HOSPICE SERVICES

Brief Coverage Statement

Hospice services are a program of palliative, supportive and interdisciplinary services that provides physical, psychological, sociological and spiritual care to terminally ill clients and his or her families. Colorado Medicaid covers Hospice services provided in a client's place of residence, which includes any private or other residence in which the client wishes to receive care. Other settings may include but are not limited to a licensed Hospice facility, inpatient hospital, Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID), nursing facility (NF), Individual Residential Services & Supports (IRSS) Host Homes and Settings and Group Residential Services & Supports (GRSS).

Medicaid clients enrolled in Colorado Medicaid managed care organizations (MCOs) do not receive Hospice services from his or her MCO. Clients enrolled in a MCO may receive Hospice services through Medicaid fee-for-service as a wrap-around benefit.

Medicaid clients enrolled in a Colorado Medicaid home and community-based services (HCBS) waiver may receive Hospice services.

Services Addressed in Other Benefit Coverage Standards

- None

Eligible Providers

Only Hospices licensed by the Colorado Department of Public Health and Environment that are Medicare certified as being in compliance with the conditions of participation for a Hospice as set forth at 42 C.F.R. Sections 418.50 through 418.98 and 42 C.F.R. Section 418.100 (a)-(c) are eligible providers.

Hospice services shall be performed by appropriately qualified personnel, including:

1. Physicians who are a doctor of medicine or osteopathy licensed in accordance with the Colorado Medical Practice Act (CRS 12-36-102);
2. Advanced Practice Nurses and Physician Assistants licensed in accordance with the Colorado Nurse Practice Act and the Colorado Medical Practice Act.
3. Registered Nurses (RN) and Licensed Practical Nurses (LPN), licensed in accordance with the Colorado Nurse Practice Act (CRS 12-38-1010);
4. Physical therapists who are licensed in accordance with the Colorado Physical Therapy Practice Act (CRS 12-41-101);

5. Occupational therapists who are licensed in accordance with the Colorado Occupational Therapy Practice Act (CRS 12-40.5-101);
6. Speech language pathologists who are certified by the American Speech-Language-Hearing Association (ASHA);
7. Licensed clinical social workers who have a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education, or a baccalaureate degree in psychology, sociology, or other field related to social work and who are supervised by a social worker with a Master's Degree in Social Work and who have one year of social work experience in a health care setting;
8. Hospice aides who are nurse's aides certified in accordance with the Colorado Nurse Aide Practice Act (CRS 12-38.1) and who have appropriate training. At the option of the Hospice provider, homemakers with appropriate training may provide homemaking services, which is included as a component of Hospice services;
9. Hospice volunteers who have received volunteer orientation and training that is consistent with Hospice industry standards; and
10. Members of the clergy or religious support services.

Counseling services may be provided by any member of the Hospice Interdisciplinary Team acting within the scope of his or her license, as determined by the Hospice provider.

Laboratory services provided by Hospices are subject to the requirements of the Clinical Laboratory Improvement Act of 1967 (CLIA). Hospices shall obtain a CLIA waiver from the Department of Public Health and Environment to perform laboratory tests. A Hospice provider that collects specimens, including drawing blood, but does not perform testing of specimens is not subject to CLIA requirements.

Eligible Place of Service

Hospice services are provided in a client's place of residence, which includes:

1. A residence such as, but not limited to, a house, apartment or other living space that the client resides within;
2. An assisted living residence including an alternative care facility (an assisted living residence enrolled as a Medicaid provider);
3. A temporary place of residence such as but not limited to a relative's home or a hotel. Temporary accommodations may include homeless shelters or other locations provided for a client to receive services for clients who have no permanent residence;
4. Other residential settings such as a group home or foster home;
5. A licensed Hospice facility or NF; or
6. An Intermediate Care Facility for the Intellectually Disabled (ICF/ID) or Individual Residential Services & Supports (IRSS) Host Homes, Settings and Group Residential Services & Supports (GRSS).

Medicaid does not reimburse Hospice services provided in hospitals except when the client has been admitted for respite services.

NURSING FACILITIES

Hospice services may be provided to a client who resides in a Medicaid-participating NF. However, when a client residing in a NF elects Hospice services, the client is considered a Hospice client and is no longer a NF client with the exception of the facility's responsibility to provide room and board to the client.

