36-000 MEDICAID HOSPICE BENEFIT

36-001 HOSPICE SERVICES: These regulations govern the Medicaid Hospice Benefit, a comprehensive package of services available to current Medicaid clients of all ages. Clients may voluntarily choose hospice services as the care option for their terminal illness. Hospice services include nursing services, physician services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services and pastoral care services. These services are offered based on individually assessed needs and choices of terminally ill clients and their families for palliative care and support.

36-002 DEFINITIONS:

Assisted living facility means a facility licensed as an assisted living facility by the Department of Health and Human Services Division of Public Health.

Attending physician means physician named by the client/representative in the hospice records. The attending physician has primary responsibility for the client's care and treatment.

Caregiver means a friend, family member, or legal guardian who provides ongoing care for an individual who is unable to care for him/herself.

Center for developmental disabilities means a facility, including a group home, where shelter, food, and care, advice, counseling, diagnosis, treatment, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have developmental disabilities.

Client representative means a person who is, because of the client's mental or physical incapacity authorized in accordance with state law to execute decisions about hospice services or terminate medical care on behalf of the terminally ill client.

CMS means the federal Centers for Medicare and Medicaid.

Home health aide means a person who is employed by a hospice to provide personal care, assistance with activities of daily living, and basic therapeutic care to the clients of the hospice.

Homemaker means person employed by, or a volunteer of, a hospice to provide domestic services including, but not limited to, meal preparation, laundry, light housekeeping, errands, and chore services as defined by hospice policy.

Hospice or hospice service means a person or legal entity which provides home care, palliative care, or other supportive services to terminally ill persons and their families.

Hospice client means a client who is diagnosed as terminally ill with a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course and who with informed consent is admitted into a hospice program.

Hospice inpatient facility means a facility in which the hospice provides inpatient care directly for respite and general inpatient care.

Hospice interdisciplinary team means the attending physician, hospice medical director, licensed professional registered nurse, certified social worker, pastoral or other counselor, and, as determined by the interdisciplinary plan of care, providers of special services such as counseling services, pharmacy services, home health aides, trained volunteers, dietary services, and any other appropriate health services, to meet the physical, psychosocial, spiritual, and economic needs which are experienced during the final stages of illness, dying, and bereavement.

Hospice volunteer means an individual specifically trained and supervised to provide support and supportive services to the hospice client and hospice client's family under the supervision of a designated hospice volunteer coordinator. This does not apply to any volunteers working on behalf of a hospice licensed under the Health Care Facility Licensure Act who, as part of their volunteer duties, provide care.

Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Intermediate care facility for mentally retarded means a facility, licensed by the Department of Health and Human Services Division of Public Health and certified to participate in Medicaid, where shelter, food, and training or habilitation services, advice, counseling, diagnosis, treatment, care, nursing care, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have mental retardation or related conditions, including epilepsy, cerebral palsy, or other developmental disabilities.

Licensed medical nutrition therapist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Licensing Law and who holds a current license issued by the Department of Health and Human Services Division of Public Health pursuant to Neb. Rev. Stat. § 38-1813.

Licensed nurse means a person licensed as a Registered Nurse or as a Practical Nurse under the provisions of the Nurse Practice Act, Neb. Rev. Stat. §§ 38-2201 to 38-2236.

Medicaid means the Nebraska Medical Assistance Program established by Neb. Rev. Stat. § 68-903 and Title XIX of the Social Security Act.

Medicaid representative means the client's services coordinator or case manager.

Medical director means a hospice employee or contracted person who is a doctor of medicine or osteopathy who is responsible for the overall coordination of medical care in the hospice.

Medication means any prescription or non-prescription drug or biological intended for treatment or prevention of disease or to effect body functions in humans.

Nursing facility means a facility or a distinct part of a facility, licensed by the Department of Health and Human Services Division of Public Health and certified for participation in the Medicaid program under Title XIX of the Social Security Act, where medical care, rehabilitation, or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled.

Palliative care means treatment directed at controlling pain, relieving other physical and emotional symptoms, and focusing on the special needs of the client and the client's family as they experience the dying process rather than treatment aimed at a cure or prolongation of life.

Physician means any person licensed to practice medicine as provided in Neb. Rev. Stat. §§ 38-2001 to 38-2062.

Social worker, certified means a person who has received a baccalaureate or masters degree in social work from an approved educational program and holds a current certificate issued by the Department of Health and Human Services Division of Public Health.

