

TO: All Providers (except Hospice Agencies and Nursing Facilities)

SUBJECT: Hospice Services

EFFECTIVE: September 1, 1992

PURPOSE: To announce the coverage of hospice care for Medicaid recipients who are terminally ill.

BACKGROUND: Reimbursement for hospice services was authorized pursuant to section 1905 (o) of the Social Security Act, codified as 42 U.S.C. 1396 (d). The New Jersey State statute (N.J.S.A. 30:4D-6d(20)) authorizes the provision of hospice services in the Title XIX (Medicaid) program. The New Jersey Register, dated August 17, 1992, (CITE: 24 NJR 2778 (a)) contains the proposed regulations for hospice services.

NOTE: This Newsletter does not apply to hospice care provided as a Medicaid Waiver service under the AIDS Community Care Alternatives Program (ACCAP). Hospice waiver services under ACCAP are described in the New Jersey Health Services Program Newsletter, P-657, dated October 15, 1990. Providers must also adhere to the special requirements applicable to patients enrolled in the Garden State Health Plan (GSHP) or a private Health Maintenance Organization (HMO).

ACTION: Hospice is defined as a philosophy and method of caring for hospice providers in New Jersey are hospital-based, or free-standing home health agencies, or free standing hospice agencies.

I. COVERED SERVICES:

The New Jersey Medicaid program reimburses hospices who are Medicaid approved and Medicare certified, for an all-inclusive package of covered services on a per diem basis. Hospice services must be reasonable and necessary for the palliation and management of the terminal illness and consistent with the hospice's plan of care for the recipient.

Hospice services include nursing care, medical social services, supervisory physician services, counseling services, durable medical equipment and supplies including drugs and biologicals, homemaker/home health aide services, physical therapy, occupational therapy and speech-language pathology services.

The New Jersey Medicaid program also reimburses a Medicaid approved hospice for room and board services provided to a Medicaid hospice recipient residing in a nursing facility (NF). Room and board services are provided under contract between a hospice and a nursing facility. For individuals dually eligible for Medicare and Medicaid, the hospice benefit must be elected under both programs. For those residing in an NF, Medicare reimburses the hospice for hospice services, except for room and board services which are reimbursed by Medicaid. Medicare co-payments for inpatient respite care and drugs and biologicals are also reimbursed by Medicaid for dually eligible Medicare/Medicaid recipients.

The hospice applicant agrees to waive most regular Medicaid services by signing the Election of Hospice Benefits Statement (FD-378). Under certain limited conditions, as listed below, other Medicaid approved services may also be provided to Medicaid hospice recipients by approved Medicaid providers. These services would be reimbursed directly to that provider and billed separately from the all-inclusive hospice per diem reimbursed to the hospice provider. The conditions are, as follows:

1. All physician services may be reimbursed directly to the provider;
2. Other services may be reimbursed with the approval of the hospice interdisciplinary team under the following conditions:
  - i. When the reasons for providing services are not, in any way, related to the terminal illness or do not duplicate hospice services. These reasons must be verified in the recipient's medical record; and
  - ii. When the services are documented in the hospice plan of care as not being covered as part of the hospice per diem by a member of the hospice's interdisciplinary team.

NOTE: "Unrelated services" mean services provided that are necessary for the diagnosis and treatment of diseases or conditions (e.g., fractures) that are not in and of themselves related to or not caused primarily by the terminal condition for which hospice services are provided.

3. The services unrelated to the terminal illness (as in #2 above) are subject to the same coverage provisions, limitations, prior authorization requirements, and conditions that are applied to services available to other non-hospice Medicaid recipients; and

4. Providers of services unrelated to the terminal illness, including hospitals (as in #2 above, except for physician services) may be denied payments for services if the approval for these services has not been obtained from the hospice's interdisciplinary team, documented in the plan of care for the recipient, and on file in the patient's medical record.

A limited access Medicaid Eligibility Identification (MEI) Card with the statement "Except for hospice and physician services, check with hospice provider for other services" will be issued to a Medicaid recipient who is eligible for hospice services. When the eligibility card is presented to the provider, the provider (except for physician services) must obtain approval from the hospice to provide the services.

## II. RECIPIENT ELIGIBILITY

In order to receive hospice services through Medicaid, an individual must be eligible for Medicaid either in the community or in an institution. A new eligibility group is being established consisting of persons residing in the community who would be eligible if they were residing in a nursing facility and are medically qualified for hospice services.

Individuals must be medically and financially eligible for hospice services. Medical eligibility requires that individuals be terminally ill and elect the hospice benefit. "Terminal illness" means having a life expectancy of six months or less as certified, in writing, by a licensed physician (M.D. or D.O.).

Applicants should be referred to a Medicaid approved hospice for the determination of medical eligibility. The list of currently Medicaid approved hospices is attached to this Newsletter.

Financial eligibility is determined by the county welfare agencies (CWA) for all individuals except for those eligible for Supplemental Security Income (SSI) and for Division of Youth and Family Services (DYFS) children under foster care. Supplemental Security Income eligibles should be referred to the appropriate Medicaid District Office (MDO) so that their records on the Medicaid eligibility file are updated for hospice services. For DYFS children under foster care, the eligibles should be referred to the appropriate DYFS District Office so that their records on the Medicaid eligibility file are updated for hospice services.

When providing services to members of the Garden State Health Plan (GSHP), or another Health Maintenance Organization (HMO), an authorization number must be obtained from the applicant's GSHP or other HMO physician case manager prior to providing hospice services.

For further information or questions regarding this Newsletter, please contact Judith Johnston, Social Work Consultant, Office of Home Care Programs, Division of Medical Assistance and Health Services at 609-588-2733 or (609) 588-2751.

Attachment: Medicaid Hospice Provider List