiency syndrome) may be excluded from the days counted toward the twenty (20) percent limit.</p> <p>If the total number of days of inpatient care furnished to Medicaid hospice recipients is less than or equal to the maximum, no adjustment shall be made. If the total number of days of inpatient care exceeds the maximum allowed number, excess payments must be refunded by the hospice to the Department.</p> <p>The hospice shall report to the Department the aggregate number of inpatient days (both for inpatient general care and inpatient respite care) and the aggregate number of days of hospice care provided to all Medicaid recipients during the "cap" period. The report shall be sent by January 1st following the end of the period (October 31 of the pervious year) to:</p> | <p><u>405 Limitation on Payments for Inpatient Care</u></p> <p>Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period. This limitation is applied once each yeat, at the end of the hospices' "cap period" (11/1 – 10/31). For purposes of this computation, if the intermediary determines that the inpatient rate should not be paid, any days for which you receive payment at a home care rate are not counted as inpatient days. The limitation is calculated by your intermediary as follows:</p> <ol style="list-style-type: none"> (1) The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.2. (2) If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary. (3) If the total number of days of inpatient exceeded the maximum allowable number, the limitation is determined by: <ol style="list-style-type: none"> (a) calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made. (b) multiplying excess inpatient care days by the routine home care rate. | |

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| <p>Hospice Program Division of Financial Services -Long Term Care Reimbursement Bureau of Medical Services 11 State House Station Augusta, ME 04333-0011</p> | <p>(c) adding together the amounts calculated in a. and b. above. (d) comparing the amount in c. above with interim payments made to the hospice for inpatient care during the “cap period” Any excess reimbursement is refunded by the hospice.</p> | |
| <p>43.07-5</p> <p>Payment Based on Location Where Care is Provided</p> <p>Hospice providers must submit claims for payment for hospice care furnished in a recipient’s home or a nursing facility based on the place of service, rather than the location of the hospice.</p> | | |
| <p>43.08</p> <p><u>BILLING</u></p> <p>Billing must be accomplished in accordance with the Department’s billing requirements as set forth in “Billing Instructions for Hospice Services”.</p> | | |