Terminal illness means that the client is diagnosed with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course.

Treatment means a therapy, modality, product, device, or other intervention used to maintain well being or to diagnose, assess, alleviate, or prevent a disability, injury, illness, disease or similar condition.

Volunteer services means services provided by unpaid persons that supplement other covered services. Services include but are not limited to caregiver relief, short-term client companionship or running errands.

36-003 PROVIDER STANDARDS

36-003.01 Standards for Providing Services: The hospice provider shall deliver services in accordance with the following standards:

1. The needs, preferences, cultural diversity, values and expectations of client/caregiver are reflected in all aspects of service delivery;
2. All service provision is done in a manner that is empowering to the client/caregiver;
3. The client/caregiver feels safe and confident that their right to privacy is protected; and
4. The client/caregiver is treated with dignity and respect at all times.

36-003.02 Hospice Provider Requirements: To participate in the Medicaid program, the hospice provider shall:

1. Be a participant in the Medicare hospice program;
2. Be licensed to provide hospice care by the Department of Health and Human Services Division of Public Health;
3. Assume full responsibility for the professional management of the client's hospice care;
4. Maintain certification by a physician that the client is terminally ill with a life expectancy of six months or less based on the physician's or medical director's clinical judgment regarding the normal course of the client's illness;
5. Maintain the signed election statement in its files;
6. Develop the plan of care and interventions based on the assessment of the needs and choices identified by client/caregiver. All service provision shall be consistent with the plan of care;
7. Provide "on call" services 24 hours a day, seven days a week;
8. Follow all applicable Nebraska Department of Health and Human Services regulations;
9. Bill only for services authorized and actually provided;
10. Comply with the requirements of 471 NAC 3 for the submission of claims for payment;
11. Retain financial and statistical records for four years from date of service provision to support and document claims;
12. Accept Medicaid payment as payment in full from the Department of Health and Human Services plus the client's share of cost;
13. Allow federal and state offices responsible for program administration or audit to review service and financial records. Inspections, reviews and audits may be conducted on site;
14. Operate a drug free work place;
15. Allow the Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place;
16. Agree and assure that any suspected abuse or neglect shall be reported to law enforcement and/or appropriate Department staff;

17. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60;
18. Agree and understand that any false claims (including claims submitted electronically), statements, documents, or concealment of material facts may be prosecuted under applicable state or federal laws (42 CFR 455.18); and
19. Respect every client's right to confidentiality and safeguard confidential information.

36-003.03 Provider Agreement and Enrollment: The hospice provider shall complete and submit Form MC-19, "Medical Assistance Provider Agreement." When the client resides in a facility, a copy of the hospice provider's contract with the facility shall be attached.

36-004 CLIENT ELIGIBILITY REQUIREMENTS: The Medicaid Hospice Benefit is available to clients who meet the following criteria:

1. The client is currently eligible for Medicaid;
2. The client is diagnosed as terminally ill by the hospice medical director and the attending physician with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course; and
3. The client is an adult and has chosen to receive palliative/comfort care to manage symptoms of terminal illness and has chosen not to receive curative treatment or disease management; or
4. The client is a child and has elected to receive palliative/comfort care to manage symptoms of terminal illness. Such election by a child shall not constitute a waiver of any rights of the child to be provided with, or receive Medicaid payment for, concurrent services related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

36-005 COVERED SERVICES: The Medicaid Hospice Benefit includes coverage for services provided in response to the palliative management of the terminal illness. The hospice provider shall assure the following criteria are met:

1. All services shall be performed by qualified personnel;
2. The cultural requirements of the client/caregiver are identified and appropriate resources are utilized including interpreters; and
3. Services are provided based on the individual needs of client by staff educated in the hospice philosophy.

36-005.01 Nursing Services: The hospice provider shall assure that nursing services are provided by or under the supervision of a registered nurse. Nursing services shall be directed and staffed to assure that the nursing needs of the clients are met. The client care responsibilities of the nursing personnel shall be specified in the hospice plan of care. Services shall be provided in accordance with recognized standards of practice. Nursing services include:

1. Regular visits by a registered nurse (RN) or licensed practical nurse (LPN) to monitor condition, provide care, and maintain comfort based on assessment of individual needs and as identified in the hospice plan of care;

2. Face to face visits, at a minimum weekly by an RN/LPN, or more frequently as needed, and the registered nurse shall visit at least every two weeks;
3. Education based on the needs of the client/caregiver and family about the changes to be expected with the dying process; the appropriate use of medications, therapies, equipment, and supplies; what hospice does and does not do; and emphasis on the importance of realistic goals;
4. An initial assessment (see 471 NAC 36-005.01A);
5. An individualized hospice plan of care (see 471 NAC 36-005.01B); and
6. Coordination of care (see 471 NAC 36-005.01C).