In order for a client to receive Hospice services while residing in the facility, the Hospice provider shall:

1. Notify the NF that the client has elected Hospice and the expected date that Hospice services will commence
2. Ensure the NF concurs with the Hospice plan of care;
3. Ensure the facility is Medicaid and Medicare certified; and
4. Execute an agreement with the NF.
   4.1. The written agreement must include, at a minimum, the following:
      4.1.1. The means through which the NF and the Hospice will communicate with each other and document these communications to ensure that the needs of clients are addressed and met 24 hours a day;
      4.1.2. Agreement on the client's Hospice service plan of care by the NF staff;
      4.1.3. A means through which changes in client status are reported to the Hospice and NF;
      4.1.4. The Hospice provider is considered the primary provider and is responsible for any necessary routine care or continuous care necessary related to the terminal illness and related conditions;
      4.1.5. A provision stating that the Hospice provider assumes responsibility for determining the appropriate course of Hospice care, including the determination to change the level of services provided;
      4.1.6. An agreement that it is the NF provider's responsibility to continue to furnish 24 hour room and board care, meeting the personal care, durable medical equipment and nursing needs that would have been provided by the NF at the same level of care provided prior to Hospice services being elected;
      4.1.7. An agreement that it is the Hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the client were residing in his or her own residence;
      4.1.8. A provision that the Hospice provider may use the NF personnel where permitted by State law and as specified by the agreement, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the

Hospice provider would routinely use the services of a client's family in implementing the plan of care;

4.1.9. The NF remains responsible for compliance with mandatory reporting of such violations or alleged violations to the State's protective services agency. As such, the Hospice provider and its staff or subcontractors shall report all alleged violations of a client's person involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client property to the NF administrator within 24 hours of the Hospice becoming aware of the alleged violation;

4.1.10. Bereavement services that the Hospice will provide to the NF staff;

4.1.11. The amount to be paid to the NF or ICF/MR by the Hospice provider; and

4.1.12. An agreement describing whether the Hospice or the NF will be responsible for collecting the client's financial contribution for his/her care.

ICF/ID, IRSS AND GRSS

Hospice services may be provided to a client who resides in a Medicaid-participating ICF/ID, IRSS or GRSS residential settings. When a client resides in one of the settings, the client remains a resident of the ICF/ID, IRSS or GRSS residence. The Hospice provides services as if treating a client in his or her place of residence. The Hospice is not responsible for reimbursing the ICF/ID, IRSS or GRSS for the client's room and board.

In order for a client to receive Hospice services while residing in these settings, the Hospice provider shall work with the ICF/ID, IRSS or GRSS to:

1. Notify the ICF/ID, IRSS or GRSS that the client has elected Hospice and the expected date that Hospice services will commence
2. Ensure the ICF/ID, IRSS or GRSS concurs with the Hospice plan of care;
3. Determine what are the responsibilities covered under the ICF/ID, IRSS or GRSS so that the Hospice does not duplicate service (to include medication and supplies). Including:
   3.1. An agreement that the Hospice will be responsible to provide services at the same level and to the same extent as those services would be provided if the client were residing in his or her private residence; and
   3.2. An agreement of the services the ICF/ID, IRSS or GRSS personnel will perform, where permitted by State law, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the Hospice provider would routinely use the services of a client's family in implementing the plan of care;
4. Develop a coordinated plan of care to ensure that the client's needs are met;
5. Develop a communication plan through which the Hospice and the ICF/ID, IRSS or GRSS will communicate changes in the client's condition or changes in the client's care plan to ensure that the client's needs are met; and
6. Ensure bereavement services are available to the staff and caregivers of client.

SETTINGS OTHER THAN NURSING FACILITIES AND ICFS/ID

The Hospice provider and assisted living residence or a foster home shall develop an agreement related to the provision of care to the client, including:

1. Hospice staff access to and communication with staff or caregivers in these facilities or homes;
2. Developing an integrated plan of care;
3. Documenting both respective entities' records or other means to ensure continuity of communication and easy access to ongoing information;
4. Role of any Hospice vendor in delivering supplies or medications;
5. Ordering, renewing, delivering and administering medications;
6. Role of the attending physician and process for obtaining and implementing orders;
7. Communicating client change of condition; and
8. Changes in the client's needs that necessitate a change in setting or level of care.

