2136 – INSTITUTIONALIZED HOSPICE

POLICY STATEMENT	Institutionalized Hospice is an ABD Medicaid Class of Assistance (COA) that provides Medicaid to terminally ill individuals who receive hospice care services while residing in a Medicaid participating nursing home.
BASIC CONSIDERATIONS	To be eligible under the Institutionalized Hospice COA, an A/R must meet the following conditions: • The A/R is receiving or elects to receive Hospice Care services while residing in a Medicaid participating nursing home. • The A/R has a medical prognosis of six months or less life expectancy. • The A/R is receiving Hospice Care services from an approved hospice care provider. • The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria. • The A/R meets all other basic and financial eligibility criteria required for the Hospice Care COA. **EXCEPTION:** A DMA-59 is not required unless the A/R leaves hospice care and remains in the nursing home under Medicaid. Hospice care services are provided to the A/R by a DMA certified hospice agency. Effective April 1, 2003, Medicaid eligible persons who receive or elect hospice care services while residing in a nursing home must pay a monthly patient liability amount to the hospice care provider. The hospice care provider will pay to the nursing home the patient liability amount. **NOTE:** DMA reimburses only those medical services provided by the hospice care agency. These recipients receive a Medicaid card that identifies them as Hospice recipients, with a notice to medical service providers that all claims must be submitted through the hospice agency.

PROCEDURES

Follow the steps below to determine ABD Medicaid eligibility under the Institutionalized Hospice 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
- The date hospice services began

Step 3 Conduct an 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 Chapter 2500, ABD Financial Responsibility and Budgeting, for determining whose resources to consider and the resource limit to use.

NOTE: The patient liability for Institutionalized Hospice is determined the same way as for non-hospice nursing home care. The personal needs allowance (PNA) is the same as the NH's PNA, and the allowable income deductions are identical to those allowed for NH A/Rs. There is no proration of patient liability if the recipient transfers between Hospice and non-Hospice in the same nursing home.

Step 6 If the A/R meets all the above eligibility criteria, approve Medicaid on the system.

Step 7 Notify the A/R of the case disposition via the system. Notify the hospice provider of the case disposition and Patient Liability using the Hospice Care Communicator (HCC) and enter the hospice provider as an Authorized Representative in the system.

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 Institutionalized Hospice services:

- by the end of the first 90 day period of Institutionalized Hospice
- by the end of the second 90 day period of Institutionalized Hospice
- every 60 days thereafter

PROCEDURES (cont.)

NOTE: Do not approve Medicaid under the Institutionalized Hospice 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 Section 2052, Continuing Medicaid Determination.

SPECIAL CONSIDERATIONS

Effective September 1, 2004, the AMN IH COA will be eliminated due to a change in the State Plan. Complete a CMD to determine if the A/R is eligible under another COA such as regular AMN.

If the A/R was Medicaid eligible under the NH COA prior to IH or no longer elects IH but remains in the NH, refer to Appendix I, SUCCESS Functions for instructions on how to code in SUCCESS.

NOTE: All SSI only recipients must be entered and processed on Success. These cases should be consistent with case management for SSI only nursing home cases. See **SSI Recipients, Section 2578.**

Sanctions

If the NH is under a Medicaid sanction resulting in a 'ban on admissions', no Hospice Care Communicator (HCC) should be sent to DFCS until such time as the ban is lifted. Until the 'ban on admissions' is lifted, no A/R should be approved for the IH COA if the A/R is admitted to IH on or after the effective date of the ban on admissions. A ban on admissions has no affect on A/Rs who are already Medicaid recipients in IH or who were admitted to IH prior to the imposition of the ban.

If an application is received on an A/R who was admitted during the time the 'ban on admissions' is in place, hold the case until either the ban is lifted and the case can be approved under the IH COA or the standard of promptness (SOP) is reached. If the case cannot be approved under the IH COA by the SOP date, determine eligibility under another COA such as regular AMN. Do not determine eligibility under any LA-D COA. If the 'ban on admissions' is subsequently lifted, historically close the other Medicaid case and approve under the IH COA back to the first month of eligibility.

The county DFCS will be copied on the facilities notification of 'Denial of Payment' from DCH/Aging and Community Health Services. The county DFCS will also be copied when the Denial of Payment ban is lifted.