36-005.01A Initial Assessment: An initial assessment shall be completed within 24 hours after Medicaid eligibility is established and the election statement is signed. The nurse completes the assessment to collect comprehensive information concerning the client's preferences, goals, health status, and to determine strengths, priorities, and resources. The assessment shall be completed by a designated registered nurse from the hospice provider and coordinated with the client's Medicaid representative. Ongoing assessments shall be completed and updated with each client visit.

36-005.01B Individualized Hospice Plan of Care: An individualized hospice plan of care shall be written to identify specific individual services to be provided in a coordinated and organized manner. The interdisciplinary team shall be involved in developing the plan of care. The hospice plan of care shall be culturally appropriate and identify in detail the services that shall address the needs identified in the assessment. The hospice plan of care shall state in detail the scope and frequency of services that shall meet the client's and family's needs. The hospice plan of care shall be developed with the client/caregiver within two calendar days of admission to the hospice program. The care provided shall be in accordance with the written plan of care. In the event of disagreement between the client and in-home caregiver, the client shall make the final decision about care, service needs, preferences, and choices. The hospice plan of care shall be reviewed and updated based on client need and a minimum of every two weeks.

36-005.01C Coordination of Care: Coordination of care shall include links to needed services and resources, and shall ensure that client choices and concerns are represented. The hospice provider shall designate a registered nurse to coordinate the implementation of the hospice plan of care with the client's Medicaid representative. Coordination shall accomplish sharing of information to prevent gaps in service, duplication of services and duplication of payment. A request for additional Medicaid services or a determination of denial of hospice services for a Medicaid client by the hospice provider shall be coordinated with the client's Medicaid representative. The hospice provider shall notify the client's Medicaid representative when a Medicaid client elects hospice services.

36-005.02 Home Health Aide/Homemaker: The hospice provider shall assure that home health aide/homemaker services are provided to promote client care and comfort and are completed at the direction of the client/caregiver based on client's individualized hospice

plan of care. Services shall be available and adequate to meet the needs of the client. Home health aide/homemaker services include:

1. Personal care services, for example, bathing, dressing, assisting with bowel and bladder requirements, assisting with ambulating, hair care, nail care, as indicated in the client's individualized hospice plan of care and at the direction of the client/caregiver; and
2. Homemaker services to maintain a safe and sanitary environment, for example, meal preparation, changing linens, light housekeeping and laundry for client cleanliness and comfort, as indicated in client's individualized hospice plan of care and at the direction of the client/caregiver.

36-005.03 Medical Social Services: The hospice provider shall assure that medical social services are provided for the client/caregiver and family under the direction of the physician. Medical social services include:

1. Crisis intervention for the client, caregiver, and/or family;
2. Psychosocial assessment to address needs identified by the client/caregiver and to develop plans for intervention;
3. Counseling to assist the client/caregiver/family, including children, cope with serious illness/death;
4. Client advocacy to assure the client/caregiver have choices in care and understand their right to refuse treatment;
5. Liaison between client and needed community resources;
6. Fostering human dignity and personal worth; and
7. Coordination of services with the Medicaid representative, when applicable.

36-005.04 Medical Equipment and Supplies including Drugs and Biologicals: The hospice provider shall assure that medical equipment and supplies, including drugs, are provided for palliation and management of the terminal illness and related conditions. All equipment, supplies, medications, and biologicals shall be provided as prescribed by the client's physician, as needed, and at the direction of the client/caregiver as indicated in the client's individualized hospice plan of care. These services include:

1. Medication for the relief of pain and related symptoms;
2. Durable medical equipment related to palliation; and
3. Personal comfort items needed for client comfort and management of terminal illness.

36-005.05 Other Counseling Services: The hospice provider shall assure that other counseling services are available for the client, caregiver, and family. Services include:

1. Dietary counseling provided by a licensed medical nutrition therapist;
2. Spiritual counseling with a person of the client's choice. The interdisciplinary team shall include pastoral care professionals who are educated in the hospice philosophy;
3. Bereavement counseling provided through an organized program of bereavement services under the supervision of a qualified professional.

