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A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. The care need not be continuous (such as, four hours can be provided in the morning and another four hours can be provided in the evening of that day). Homemaker and home health aide services can also be provided to supplement the nursing care.

Inpatient care

This type of care is provided only when necessary to relieve family members or other persons caring for the individual at home. It may not be reimbursed for more than five consecutive days at a time and may be provided only on an occasional basis. A hospice patient may enter a NF which has contracted with the hospice for the purposes of receiving respite care.

Certification that the beneficiary is terminally ill must be completed and filed with the hospice providing care. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. A plan of care must be established before services are provided. To be covered, services must be designated in the plan of care.

In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care. At least one of the persons involved in developing the initial plan of care must be a nurse or physician.

Other insurance is primary and must be billed first.

Hospice Care for Children in Medicaid

Beneficiaries receiving services reimbursed by Medicaid and Children's Health Insurance Program (CHIP) can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services. Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or CHIP.

The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit. This new provision requires states to make hospice services available to children eligible for Medicaid and Medicaid-expansion CHIP programs without terminating any other service which the child is entitled to under Medicaid for treatment of the terminal condition.

Limitations

The 210-day-per-lifetime hospice limitation does not apply to children receiving hospice services. Hospice patients 0 through 20 years of age can receive necessary hospice services for the duration needed. The 210-day-per-lifetime limitation will begin on the beneficiary's 21st birthday.

Medical services and concurrent care for children receiving hospice services

Children receiving hospice services can continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition. PA is still required.

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If PA cannot be obtained prior to rendering the service, providers will be given a total of 15 days to submit a paper claim for the service, with documentation attached to support medical necessity. Providers must submit paper claims and documentation of medical necessity to the PA team for review.

Hospice patients (0 through 20 years of age) can receive the services identified below as long as the services are not duplicative of services provided by the hospice facility.

- Case management services when provided and billed by an ARNP enrolled in KMAP
- Technology Assisted (TA) waiver program attendant care services

Note: Hospice providers will continue to be responsible for all durable medical equipment and supplies.

Reimbursement criteria

KHPA Medical Plans reimbursement for hospice care will be made at one of four predetermined rates for each day in which a beneficiary is under the care of the hospice. Physician services in excess of hospice physician services will be billed and reimbursed in accordance with the benefits and limitations of KHPA Medical Plans. There will be one attending physician designated for each hospice beneficiary.

Routine home care

The hospice is reimbursed at the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. The rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

Continuous home care

The hospice is reimbursed at a continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 in order to arrive at an hourly rate. A minimum of eight hours per day must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

Inpatient respite care

The hospice is reimbursed at the inpatient respite care rate for each day the beneficiary is in an inpatient facility, as previously defined, and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time (including the date of admission, but excluding the date of discharge) at the respite care rate. Payment for the sixth and subsequent days of respite care is made at the routine home care rate.

General inpatient care

Payment at the inpatient rate is made when general inpatient care is provided. None of the other fixed payment rates are applicable for a day on which the patient receives hospice inpatient care, except for the day of discharge from an inpatient unit when the appropriate home care rate is to be paid. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

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Services not related to the terminal illness

Services for illnesses or conditions not related to the terminal illness of the beneficiary and which are usually covered are considered separately. They may be reimbursed with PA (refer to Section 4300 of the *General Special Requirements Provider Manual*) if the service is determined to be unrelated to the terminal illness of the patient.

Swing bed

When a beneficiary has elected hospice and the beneficiary is in a swing bed, the hospice is to bill procedure code T2046 and the payment will be reimbursed at 95% of the hospital's swing bed rate. Indicate "Beneficiary in swing bed facility" in field 19 for paper claims or in the narrative box for electronic claims.

Note: The Medicaid hospice benefit is limited to 210 days per lifetime, regardless of provider or place of service.

Transportation services for hospice beneficiaries

Transportation to hospice-related services is the responsibility of the hospice provider. Medical services unrelated to hospice treatment or diagnosis may be covered if medical criteria are met.

Waiver of rights to Medicaid payment

The beneficiary waives all rights to the KHPA Medical Plans payments for the duration of the election of hospice care for the following services:

- Any KHPA Medical Plans-covered services that are either:
    - Related to the treatment of the terminal condition for which hospice care was elected or a related condition
    - Equivalent to hospice care **except** for services:
        - Provided directly or under arrangement by the designated hospice
        - Provided by another hospice under arrangement by the designated hospice
        - Provided by the beneficiary's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services
- Hospice care provided by a hospice other than the hospice designated by the beneficiary