Title 23: Division of Medicaid

Part 205: Hospice Services

Part 205 Chapter 1: Program Overview

Rule 1.4: Hospice Eligibility, Election, Transfer, Revocation, and Discharge

A. A beneficiary must meet eligibility requirements for hospice care services. For the duration of an election of hospice care services, a beneficiary waives all rights to Medicaid State Plan services for treatment related to the terminal illness and related conditions. In order to be eligible to elect hospice care services under Medicaid, a beneficiary must:

1. Be Medicaid eligible for full benefits,

2. Be certified by a physician as terminally ill in compliance with 42 C.F.R. § 418.22,

3. Require medically necessary treatment for the palliation and management of a terminal illness and related conditions,

4. The beneficiary or legal guardian/representative must elect hospice care in accordance with 42 C.F.R. § 418.24.

B. A beneficiary that meets hospice care eligibility requirements, and chooses the Medicaid hospice benefit must file an election statement with a Mississippi Medicaid enrolled hospice provider. For dual eligible beneficiaries, refer to Rule 1.10.

C. The Medicaid enrolled hospice provider must submit the following to the Utilization Management / Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity within five (5) calendar days of a beneficiary's admission to hospice which includes the following:

1. The beneficiary's election statement, which includes the following:

a) Identification of the particular hospice that will provide care to the beneficiary,

b) The beneficiary's acknowledgment or legal guardian's/representative's acknowledgment, if applicable, that the beneficiary has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment,

c) The beneficiary's acknowledgement or legal guardian's/representative's acknowledgment, if applicable, that the beneficiary understands that certain Medicaid State Plan services are waived by the election of hospice,

d) An effective date of the election period which cannot be earlier than the date of the election statement,

e) The name of the beneficiary's attending physician, if any, along with the following information including, but not limited to, the attending physician's:

1) Full name,

2) Office address,

3) National Provider Identification (NPI) number, and

4) Other detailed identifying information.

f) The beneficiary's acknowledgement or legal guardian's/representative's acknowledgment, if applicable, that the designated attending physician is the beneficiary's or legal guardian's/representative's choice.

g) The signature of the beneficiary or signature of the legal guardian/representative, if applicable, and date signed.

2. Prior authorization requests must include the following for the initial ninety (90) day election period:

a) Signed notice of election form,

b) Signed Physician Certification/Recertification of Terminal Illness Form,

c) Clinical/medical information supporting terminal prognosis,

d) Physician orders,

e) Current medication list, and

f) Hospice provider plan of care.

D. The Medicaid hospice provider must submit prior authorization for any subsequent ninety (90) day election period and subsequent sixty (60) day hospice election periods five (5) calendar days prior to the end of the current election period.

1. The following prior authorization documentation is required:

a) Signed Physician Certification/Recertification of Terminal Illness Form (DOM 1165 C),

b) Updated clinical/medical information supporting terminal prognosis,

c) Updated physician orders,

d) Updated medication record,

e) Updated plan of care,

f) Beneficiary's current weight, vital sign ranges, lab tests, and

g) Any other documentation supporting continuation of hospice services.

2. An election to receive hospice care services is considered to continue through the initial election period and through subsequent election periods without a break in service as long as the beneficiary:

a) Remains in the care of a hospice,

b) Does not revoke the election,

c) Is not discharged from the hospice, and

d) Continues to meet Medicaid eligibility requirements.

E. Additional documentation that is requested by the UM/QIO that is not received within the time period outlined in the Notice of Pending or Suspended Review will result in the effective date beginning when completed required documentation is received.

1. The Division of Medicaid may waive the consequences of failure to submit timely documentation for exceptional circumstances. Exceptions to notice within five (5) calendar days:

a) Fire,

b) Floods,

c) Embargoes,

d) War, acts of war, insurrections, riots,

e) Strikes, lockouts or other labor disturbances,

f) Or acts of God.

2. A provider so affected shall use reasonable commercial efforts to avoid or remove such causes of nonperformance, and shall provide proper notice hereunder immediately whenever such causes are removed. Changes to the scope of available services or

reimbursement methodology for the provision of certain services through legislative or regulatory action shall not constitute an unforeseeable circumstance within the meaning of this section.

F. A beneficiary or legal guardian/representative may change, once per election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not considered a revocation of the election or discharge from hospice services, but is a transfer.

1. The beneficiary or legal guardian/representative must file, with the hospice from which hospice care has been received and with the newly designated hospice, a signed statement that includes the following information:

   a) The name of the hospice from which the beneficiary currently receives hospice care,

   b) The name of the hospice the beneficiary chooses to transfer to, and

   c) The effective date of the transfer.