Bereavement services shall be offered to the client's family at least quarterly for one year following death of the client. Bereavement services shall identify "at risk" survivors and provide resources for follow-up. It is the choice of the family to accept bereavement services.

36-005.06 Volunteer Services: The hospice provider shall sponsor a volunteer program and shall assure that volunteers participate in an initial volunteer education program. Opportunities for ongoing education shall be available for volunteers.

36-005.07 Physician Services: The client's attending physician or a physician associated with the hospice provider shall provide medical direction. The physician associated with the hospice provider shall ultimately assure the general medical needs are met in all settings, including long term care.

36-005.08 Physical Therapy, Occupational Therapy, and Speech Language Pathology Services: The hospice provider shall assure that physical therapy, occupation therapy, and speech language/pathology services are provided to control symptoms or to enable the client to maintain activities of daily living and basic functional skills. These services shall be provided under the direction of the physician and shall be included in the hospice plan of care. The client/caregiver makes the final decision regarding acceptance/refusal of a therapy program.

36-005.09 Medical Interventions: The hospice provider shall assure that medical interventions are provided when the interventions related to the terminal illness, either in use or planned, have been evaluated by the attending physician, hospice medical director, hospice team, client/caregiver, and family, based on the quality of life, value of the treatment to the client, and the service's congruence with the palliative care goals of the client/caregiver, family, and hospice. Planned interventions shall be included in the hospice plan of care.

36-006 ELECTION OF HOSPICE SERVICES: A client or the client's legal representative shall file a voluntary, written expression to choose hospice care, called an election statement designating the Medicaid Hospice Benefit as the care preference for terminal illness. The election statement shall include:

1. The date that hospice services are to begin;
2. The name of the hospice provider; and
3. The client's signature or the signature of the client's legal representative when client is unable to sign. The reason the client cannot sign shall be documented.

A client who has Medicare coverage shall use Medicare coverage as primary payer until Medicare benefits are exhausted. Medicaid pays the Medicare co-insurance and deductible when the client is covered by both Medicare and Medicaid. See 471 NAC 3-004.

36-006.01 Hospice's Responsibilities at Election: When a client elects to receive hospice services, the hospice program shall:

1. Explain the benefits the client shall receive;

2.

2. Explain the benefits the client is waiving;
3. Give the client or legal representative a copy of the signed statement; and
4. Retain the signed statement in its files.

36-006.02 Benefit Periods: Medicaid provides two 90-day benefit periods during the client's lifetime. If additional benefit periods are needed, Medicaid provides three 60-day benefit periods. Hospice services beyond these benefit periods shall be approved as an exception under the prior authorization provisions in 471 NAC 36-007. The benefit periods may be used consecutively or at intervals.

36-006.02A Certification: The client shall be certified as terminally ill with a six- month life expectancy by the hospice medical director and the attending physician at the beginning of the first benefit period and by the hospice medical director for all subsequent benefit periods.

36-006.03 Waiver of Medicaid Benefits for Adult Clients: An adult client shall be deemed to have waived all rights to Medicaid payment for treatment associated with the terminal illness for the duration of the election of hospice care. Medicaid services provided for conditions/illnesses that are unrelated to the terminal illness may be covered by Medicaid separate from the hospice benefit. These services shall be based on individual assessed need and medical necessity as specified in the appropriate chapters of Title 471. If the client/representative revokes election of the Medicaid Hospice Benefit, Medicaid coverage of the benefits deemed to have been waived is restored.

36-006.04 Revocation of Election of Hospice Benefit: A client/representative may revoke election of the hospice benefit at any time. The days that are remaining in the current benefit period are lost. The client/representative shall initiate the process of revocation and follow through with the hospice provider.

The client may initiate re-election of the Medicaid Hospice Benefit if eligibility criteria are met.

36-006.05 Change of Hospice: The client/representative may choose to change from one hospice provider to another hospice provider. A change of hospice may occur only once in each benefit period.

36-007 PRIOR AUTHORIZATION: All hospice services shall be prior authorized. The hospice shall submit prior authorization requests to the Department within 72 hours of the initial assessment. Prior authorization may be retroactive for up to seven days, based on the client's entry date into the hospice program. To request prior authorization, the hospice shall submit:

1. Agency name and provider number;
2. Signed election statement;
3. Physician certification of terminal illness and 6 month or less life expectancy;
4. Hospice plan of care; and
5. List of all medications, biologicals, supplies, and equipment for which the hospice is responsible.