Eligible Clients

Medicaid clients qualify for Hospice services when they meet all of the following requirements:

1. The client has been certified as being terminally ill with a life expectancy of nine months or less should the illness run its normal course by a physician and/or the Hospice's medical director;
2. The client has agreed to cease any and all curative treatment. (Client's ages 20 and younger are exempt from this requirement.)
3. Clients who do not meet eligibility requirements for State Plan Medicaid may be eligible for Medicaid through the long-term care eligibility criteria, which may require the client to pass a level of care assessment through a designated case management agency.

General Requirements

Medicaid covers Hospice services when:

1. The Hospice services are medically necessary and reasonable for the palliation or management of the terminal illness as well as any related condition
2. Services are not for the prolongation of life (clients ages 20 and under are exempt from this requirement);
3. The client has voluntarily elected Hospice services and has signed and dated the Hospice election form;
4. An initial plan of care has been established by the Hospice provider in collaboration with the client and anyone else that the client wishes to have present for care planning. , When the

client is unable to direct his or her own care, care planning must involve the client's family/caregiver; and

5. For Hospice clients residing in a NF, ICF/ID IRSS or GRSS, the client meets both the Hospice requirements and the requirements for receipt of those Medicaid-covered services.

Provider Responsibilities

CORE SERVICES

A Hospice must routinely provide all core services by staff employed by the Hospice. These services must be provided in a manner consistent with acceptable standards of practice. Core services include nursing services, certified nursing assistant, medical social services, and counseling.

The Hospice may contract for physician services. The contracted provider(s) will function under the direction of the Hospice provider's medical director.

A Hospice provider may use contracted staff, if necessary, to supplement Hospice employees in order to meet the needs of the client. A Hospice may also enter into a written arrangement with another Colorado Medicaid and Medicare certified Hospice program for the provision of core services to supplement Hospice employee/staff to meet the needs of clients. Circumstances under which a Hospice may enter into a written arrangement for the provision of core services include:

1. Unanticipated periods of high client loads, staffing shortages due to illness or other short-term, temporary situations that interrupt client care;
2. Temporary travel of a client outside of the Hospice's service area; and
3. When a client resides in a NF, ICF/ID, IRSS or GRSS.

CLIENT ELIGIBILITY FOR MEDICARE

The Hospice provider shall ensure, prior to the provision of Medicaid Hospice services, that clients are evaluated to determine whether or not they are Medicare eligible. Hospice services are not covered by Medicaid during the period when a client is Medicare eligible, except for clients residing in a NF in which case Medicaid pays to the Hospice provider an amount for room and board.

Because Medicare Hospice election may not occur retroactively, clients with retroactive Medicare eligibility may receive Medicaid covered services during the retroactive coverage period. The Hospice provider shall make reasonable efforts to determine a client's status concerning Medicare eligibility or a client's application for Medicare and shall maintain documentation of these efforts. These efforts shall include routine and regular inquiry to determine Medicare eligibility for clients who reach the age of sixty-five and regular inquiry for

clients who indicate they receive Supplemental Security Disability Income (SSDI) and are approaching the 24th month of receipt of SSDI. See the Hospice election section for more information.

Clients who are eligible for Medicare and Medicaid must elect Hospice services under both programs.

If a client becomes eligible for Medicaid while receiving Medicare Hospice benefits, Medicare Hospice coverage continues under its current election period and Medicaid Hospice coverage begins at Medicaid's first election period.

INDIVIDUAL CLIENT RECORD

The Hospice provider shall maintain an individual client record that includes:

1. Documentation of the client's eligibility for, and election, of Hospice services including the physician certification and recertification of terminal illness;
2. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;
3. Medicaid provider orders; and
4. Documentation to support the care level for which the Hospice provider has claimed reimbursement.

NOTICE OF CLIENT'S ELECTION OF HOSPICE

The Hospice provider shall ensure a client, or his or her legally authorized representative, completes the Hospice election form prior to or at the time Medicaid Hospice services are provided.

The Hospice provider shall provide a client's election form and documentation of the client's Hospice benefit periods upon request by the Department or its designated entities.

INTERDISCIPLINARY TEAM

The Hospice provider shall designate an interdisciplinary team(s) composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the clients and his or her family facing terminal illness and bereavement. Interdisciplinary team members must provide the care and services offered by the Hospice, and the group, in its entirety, must supervise the care and services.

