2135 – HOSPICE CARE

POLICY STATEMENT	Hospice Care is a class of assistance (COA) that provides Medicaid to cover care for terminally ill individuals.
BASIC CONSIDERATIONS	To be eligible under the Hospice Care class of assistance an A/R must meet the following conditions: • The A/R has a medical prognosis of six months or less li expectancy. • The A/R is receiving hospice care services from an approve hospice care provider. • The A/R meets the Length of Stay (LOS) and Level of Care (LO(basic eligibility criteria. • The A/R meets all other basic and financial eligibility criteria. Hospice care services are provided to the A/R by a Medicaid hospice agency. The A/R may reside at home or in a nursing home. Hospice care services include but are not limited to the following: • nursing home • medical social services • physician services • counseling services • respite care • home health aide services. **NOTE:** DMA only reimburses for medical services provided by the hospice care agency. These recipients receive a Medicaid card that identifies them as hospice care recipients, with a notation to medical service providers that all claims must be submitted through the hospice agency. There is no patient liability or cost share under this COA.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the Hospice Care COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Verify the following through receipt of a Hospice Care Communicator (HCC) from the hospice agency:

- A/R's medical prognosis (life expectancy)
- A/R's (or PR's) election of hospice services
- Date hospice care services began.

Step 3 Conduct a face-to-face interview.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility.

- Refer to the Chapter 2500, ABD Financial Responsibility a Budgeting, for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.

  - Complete a Medicaid CAP budget to determine incon eligibility. Refer to the Section 2510, Medicaid CAP Budgeting.

Step 6 Approve Medicaid on the system using the Hospice Care COA if the A/R meets all the above eligibility criteria.

For an A/R receiving hospice care services in a **nursing home** who has income in excess of the Medicaid CAP, determine AMN eligibility by projecting the monthly cost of the hospice in the same manner as for an AMN nursing home case. See Section 2151, AMN Nursing Home.

Step 7 Notify the A/R of the case disposition via the system. Notify the hospice provider of the case disposition using the Hospice Care Communicator.

PROCEDURES (cont.)	
Step 8	Verify at the following intervals through receipt of an HCC that the hospice care provider has received a signed statement from the A/R electing to continue hospice care services: • by the end of the first 90 day period of hospice care • by the end of the second 90 day period of hospice care • every 60 days thereafter. **NOTE:** Do **not** approve Medicaid under the Hospice Care COA for any month in which the A/R will not receive hospice services from an approved hospice agency. If the A/R does not elect to continue hospice services at the intervals specified above, complete a CMD. Refer to the Section 2052, Continuing Medicaid Determination.
SPECIAL CONSIDERATIONS	For any month in which an A/R is in Hospice care **and** another COA such as Hospital or Nursing Home, approve the case on the system under the **other** COA. Use Hospice COA when the A/R is in Hospice and not eligible under any other COA for a particular month.