Claims may be denied when prior authorization is not completed.

Re-authorization shall be requested for clients who surpass the six-month prognosis.

36-007.01 Clinical Criteria for Non-Cancer Diagnosis: Coverage of the Medicaid Hospice Benefit depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. The client shall be discharged from the Medicaid Hospice Benefit when the client improves or stabilizes enough that the six months or less prognosis is no longer accurate. The client may be re-enrolled for a new benefit period when a decline in the clinical status is such that the life expectancy is again six months or less.

36-007.01A Guidelines for Decline in Clinical Status: Clients shall be considered to have a life expectancy of six months or less only when there is documented evidence of a decline in clinical status. Baseline data is established on admission to hospice through nursing assessment in addition to utilization of existing information from records. It is essential that baseline and follow-up determinations are documented thoroughly to establish a decline in clinical status.

Coverage of hospice care for clients not meeting the guidelines may be denied. Some clients may not meet the guidelines, yet still be appropriate for hospice care, because of co-morbidities or decline. Coverage for these clients may be approved through the prior authorization process.

36-008 MEDICAID HOSPICE BENEFIT IN CERTAIN FACILITIES: A client who meets the eligibility requirements in 471 NAC 36-004 and resides in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), a Nursing Facility (NF), an Institution for Mental Disease (IMD), an Assisted Living Facility (ALF), or a Center for the Developmental Disabilities (CDD) may elect to receive hospice services where s/he lives. The Medicaid Hospice Benefit is available to Medicaid eligible persons in an IMD who are age 20 or younger or 65 or older. The facility shall agree to the provision of hospice services and the hospice provider shall have a signed contract with the facility before provision of hospice services.

36-008.01 Facility's Responsibilities: The facility shall:

1. Provide room and board for the client;
2. Perform personal care;
3. Assist with activities of daily living;
4. Administer medications;
5. Provide social activities;
6. Provide housekeeping;
7. Supervise and assist with the use of durable medical equipment and prescribed therapies; and
8. Develop plan of care in collaboration with the hospice provider, client/caregiver and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the plan.

36-008.02 Hospice Responsibilities: The hospice provider shall:

1. Assess the client's needs in coordination with the designated facility representative and client/caregiver;
2. Develop a hospice plan of care in collaboration with client/caregiver, facility caregivers and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the hospice plan of care;
3. Assume the professional management responsibility for ensuring the implementation of the hospice plan of care at the direction of the client/caregiver;
4. Coordinate, with the facility's representative, the responsibilities of the facility and the responsibilities of the hospice provider and document in all client records;
5. Involve family and facility personnel in assisting with provision of services as designated by the hospice plan of care, and at the direction of the client/caregiver. The same level of services that would be provided in the home shall be provided in the facility; and
6. Provide social services and counseling utilizing hospice personnel. This service may not be delegated to the facility's personnel.

The hospice provider may not require the client to move from the facility as long as the client's needs can be appropriately and safely met.

36-009 WAIVERS: Clients who elect the hospice benefit while receiving home and community-based (HCB) waiver services may continue to receive HCB waiver services that are based on assessed need and medical necessity. All medical services related to the terminal illness or the hospice plan of care are the responsibility of the hospice and all services shall be coordinated with the waiver services coordinator. The waiver services coordinator retains full responsibility for waiver planning and service authorization.

36-010 DISCHARGE GUIDELINES: The hospice provider shall discontinue services for a client when:

1. The home environment is not safe for hospice personnel, caregiver, or client;
2. The client no longer meets admission guidelines;
3. Life expectancy exceeds one year of benefit periods;
4. The client revokes hospice election; or
5. The client is no longer Medicaid eligible.

36-011 QUALITY ASSURANCE: The Department of Health and Human Services may refuse to execute or may cancel a contract/provider agreement with a hospice provider when the hospice provider:

1. Does not meet the hospice requirements in 471 NAC 36-000;
2. Consistently admits clients who do not meet the eligibility requirements for terminal illness or consistently exceed the six-month prognosis;
3. Consistently refuses to provide or is unable to provide services identified in the assessment and on the hospice plan of care;
4. Consistently bills the majority of claims at the “Continuous Home Care” rate; or
5. Consistently discharges clients in conflict with 471 NAC 36-000.

36-012 PAYMENT: Medicaid pays for services provided under the Medicaid Hospice Benefit using the Medicaid hospice payment rates established by CMS.