The interdisciplinary team that includes, but is not limited to:

1. A doctor of medicine or osteopathy, advanced practice nurse, or physician assistants (who is an employee or under contract with the Hospice);

2. A registered nurse or licensed practical nurse;
3. A social worker;
4. A pastoral or other counselor; and
5. The Volunteer Coordinator or designee.

COORDINATION OF CARE

The Hospice provider shall designate a member of the interdisciplinary team to provide coordination of care and to ensure continuous assessment of each client's and family's needs and implementation of the interdisciplinary plan of care. The designated member shall oversee coordination of care with other medical providers and agencies providing care to the client.

CERTIFICATION OF NEED AND THE INTERDISCIPLINARY PLAN OF CARE

All Hospice care and services furnished to clients and his or her families must follow an individualized written plan of care established by the Hospice interdisciplinary team in collaboration with the client's primary provider (if any), the client or his or her representative, and the primary caregiver in accordance with the client's needs and desires.

The plan of care shall be established prior to providing Hospice services and shall be based on a medical evaluation and the written assessment of the client's needs and the needs of the client's primary caregiver(s).

The plan of care shall be maintained in the client's record and must specify:

1. The client's medical diagnosis and prognosis;
2. The medical and health related needs of the client;
3. The specific services to be provided to the client through the Hospice and when necessary the NF, ICF/ID, IRSS or GRSS;
4. The amount, frequency and duration of these services; and
5. The plan of care review date.

The plan of care shall be reviewed as needed but no less frequently than every 15 days. The interdisciplinary team leader shall document each review. The interdisciplinary team members including the Medicaid provider who is managing the client's care shall sign the plan of care.

Certification That a Client Has a Terminal Illness

The Hospice provider shall obtain certification that a client is terminally ill in accordance with the following procedures.

For the first benefit period of Hospice services coverage (the initial 90-day period, which is the first 90 days during which the client receives Medicaid-covered Hospice services or when the client re-elects Hospice services following revocation or termination of Hospice services), the Hospice provider shall obtain a written certification signed by either the Hospice provider's medical director or a physician member of the Hospice interdisciplinary team and the client's primary provider. The written certification shall be obtained within two calendar days after Hospice services are initiated. The written certification shall include:

1. A statement of the client's life expectancy including diagnosis of the terminal condition, other health conditions whether related or unrelated to the terminal condition, and current clinically relevant information supporting the diagnoses and prognosis for life expectancy and terminal illness; and
2. The Hospice provider(s) approval for Hospice services for the client.

If written certification cannot be obtained within two calendar days after Hospice services are initiated, a verbal certification statement from either the medical director of the Hospice or the physician member of the Hospice interdisciplinary team and the client's primary provider shall be obtained, documented in the client's record, and shall include the information required for a written certification. As soon as possible following verbal certification, the Hospice provider shall obtain written certification and shall file this certification in the client's record prior to submitting a claim for payment.

At the beginning of each subsequent benefit period, the Hospice provider shall obtain a written re-certification prepared by either the attending physician, the medical director of the Hospice or the physician member of the Hospice interdisciplinary team.

Election of Hospice

A client elects Hospice services for a specific benefit period, which is:

1. An initial 90-day period.
2. A subsequent 90-day period.
3. An unlimited number of subsequent 60-day periods.

The periods of care are available in the order listed and each period may be elected separately at different times (for example, the subsequent 90-day period is not required to be elected immediately following the initial period).

The client or client's representative shall file an election statement with the Hospice provider that shall be maintained in the client's record and shall include:

1. The name of the Hospice provider selected/designated by the client or client representative. A client must choose only one Hospice provider as the designated Hospice provider;
2. Acknowledgment that the client or client representative has been fully informed of the palliative rather than curative nature of Hospice services;

3. Designation by the client or client representative of the effective date for the election period. The effective date of service provision may be the same or a later date but not before the Hospice services election date designated on the election statement;
4. An acknowledgement that for the duration of the Hospice services, the client waives all rights to Medicaid payments for the following services:
   4.1. Hospice services provided by a Hospice other than the Hospice provider designated by the client (unless provided under arrangements made by the designated Hospice provider).
   4.2. Any Medicaid services that are related to the treatment of the terminal condition and related conditions for which Hospice services were elected:
      4.2.1. Provided by the designated Hospice provider;
      4.2.2. Provided by another Hospice under arrangements made by the designated Hospice;
      4.2.3. Provided by the client's primary provider if that provider is not an employee of the designated Hospice or receiving compensation from the Hospice for those services or
      4.2.4. Services provided to clients ages 20 and under.
5. A signature of either the client or client representative as allowed by Colorado law.

