310–J HOSPICE SERVICES

REVISION DATE: 5/8/2019
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REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, and Arizona's Section 115(a) Medicaid Demonstration Extension.

This Policy establishes requirements for Hospice Services. Hospice services are covered for members eligible for AHCCCS. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989, and 42 CFR 418.20, for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member's own home, an alternative residential setting, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

A. Hospital

B. Nursing care institution

C. Freestanding hospice.

Providers of hospice must be Medicare certified, licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, members receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

For dual eligible members, Medicare is the primary payer of hospice services.

Definitions

The following definitions apply to Hospice Services:

A. Bereavement Counseling - Emotional, psychosocial, and spiritual support and services provided before and after the death of a member to assist the family with issues related to grief, loss, and adjustment.

B. Continuous home care - Services provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous) to maintain residence in their own home as specified in 42 CFR 418.204(a). Care must be predominantly nursing care, provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Homemaker and home health aide services may also be provided to supplement the care.

C. Palliative care - Member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering and is provided to address physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice.

D. Period of crisis - A period (up to 24 hours per day) in which the hospice-eligible member

requires continuous care to achieve palliation or management of acute medical symptoms.

E. Terminally ill - A medical prognosis of life expectancy for six months or less if the illness runs its normal course.

Policy

Hospice Care is a comprehensive set of services identified and coordinated by an interdisciplinary group to provide palliative and support care for terminally ill members and their family members and caregivers for the physical, psychosocial, spiritual, and emotional needs as delineated in a specific patient plan of care.

Hospice Services are covered for all terminally ill members who meet the specified medical criteria and requirements under A.R.S. §§ 36-2907, 36-2939, and 36-2989, and 42 CFR Part 418 et seq.

In order to receive Hospice Care, Members must waive the right to duplicative services including: hospice care provided by a non-designated hospice service; services that are related to the treatment of the terminal condition or a related condition, unless provided by the designated hospice, provided by the attending physician, or provided as room and board by a nursing facility where the member is a resident as specified in CMS Medicaid Manual section 4305.2. This waiver does not apply to EPSDT-aged members.

If the Hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor however must report such cases to ADHS as the hospice licensing agency in Arizona.

A. Eligibility

1. A physician must provide a signed certification stating that the member's prognosis is terminal, with the member's life expectancy not exceeding six months. However, due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months, provided additional physician certifications are completed.

2. A member may elect to receive Hospice Care during one or more of the following election periods:

   a. An initial 90-day period,

   b. A subsequent 90-day period, or

   c. An unlimited number of subsequent 60-day periods.

3. As specified in Section 2302 of the Affordable Care Act, EPSDT-aged members may continue to receive curative treatment for a terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care related to the terminal diagnosis but may continue to receive services unrelated to the hospice diagnosis.

B. Hospice Services

Hospice services provide palliative and support care for terminally ill members and

their family members and caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement. When the conditions of participation are met as specified in 42 CFR Part 418, hospice services are provided in the member's own home, or the following inpatient settings:

1. Hospital.

2. Nursing care institution.

3. Free standing Hospice Unit.

Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services, and inpatient services available as necessary to meet the member's needs. The following bundled hospice services are covered when provided in approved settings:

1. Physicians' services for the treatment of the member's terminal illnesses and related administrative and general supervisory activities, except for attending physician services provided by non-hospice employees;

2. Continuous Home Care;

3. Dietary services, which include a nutritional evaluation and dietary counseling when necessary;

4. Home health aide services;

5. Homemaker services;

6. Nursing services provided by or under the supervision of a registered nurse;

7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology, or a related field and who is appropriately licensed or certified;

8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting;

9. Routine Home Care;

10. Social services provided by a qualified social worker;

11. Therapies that include physical, occupational, or speech therapy;

12. A 24 hour on-call availability to provide services such as reassurance, information, and referral for members and family members and caregivers;

13. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee. Under 42 C.F.R. 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services;

14. Medical supplies, appliances, and equipment, including:

    a. Pharmaceuticals, which are used in relationship to the palliation or management of the member's terminal illness; and

    b. Medical equipment and appliances may include but are not limited to:

        i. Wheelchairs,

        ii. Hospital beds, and

        iii. Oxygen equipment.

15. Bereavement counseling to the member's family and caregiver both before and up to 12 months following the death of that member. Bereavement Counseling, to the member's family and caregiver both before and up to 12 months following the death of the member, is part of the bundled hospice services and is not separately reimbursable, as specified in 42 CFR 418.204.30.