2. The new hospice provider chosen by the beneficiary or legal guardian/representative must file the transfer notice and complete all assessments as required by the hospice Conditions of Participation and any federal and state laws.

G. A beneficiary or legal guardian/representative may revoke the election of hospice care services at any time which results in forfeiture of any remaining days in that election period.

1. The revocation must be in writing and filed with the hospice provider and must include:

   a) A signed statement that the beneficiary revokes the election for hospice care services for the remainder of that election period, and

   b) The effective date of the revocation which cannot be earlier than the date that the revocation is made.

2. Verbal revocation of hospice care services is not acceptable.

3. Upon revoking hospice care services, the beneficiary's waived Medicaid benefits will resume.

4. The provider must file a revocation of hospice services notice to the UM/QIO Division of Medicaid or designee within five (5) calendar days after the effective date of the revocation.

5. The beneficiary or legal guardian/representative may, at any time after a revocation, elect to receive hospice coverage for any other hospice election periods the beneficiary is eligible to receive.

H. The hospice provider must notify the Division of Medicaid of any discharge by filing a discharge notice within five (5) calendar days after the effective date of discharge.

1. A hospice provider can only discharge a beneficiary as a result of one (1) of the following:

   a) The beneficiary or guardian/legal representative transfers to another hospice provider,

   b) The beneficiary moves out of the geographic area that the hospice defines in its service area,

   c) The beneficiary's condition improves and he/she is no longer considered terminally ill,

   d) Discharge for cause which is extraordinary circumstances in which the hospice provider would be unable to continue to provide hospice care services. Before seeking a discharge for cause of a beneficiary, the hospice provider must:

      1) Advise the beneficiary that a discharge for cause is being considered,

      2) Make a serious effort to resolve the problem(s) presented by the beneficiary's behavior or situation, and

      3) Ascertain that the beneficiary's proposed discharge is not due to the beneficiary's use of necessary hospice services,

      4) Document the problem(s) and efforts made to resolve the problem(s) in the beneficiary's medical records, and

      5) Notify the UM/QIO Division of Medicaid or designee of the circumstances surrounding the impending discharge.

   e) Beneficiary or guardian/legal representative decides to revoke the hospice benefit, or

   f) The beneficiary dies,

2. The hospice provider, prior to discharging a beneficiary for any reason other than revocation, transfer, or death, must obtain a written physician's discharge order from the hospice medical director. If a beneficiary has an attending physician involved in his or her care, this physician should be consulted before discharge and the physician's review and decision included in the discharge note.

3. A beneficiary, upon discharge from a hospice provider during a particular election period for reasons other than immediate transfer to another hospice, is no longer covered under Medicaid for hospice care and:

a) Resumes Medicaid coverage of the benefits waived, if eligible, and

b) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

4. The hospice provider must have in place a discharge planning process that takes into account the prospect that a beneficiary's condition might stabilize or otherwise change such that the beneficiary cannot continue to be certified as terminally ill. Prior to discharging a beneficiary who is no longer certified as terminally ill, the discharge planning process must include planning for any necessary:

a) Family counseling,

b) Beneficiary education, and/or

c) Other services.

I. Hospice providers cannot automatically or routinely discharge a beneficiary at its discretion, even if the hospice care is costly or inconvenient.

Source: 42 C.F.R. Part 418; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2022; Revised eff. 04/01/2018; Revised Miss. Admin. Code Part 205, Rule 1.4.E. eff. 06/01/2016.

Rule 1.8: Reimbursement

A. A hospice provider must obtain written certification/recertification of terminal illness before billing for hospice services.

B. The Division of Medicaid reimburses hospice providers at one (1) of the four (4) following predetermined rates for each day that the beneficiary is under the care of the hospice based on the level of care required to meet the beneficiary's and family's needs:

1. Routine Home Care (RHC):

a) Is reimbursed for each day the beneficiary is under the care of the hospice provider and not receiving one of the other categories of hospice care. This rate is reimbursed without regard to the volume or intensity of routine home care services provided on any given day, and is also reimbursed when the beneficiary is receiving outpatient hospital care for a condition unrelated to the terminal condition.

b) Beginning January 1, 2016 is reimbursed:

1) At a higher payment rate for the first sixty (60) days of hospice care, and

2) At a reduced payment rate for hospice care for sixty-one (61) days and over, and

c) Includes a service intensity add-on (SAI) payment in addition to the per-diem RHC rate for the actual direct patient care hours provided by a registered nurse (RN) or social worker, up to four (4) hours total per day, during the last seven (7) days of a beneficiary's life when discharged due to death. The SAI payment is equal to the continuous home care hourly payment rate multiplied by the amount of direct care actually provided by an RN and/or social worker.