An election of Hospice services continues as long as the client is eligible for Hospice services, there is no break in care and the client remains with the designated Hospice provider.

COORDINATION OF CARE FOR CLIENTS ENROLLED IN A HCBS WAIVER

Hospice services may be provided to a client who is enrolled in one of the Colorado Medicaid home and community-based services (HCBS) waivers, including the children with life limiting illness waiver. HCBS waiver services may be provided for conditions unrelated to the client's terminal diagnosis. HCBS waiver services may also be provided to the client when these services are not duplicative of the services that are the responsibility of the Hospice provider.

The Hospice provider shall notify the HCBS waiver case manager or support coordinator of the client's election of Hospice services and the anticipated start date. The Hospice provider shall coordinate Hospice services and HCBS waiver services with the HCBS waiver case manager or support coordinator and shall document coordination of these services in the client's record. Documentation shall include:

1. Identification of the Hospice services that will be provided;
2. Identification of the HCBS waiver services that will be provided under the waiver; and
3. Integration of Hospice services and HCBS waiver services in the Hospice plan of care.

The Hospice provider shall invite the HCBS waiver case manager or support coordinator to participate in the interdisciplinary team meetings for the client when possible.

CLIENT AND PRIMARY CAREGIVER TRAINING

The Hospice provider shall ensure that each client and his or her primary care giver(s) receive education and training provided by the Hospice provider as appropriate based on the client's and primary care giver(s)' responsibilities for the care and services identified in the plan of care.

DISCHARGE PLANNING

The Hospice provider shall have in place a discharge planning process that takes into account the prospect that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as terminally ill. The discharge planning process shall include planning for any necessary family counseling, client education, or other services before the client is discharged because they are no longer terminally ill.

A Hospice provider may discharge a client when:

1. The client moves out of the Hospice provider's service area or transfers to another Hospice provider;
2. The Hospice provider determines that the client is no longer terminally ill; or
3. The Hospice provider determines, under a policy set by the Hospice for the purpose of addressing discharge for cause that meets the requirements of 42 C.F.R. Section 418.26, that the client's behavior (or the behavior of another person in the client's home) is disruptive, abusive, or uncooperative to the extent that delivery of care or the Hospice provider's ability to operate effectively is seriously impaired.
    3.1. The Hospice provider shall advise the client that a discharge for cause is being considered, make a serious effort to resolve the problem presented by the situation, ascertain that the proposed discharge is not due to the client's use of necessary Hospice services, document the problem and the effort made to resolve the problem, and enter this documentation into the client's record.

In the event that discharge is necessary, the Hospice provider shall:

1. Obtain a written discharge order from the Hospice provider's medical director prior to discharging a client for any of the reasons in this section;
2. Implement the discharge planning process to ensure to the maximum extent feasible, that the client's needs for health care and related services upon termination of Hospice services will be met;
3. Document that the client's primary provider was involved in the client's care, has been consulted about the termination of Medicaid-covered Hospice services and include the attending physician's review and decision in the discharge note;
4. Document, to the extent possible, client or client's authorized representative was involved in the discharge planning; and
5. Document, to the extent possible, the transition plan for the client.

PAYMENT

The Hospice provider is also responsible for paying for medications, durable medical equipment, and medical supplies needed for the palliation and management of the client's terminal illness.

Revocation of Hospice Election

A client or client representative may revoke the election of Hospice services by filing a signed statement of revocation with the Hospice provider. The statement shall include the effective date of the revocation. The client shall not designate an effective date earlier than the date that the revocation is made. Revocation of the election of Hospice services ends the current Hospice benefit period (i.e., the client forfeits Medicaid or Medicare coverage of Hospice services for any remaining days in an election period). Clients who are dually eligible for Medicare and Medicaid must revoke Hospice services under both programs.

