Volume 2 No. 58 September 1992

TO: NURSING FACILITIES

SUBJECT: HOSPICE SERVICES

EFFECTIVE: SEPTEMBER 1, 1992

PURPOSE: To inform nursing facilities of the changes in the policies and procedures governing the reimbursement for room and board services provided on and after September 1, 1992 to a Medicaid recipient residing in a nursing facility and receiving hospice services.

BACKGROUND: Effective July 1, 1991, pursuant to the Omnibus Budget Reconciliation Act of 1986 (OBRA), the New Jersey Medicaid program initiated reimbursement to hospice providers for room and board services in conjunction with MEDICARE hospice care for dually Medicare/Medicaid eligible individuals.

Effective September 1, 1992, in addition to providing room and board services to those dually eligible for Medicare and Medicaid, Medicaid shall also reimburse for room and board services for hospice recipients eligible only for MEDICAID hospice services residing in a nursing facility. (See also the Hospice Services Manual proposed in the New Jersey Register, dated August 17, 1992 at 24 N.J.R. 2778(a)).

Hospice is defined as a philosophy and method of caring for the terminally ill, emphasizing supportive and palliative care rather than curative care. Hospice services also include bereavement counseling and pain control. Currently, hospice providers in New Jersey are hospital-based, or free-standing home health agencies, or free-standing hospice agencies.

ACTION: PLEASE DISCARD AS OBSOLETE THE MEDICAID NURSING FACILITY SERVICES BULLETIN NO. 91-7, DATED JULY 1, 1991 AND REPLACE IT WITH

I. COVERED SERVICES

The New Jersey Medicaid program reimburses hospices who are Medicaid approved and Medicare certified, for nursing facility (NF) room and board services which include the performance of personal care services, assistance in activities of daily living, provision of patient social activities, the administration of medications, the maintenance of cleanliness of the resident's room, and supervision and assistance in the use of durable equipment and prescribed therapies (identical to those provided to non-hospice recipients in a nursing facility).

The hospice recipient agrees to waive most regular Medicaid services by signing the Election of Hospice Benefits Statement (FD-378). Under certain limited conditions, other Medicaid approved services may be provided which are unrelated to the terminal illness and not duplicative of hospice services, e.g., transportation, dental and vision care services. These services must be approved in the hospice plan of care and may continue to be billed to the fiscal agent by each provider in accordance with the established policies and procedures specified in each relevant Medicaid provider manual.

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 of other than hospice services (except physicians services), the provider must obtain approval from the hospice to provide the service.

II. HOSPICE PROVIDER REQUIREMENTS

A hospice must be certified for Medicare (Title XVIII) participation by HCFA as a hospice provider and be enrolled by New Jersey Medicaid program to provide hospice services. A list of currently approved Medicaid providers is attached for your reference.

III. NURSING FACILITY CONTRACT

The nursing facility must also have a written contract with the hospice under which the hospice takes full responsibility for the professional management of the recipient's hospice services and the nursing facility agrees to provide room and board services.

NOTE: The Pre-admission Screening (PAS) regulations do not apply to a hospice patient admitted directly to a nursing facility or transferred from nursing facility care to hospice care. This individual would be considered a hospice patient, not an NF patient. If the hospice patient revokes the hospice benefit and returns to NF care within that or another

nursing facility, the PAS regulations in the Long Term Care Services Manual apply. (See N.J.A.C. 10:63).

IV. 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 were medically qualified for hospice services.

In addition to financial eligibility, the individual applying for Medicaid hospice eligibility must meet the following conditions prior to being determined medically eligible by the hospice:

i. Voluntarily elect the hospice services;

ii. If eligible for Medicare, must assign his or her Medicare Part A bene Medicare and Medicaid programs;

iii. Be certified terminally ill by the attending physician;

iv. Be certified that hospice services are reasonable and necessary for the palliation or management of the terminal illness or related conditions by the attending physician by the completion of the Physician Certification/Recertification for Hospice Benefit Form (FD-385); and

v. Have a plan of care for hospice services established prior to and consistent with the provision of hospice services and waive all rights to those hospice services provided by a hospice other than the one designated by the recipient (unless provided under written arrangements made by the designated hospice).

Medicaid eligible persons or persons who might be applicants for Medicaid hospice services, already residing in a nursing facility, who express interest in hospice services should be referred to the hospice for medical eligibility.

After medical eligibility is determined by the hospice, financial eligibility is determined by the county welfare agencies (CWA) for all individuals except for those eligible for Supplemental Security Income (SSI) and Division of Youth and Family Services (DYFS) foster children. SSI 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 children under DYFS foster care, the appropriate DYFS District Office should be contacted to update the Medicaid eligibility files for hospice services.

When providing services to a member of the Garden State Health Plan (GSHP) or another HMO, an authorization number must be obtained from the recipient's GSHP or other HMO physician case manager prior to providing services to hospice recipients. Hospice agencies must use that authorization number when billing for services provided to a GSHP or other HMO member.

V. RETROACTIVE ELIGIBILITY

Retroactive eligibility for hospice services will not be available prior to September 1, 1992. No retroactive eligibility payment will be authorized for hospice services prior to the date the Election of Hospice Benefits Statement (FD-378) is signed. Retroactive eligibility for hospice services may be established for up to three months prior to the date of Medicaid eligibility, provided the Election of Hospice Benefits Statement (FD-378) had been signed. Such cases must be referred to the following address for determination of retroactive eligibility:

Division of Medical Assistance and Health Services
Retroactive Eligibility Unit
CN-712
Trenton, New Jersey 08625-0712

VI. REIMBURSEMENT

The New Jersey Medicaid program reimburses the hospice on a per diem basis for room and board services provided at the specific NF where the hospice recipient is residing in addition to payment for routine or continuous home care services. The rate is calculated at 95% of the Medicaid nursing facility per diem rate, institutionally specific, effective at the time the services are provided, excluding retroactive rate adjustments, retroactive add-ons and special program rates. The NF contracts with the hospice to accept the recipient based on actual room and board components provided to the recipient by the NF.