36-012.01 For adult clients: Medicaid pays the inpatient respite care rate to the Hospice provider for each day the client is in an inpatient facility (hospital or nursing facility) and receiving respite care (see 471 NAC 36-012.03).

Medicaid pays the general inpatient care rate to the Hospice provider during a period of acute medical crisis (See 471 NAC 36-012.04). Payment shall be made only when the care is provided in a hospital or a contracted hospice inpatient facility.

Medicaid pays all costs for hospital services provided when a client receiving the Medicaid Hospice Benefit is hospitalized for an acute medical condition that is not related to the terminal diagnosis and/or complications secondary to the terminal diagnosis.

Determination of the cause of hospitalization shall be made by the Hospice disciplinary team with consultation with the Medicaid Hospice Program Specialist. Payment for hospital services shall be made directly to the hospital.

36-012.02 For child clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility, including Inpatient Respite Care (see 471 NAC 36-012.05) and General Inpatient Care (see 471 NAC 36-012.06).

36-012.03 Routine Home Care: Medicaid pays the routine home care rate to the hospice provider for every day the client is at home, under the care of hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

36-012.04 Continuous Home Care: Medicaid pays the continuous home care rate to the hospice provider to maintain a client at his/her place of residence when a period of medical crisis occurs. A period of medical crisis is a time when a client requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. A registered nurse or a licensed practical nurse shall provide nursing care. A nurse shall be providing more than one half (51% or greater) of care given in a 24-hour period. A minimum of eight hours of care shall be provided in a 24-hour period, which begins and ends at midnight. When the number of hours is less than 24, Medicaid pays the hourly rate. The hours may be split over the 24 hours to meet the needs of the client. Routine home care shall be billed when fewer than eight hours of nursing care are provided.

36-012.05 Inpatient Hospital or Nursing Facility Respite Care: For adult clients, Medicaid pays the inpatient respite care rate to the hospice provider for each day the client is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the client when necessary to relieve the caregiver. Payment may be made for a maximum of five days per month counting the day of admission but not the day of discharge. The discharge day for inpatient respite care is billed at routine home care unless the client is discharged as deceased. When the client dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Inpatient respite care is not paid when the client is residing in a facility listed in 471 NAC 36-008.

36-012.06 General Inpatient Care: For adult clients, Medicaid pays the general inpatient care rate to the hospice provider during a period of acute medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management that cannot be provided in any other setting. Care shall be provided in a hospital or a contracted hospice inpatient facility that meets the hospice standards regarding staffing and client care. When a severe breakdown in caregiving occurs, the general inpatient care rate shall be paid until other arrangements can be made, up to a maximum of ten days per month. The discharge day for general inpatient care is billed as routine home care unless the client is discharged as deceased. When the client dies under general inpatient care, the day of death is paid at the general inpatient care rate.

36-012.06A Limitation On Payments To A Hospice: Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid 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 Medicaid clients during that same period. Medicaid clients who have been diagnosed with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospice's "cap period" (11/1 -10/31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate are not counted as inpatient days. The Department calculates the limitation as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.
2. If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment is necessary.
3. If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

    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;
    c. Adding together the amounts calculated in a and b; and comparing the amount in c with interim payments made to the hospice for inpatient care during the "cap period." Any excess reimbursement is refunded by the hospice.

36-013 PAYMENT FOR SERVICES RECEIVED IN FACILITIES:

36-013.01 For adult clients: Medicaid pays the hospice provider for both the hospice services provided and for the residential services provided by the facility.

36-013.01A Payment for the Medicaid Hospice Benefit When Provided in an ICF/MR, Nursing Facility, or IMD: Residential payment is 95% of the rate that would have been paid to the facility for residential services.

36-013.01B Payment and Medicaid Managed Care: When the Medicaid Hospice Benefit is elected by the client who is participating in the Nebraska Health Connection (Medicaid Managed Care), services not covered in the Medicaid Hospice Benefit are covered as part of the benefits of the managed care plan, as provided in Title 471 and 482.

36-013.02 For child clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility.

36-014 BILLING: The hospice provider shall bill for services provided using Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For claim submission instructions, see the Claim Submission Table at 471-000-49.

HCPCS/CPT procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Fee Schedule (see 471-000-536).

36-015 MEDICAID PAYMENT WHEN A MEDICAID CLIENT RESIDING IN A NURSING FACILITY OR ICF/MR ELECTS THE MEDICARE HOSPICE BENEFIT : See 471 NAC 12-015.