The client may re-elect to receive Hospice services at any time after a client elects to revoke Hospice services or after Hospice services are discontinued due to loss of eligibility for Medicaid-covered Hospice services, should the client thereafter become eligible.

Client Change of Hospice Provider

The client may change the designation of the Hospice provider once each benefit period. A change in designation of Hospice provider is not a revocation of the client's Hospice services election. To change the designation of the Hospice provider the client shall file a statement with the current and new provider, which includes:

1. The name of the Hospice provider from which the client is receiving care and the name of the Hospice provider from which he or she plans to receive care;
2. The date the change is to be effective; and
3. The signature of the client or client representative.

An election of Hospice services continues as long as there is no break in care, the client remains eligible for services and the client remains with the elected Hospice provider.

Covered Services and Billing Guidelines

Hospice services are delivered and reimbursed in one of four predetermined service types with their associated reimbursement rates, which are:

1. Routine home care;
2. Continuous home care;
3. Inpatient respite care; or

4. General inpatient care.

If no other level of care is indicated on a given day, it is presumed that routine home care is the applicable service type.

Routine Home Care Rate

The routine home care rate is reimbursed for each day the client is in his or her place of residence and is not receiving continuous home care. This rate is paid without regard to the volume or intensity of home care services provided. This is the service type that shall be utilized when a client resides in a NF, ICF/ID, IRSS or GRSS unless the client is in a period of crisis.

Continuous Home Care Rate

The continuous home care rate is reimbursed when continuous home care is provided during a period of medical crisis to maintain a client at home. A period of crisis is a period in which a client requires continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. The Hospice nurse (either a registered nurse or a licensed practical nurse) shall provide more than half of the billed continuous home care hours. Homemaker and Hospice aide services may also be provided to supplement nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours shall be provided. For every hour or part of an hour of continuous care furnished, the hourly rate shall be reimbursed up to 24 hours a day. Continuous home care shall not be utilized when a client resides in a NF, ICF/ID, IRSS or GRSS unless the client is in a period of crisis.

Inpatient Respite Care Rate

The inpatient respite care rate is paid for each day on which the client is in an approved inpatient facility for respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission to the inpatient facility 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. Payment for inpatient respite care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in the section entitled “Aggregate Cost Cap.”

General Inpatient Rate

The general inpatient rate is paid only during a period of medical crisis in which a client requires 24 hour continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Payment for general inpatient care is subject to the Hospice provider's 20 percent aggregate inpatient days cap as outlined in the section entitled “Aggregate Cost Cap.”

Aggregate Cost Cap

Aggregate payment to the Hospice provider is subject to an annual indexed aggregate cost cap. The method for determining and reporting the cost cap is identical to the Medicare Hospice benefit requirements as contained in 42 C.F.R. Sections 418.308 and 418.309.

Aggregate days of care provided by the Hospice are subject to an annual limitation of no more than 20 percent general and respite inpatient care days. The method for determining and reporting the inpatient days percentage is identical to the Medicare Hospice benefit requirements as contained in 42 C.F.R. Section 418.302. Inpatient days in excess of the 20 percent limitation shall be reimbursed at the routine home care rate.

The Hospice provider shall not collect co-payments, deductibles, cost-sharing or similar charges from the client for Hospice care benefits including biological and respite care. The Hospice provider shall submit all billing to the Medicaid fiscal agent within the timeframes and in the form the Department requires.

Payment for Clients Residing in a Nursing Facility

For clients who reside in a NF during any part of their Hospice election period(s), Medicaid reimburses 95% of the facility per diem amount (less the client's financial responsibility) for room and board. The Hospice provider is responsible to bill Medicaid for the room and board reimbursement. Once this reimbursement is received, the Hospice must pass the room and board reimbursement to the NF. Payments for room and board are exempt from the computation of the Hospice payment cap.

The Hospice provider is also reimbursed for routine home care or continuous home care provided to clients residing in a NF. If a client is dually-eligible and the Hospice client resides in a NF, Medicare reimburses the Hospice services, and Medicaid reimburses for room and board.

Clients who are eligible for Post Eligibility Treatment of Income (PETI) shall be eligible for PETI payments while receiving services from a Hospice provider. The Hospice provider shall submit claims on behalf of the client and NF.