2. Continuous Home Care:

a) Is reimbursed only during a period of crisis, defined as a period in which the beneficiary requires continuous care to achieve palliation and management of acute medical symptoms, and only as necessary to maintain the terminally ill beneficiary at home.

b) Must be a minimum of eight (8) aggregate hours of predominantly nursing care during a twenty-four (24) hour day, which begins and ends at midnight, and:

1) Nursing care must be provided for more than half of the period of care, and

2) Must be provided by a registered nurse.

c) Is reimbursed at the hourly rate up to twenty-four (24) hours per day.

d) Is not reimbursed during a hospital, long-term care facility, or inpatient free-standing hospice facility stay.

3. Inpatient Respite Care:

a) Is reimbursed on any day on which the beneficiary is an inpatient in an approved facility for inpatient respite care.

b) Is limited to a maximum of five (5) consecutive days at a time.

c) Is not reimbursed when the hospice beneficiary is a long-term care facility resident, assisted living (AL) waiver participant, or an inpatient of a free-standing hospice.

4. General Inpatient Care:

a) Is reimbursed at the general inpatient care rate for each day such care is consistent with the beneficiary's plan of care.

b) Is reimbursed on any day on which the beneficiary is an inpatient in an approved facility for general inpatient care.

c) Is reimbursed at the general inpatient care rate for the date of admission and all subsequent inpatient days, except the day on which the beneficiary is discharged.

C. The Division of Medicaid reimburses the hospice for respite and general inpatient days. The hospice must reimburse the facility that provides respite inpatient care.

D. The Division of Medicaid does not reimburse for the date of discharge or the date of death.

E. Payment for physician services provided in conjunction with the hospice benefit is based on the type of service performed.

F. Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates which include:

1. Participating in the establishment, review and updating of plans of care,

2. Supervising care and services, and

3. Establishing governing policies.

G. The Division of Medicaid reimburses the hospice provider for beneficiaries in a long-term care facility at ninety-five percent (95%) of the long-term care facility's Medicaid per-diem rate.

1. If the hospice provider fails to submit the required documentation to the UM/QIO within five (5) calendar days of the hospice election, the effective date will be the date when the completed documentation is received.

a) The Division of Medicaid will not reimburse the hospice or nursing facility providers for days prior to the effective date of the election statement.

b) The hospice and/or nursing facility cannot seek payment from the beneficiary.

2. The Division of Medicaid does not reimburse the hospice provider for long-term care bed-hold days.

H. Hospice providers must report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual.

I. The Division of Medicaid reimburses drugs not related to the beneficiary's terminal illness or related conditions to the dispensing pharmacy through the Medicaid Pharmacy Program.

J. The Division of Medicaid reimburses disease specific drugs as well as other drugs related to the palliation and management of the beneficiary's terminal illness and related conditions in

the hospice per diem rates and are not be reimbursed through the Medicaid Pharmacy Program.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2022; Revised eff. 04/01/2018.

Rule 1.10: Dual Eligibles

A. The hospice benefit must be used simultaneously under Medicare and Medicaid with Medicare providing primary coverage for dual eligible beneficiaries.

B. The Division of Medicaid requires the hospice provider to submit the Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries (Form DOM 1166C) to the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO) within five (5) calendar days of the beneficiary's hospice election or discharge date.

    1. If the hospice provider fails to submit Form DOM 1166C to the UM/QIO within five (5) calendar days of the election period, the effective date will be the date when the completed Form DOM 1166C is received.

        a) The Division of Medicaid will not reimburse the hospice or nursing facility providers for days prior to the effective date of the election statement.

        b) The hospice and/or nursing facility cannot seek payment from the beneficiary.

    2. The UM/QIO will issue a prior authorization number once Form DOM 1166C is received to be notated on the claim by the hospice provider for nursing facility room and board reimbursement.

    3. If the beneficiary elects the hospice benefit in a home setting, the UM/QIO will issue a prior authorization number once Form DOM 1166C is received.

C. The Division of Medicaid may waive the consequences of failure to submit timely documentation for exceptional circumstances.

    1. Exceptions to notice within five (5) calendar days:

        a) Fire,

        b) Floods,

        c) Embargoes,

        d) War, acts of war, insurrections, riots,

e) Strikes, lockouts or other labor disturbances,

f) Or acts of God.

2. A provider so affected shall use reasonable commercial efforts to avoid or remove such causes of nonperformance, and shall provide proper notice hereunder immediately whenever such causes are removed. Changes to the scope of available services or reimbursement methodology for the provision of certain services through legislative or regulatory action shall not constitute an unforeseeable circumstance within the meaning of this section.

Source: 42 C.F.R. § 418.24; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2022; Revised eff. 03/01/2021; Revised eff. 04/01/2018.