The New Jersey Medicaid program shall continue to pay the hospice the room and board rate for the purpose of retaining the bed for therapeutic leave or during a period of hospitalization, if indicated. The hospice is responsible through its contract with the NF to reimburse the NF to retain the bed.

i. Nursing Facility Bed Reservation Days - For therapeutic leave from the NF to home: The rate for therapeutic leave, not to exceed 24 days per calendar year, is paid to the hospice provider in addition to the rate for routine or continuous home care.

ii. Nursing Facility Bed Reservation Days - During a period of hospitalization: Bed Hold days are not to exceed 10 consecutive days per period of hospitalization. The bed hold days rate is paid to the hospice in addition to the rate for general inpatient care.

VII. NURSING FACILITY ADMINISTRATIVE PROCESS (for admission and discharge)

1. If a recipient of hospice services is admitted to a nursing facility (NF) from any location, or is changed from nursing facility status to hospice status (while residing in a nursing facility), the NF must submit to the appropriate MDO and the CWA, a completed Notification from Long-Term Care Facility of Admission or Termination of a Medicaid Patient (MCNH-33) to prompt a change in the recipient's status from nursing facility patient to hospice patient.

    i. This process prompts the CWA or MDO to convert the patient from an NF patient to a hospice patient using a unique "Special Program Number 15" which reflects hospice status.

    ii. Also, if the hospice recipient revokes hospice services and returns to NF care, the NF must again submit a completed MCNH-33 to the CWA and the MDO to reflect the change in eligibility status.

2. If the recipient residing in an NF chooses hospice benefits, the NF must submit to the fiscal agent a completed Long Term Care Facility Turnaround Document (TAD)(MCNH-117) to remove the patient from the Long Term Billing System. The following information should be placed on the MCNH-117 in the Remarks column (Field #38):

    "DISCHARGED FROM NURSING FACILITY TO HOSPICE"

    The hospice recipient is removed from the Long Term Care Billing System effective on the date the Election of Hospice Benefits Statement (FD-378)(6/92) is signed. On the date the recipient signs the Election of Hospice Benefits Statement and thereafter, Medicaid will no longer reimburse the NF directly for any services rendered to the hospice recipient. The hospice under contract with the NF will be responsible for reimbursing the NF for room and board services provided by the NF.

3. If the recipient revokes hospice benefits and returns to NF care, the NF must complete and submit the MCNH-117 form to the fiscal agent to admit the patient back into NF care and the Long Term Care Billing System. The following information should be placed on the MCNH-117 in the Remarks column (Field #38):

"ADMITTED TO NURSING FACILITY AND DISCHARGED FROM HOSPICE"

The effective date of the change from hospice care to nursing facility care is the date the Revocation of Hospice Benefits Statement is signed. The nursing facility will be reimbursed for care provided on this date and thereafter, and the hospice will no longer be reimbursed for care beginning on this date.

VIII. APPLICATION OF RECIPIENT'S AVAILABLE INCOME

For a recipient who is residing in a nursing facility and receiving hospice under Medicaid, payment to the hospice for room and board services must be reduced by the recipient's available income. An accurate Statement of Available Income for Medicaid Payment (PA-3L) must be generated in accordance with usual practice by the CWA and sent to the hospice.

1. ON ADMISSION FROM A NURSING FACILITY: For the recipient who is admitted to hospice care status from an NF during a given calendar month, the available income may have already been utilized by the NF to offset the cost of care in the same month of admission to hospice care status. Thus, no income is available to the hospice for the first calendar month. This applies only if it is a partial calendar month of hospice room and board services. No new PA-3L is generated by the CWA but a copy of the PA-3L form must be provided to the hospice from the NF and kept in the patient's record.

2. ON DISCHARGE: For the discharge month in hospice care, the available income amount shown on the PA-3L must be applied to the cost of care. If the income exceeds the charge for that month, the balance of income not applied to the cost of care shall be returned to the recipient, except under the following circumstances:

    i. In accordance with existing policy, for the hospice recipient who is discharged to the community, the amount of available income may be reduced by an amount to cover living expenses. This amount must be reflected on the PA-3L form. When the PA-3L does not reflect the reduction, the hospice has been advised to contact the CWA to effect the change.

    ii. For the hospice recipient who dies on the first, second, or third day of the month, and income is not available because the check could not be endorsed and was returned, the hospice must so annotate this fact in Field 34 (Remarks) on the 1500 N.J. claim form. No further documentation is required by the hospice.

    iii. For the hospice recipient who dies after the third day of the month and the income was not available because the check was returned, the hospice must so annotate this fact in Field 34

(Remarks) on the 1500 N.J. claim form and retain this documentation (e.g. SSA transmittal receipt) in the hospice billing files.

iv. For the hospice recipient who is admitted to nursing facility care (in the same or a different NF) after being discharged from the hospice, the hospice must provide information to the NF concerning the amount of available income which was applied to the bill in the discharge month so that the NF may accurately reflect the balance amount for the NF admission month billing. The nursing facility must also complete an MCNH-33 form to notify the CWA and MDO of the discharge of the hospice patient from hospice care and the income applied to the hospice service, so that the CWA can issue a new PA-3L form for the month of admission to the NF.

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

Attachment: Medicaid Hospice Provider List