Reimbursement for Date of Discharge

Reimbursement for date of discharge shall be made at the appropriate home care rate for the day of discharge from general or respite inpatient care, unless the client dies at an inpatient level of care. When the client dies at an inpatient level of care, the applicable general or respite inpatient rate is paid for the discharge date.

Reimbursement for NF residents is made for services delivered up to the date of discharge when the client is discharged, alive or deceased, including applicable per diem payment for the date of discharge.

Reimbursement Rates

The Department published the Medicaid Hospice reimbursement rates annually. Reimbursement rates are determined by the following:

1. Each care-level per-diem rate is subject to a wage index multiplier, to compensate for regional differences in wage costs, plus a fixed non-wage component.
2. The Hospice wage indices are published annually by October 1 in the Federal Register.
3. Rates are adjusted for cost-of-living increases and other factors as published by the Centers for Medicare and Medicaid Services.
4. Continuous home care is reimbursed at the applicable hourly rate (the per-diem rate divided by 24 hours) multiplied by the number of hourly units billed, from 8 up to 24 hours per day of continuous care (from midnight to midnight).
5. Reimbursement for routine home care and continuous home care is based on the geographic location at which the service is furnished and not on the business address of the Hospice provider.

Note: Specific billing instructions for submission and processing of claims is provided in the Hospice billing manual available on the billing manuals page for download from: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542320888.

Covered Services and General Limitations

Covered Hospice services include, but are not limited to:

1. Nursing care provided by or under the supervision of a registered nurse;
2. Medical social services provided by a qualified social worker or counselor under the direction of a physician;
3. Counseling services, including dietary and spiritual counseling, provided to the client and his or her family members or other persons caring for the client;
4. Bereavement counseling delivered through an organized program under the supervision of a qualified professional. 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 client);
5. Short-term general inpatient care necessary for pain control or symptom management;
6. Short-term inpatient care of up to five consecutive days to provide respite for the client's family or other home caregiver;

7. Medical appliances and supplies, including drugs and biologicals which are used primarily for symptom control and relief of pain related to the terminal illness;
8. Intermittent Hospice aide services available and adequate in frequency to meet the needs of the client. Hospice aide services may include unskilled personal care and homemaker services that are incidental to a visit;
9. Occupational therapy, physical therapy, and speech-language pathology appropriate to the terminal condition, provided for the purposes of symptom control or to enable the terminal client to maintain activities of daily living and basic functional skills;
10. Volunteer services; and
11. Any other service that is specified in the client's plan of care as reasonable and necessary for the palliation and management of the client's terminal illness and related conditions and for which payment may otherwise be made under Medicaid.

Prior Authorization Requirements

Prior authorization is not required for Hospice services.

Non-Covered Services and General Limitations

Clients must be Medicaid eligible on the dates of service for which Medicaid-covered Hospice services are billed (and the services must be medically necessary, which includes certification of the client's terminal illness and appropriate to the client's needs) in order for Hospice services to be covered by Medicaid.

Intermittent Home Health Services may be utilized with Hospice coordination for treatment of conditions that are not related to the terminal diagnosis and are not meant to extend and cure the client's terminal condition.

Services not covered as part of the Hospice benefit include, but are not limited to:

1. Services provided before or after the effective date of a client's Hospice election period;
2. Services of the client's primary care provider, attending or consulting physician that are unrelated to the terminal condition (and which therefore are not covered as part of the Hospice benefit);
3. Services or medications received for the treatment of an illness or injury not related to the client's terminal condition;
4. Services which are not otherwise included in the Hospice benefit including services such as electronic monitoring or home modification which may be available to a client through a Medicaid (HCBS) waiver;

5. Personal care and homemaker services that are beyond the scope provided under the Hospice benefit including personal care and homemaker services which are contiguous with a home health aide visit (and therefore, are a Home Health benefit);
6. Hospice services covered by other health insurance, such as Medicare or private insurance; and
7. Hospice services provided by family members.

Medicaid does not separately reimburse for activities that are the responsibility of the Hospice provider including coordination of care for the client and bereavement counseling.

Definitions

Term	Definition
Alternative Care Facility (ACF)	An alternative care facility is an assisted living residence that is enrolled as Medicaid provider.
Assisted Living Residence	An assisted living residence as defined in 6 CCR 1011-1 Chapter VII.
Attending Physician	A client's primary care provider, personal physician or medical home or, for clients in a hospital or nursing facility, the physician responsible for writing discharge orders until such time as the client is discharged.
Benefit Period	Benefit Period means a period during which the client has made an election to receive Hospice care defined as one or more of the following: 1. An initial 90-day period; 2. A subsequent 90-day period; or 3. An unlimited number of subsequent 60-day periods. The periods of care are available in the order listed and may be elected separately at different times.
Certification	Certification means that the client's attending physician and/or the Hospice medical director have affirmed that the client is terminally ill.
Department	Colorado Department of Health Care Policy and Financing. The Department is designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.
Election/Elect	Election/Elect means the client's written expression to choose Hospice care for Palliative and Supportive Medical Services.

Term	Definition
HCBS Waiver Case Manager or Support Coordinator	A case manager or support coordinator who provides case management services to clients enrolled in HCBS waivers. More information about Colorado's HCBS waivers and case managers/support coordinators may be obtained from: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1223894302742, or by contacting a local case management agency, which is either Colorado's Single Entry Point (SEP) agencies for adults with disabilities and persons 65 years of age or older or Colorado's Community Centered Boards (CCBs) for persons with a developmental disability. A list of CCBs is available at: http://www.cdhs.state.co.us/ddd/CCB_Main.htm A list SEP agencies is available at: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1205189474220.
Home Health Benefit	Home Health services as described in the Home Health Benefit Collaborative policy which consists of intermittent, medically necessary skilled nursing, home health aide services, physical therapy, occupational therapy and speech/language pathology services, reimbursed either by Medicare or by Medicaid.
Hospice	Hospice means a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, sociological, and spiritual care to terminally ill clients and his or her families.
Hospice Provider	A Medicaid and Medicare-certified Hospice provider.
Hospice Services	Hospice services means counseling, home health aide, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteers.

Term	Definition
Interdisciplinary Team or Interdisciplinary Group	interdisciplinary team or interdisciplinary group means a group of qualified individuals who collectively have expertise in meeting the special needs of Hospice clients/families, that includes, but is not limited to: 1. A doctor of medicine or osteopathy or a physician's assistant or advanced practice nurse (who is an employee or under contract with the Hospice); 2. A registered nurse; 3. A social worker; 4. A pastoral or other counselor; and 5. The Volunteer Coordinator.
Intermediate Care Facility for People with Intellectual Disabilities	An Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID) is designed, and functions, to meet the needs of four or more individuals with developmental disabilities, or related conditions, who require twenty-four hour active treatment services. May also be referred to as an Intermediate Care Facility for People with Mental Retardation or ICF/MR.
Medical Necessity	Medical necessity is defined in 10 CCR 2505-10, Sec. 8.076.1.8 Program Integrity – Definitions. Medical necessity means a Medical Assistance program good or service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. It may also include a course of treatment that includes mere observation or no treatment at all. The good or service must be: 1. Provided in accordance with generally accepted standards of medical practice in the United States; 2. Clinically appropriate in terms of type, frequency, extent, site, and duration; 3. Not primarily for the economic benefit of the provider or for the convenience of the client, caretaker, or provider; and 4. Performed in a cost effective and most appropriate setting required by the client's condition.

Term	Definition
Palliative and Supportive Medical Services	Palliative and Supportive Medical Services means those services and/or interventions which are not curative but which produce the greatest degree of relief from the symptoms of the terminal illness.
Room and Board	Room and board includes a place to live and the amenities that come with that place to live, which includes but is not limited to provision of: 1. Meals and additional nutritional requirements, as prescribed; 2. Performance of personal care services, including assistance in the activities of daily living; 3. Provision of socializing activities; 4. Equipment necessary to safely care for the client and to transport the client as necessary; 5. Administration of medication; 6. Maintenance of the cleanliness of a client's room; and 7. Supervision and assistance in the use of durable medical equipment and prescribed therapies.
Terminally Ill/Terminal Illness	Terminally ill/terminal illness means a medical prognosis of life expectancy of nine months or less, should the illness run its normal course.

References

Section 1905(a)(18) of the Social Security Act (P.L. 74-271)
Title 42, Code of Federal Regulations, Part 418.
State Operations Manual. Appendix M: Hospice
Sections 25.5-5-303. C.R.S.