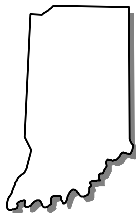
Indiana Title XIX



MEDICAID BULLETIN

BT199904 JANUARY 26, 1999

To: **Medicaid Hospice and Home- and Community-Based Services Waiver Providers**

Subject: **Election of Hospice Services by Home- and Community-Based Services Waiver Recipients**

Overview

The Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP), modified the Indiana*AIM* system, effective March 20, 1998, so that home- and community-based services (HCBS) waiver recipients may enroll in the Medicaid hospice benefit without having to disenroll from the Medicaid waiver program. The impact this modification will have on both providers and Medicaid waiver recipients is outlined in this bulletin.

Requirements of Hospice/Waiver Providers to Ensure an Overall Continuum of Care for the Medicaid Waiver/Hospice Recipient

The hospice provider and the waiver case manager should collaborate to ensure that the waiver recipient is provided with as much information as possible prior to the election of the Medicaid hospice benefit. It should be made clear to the waiver recipient that the hospice provider will serve as the case manager of the recipient's hospice care, NOT the waiver provider. As such, the hospice provider is responsible for providing all the services necessary for the treatment of the Medicaid recipient's terminal illness. The hospice covered services are outlined in the *hospice covered services and reimbursement rule*. The waiver case manager will still coordinate those waiver services not duplicative of hospice care that are necessary to meet the needs of the Medicaid recipient's nonterminal conditions.

Hospice providers are reminded that the Indiana Medicaid program expects the hospice provider to actively interface with other providers

providing nonhospice services based on the individual needs of the Medicaid hospice/waiver recipient. When a waiver recipient is enrolled in the Medicaid hospice benefit, the following is required of each provider:

- The hospice provider's plan of care must reflect those hospice services required to care for the Medicaid recipient's terminal condition(s).
- The waiver provider's plan of care must reflect those waiver services required to care for the Medicaid recipient's nonterminal condition(s).
- The collaboration between hospice providers and waiver providers is required to ensure a continuum of the overall care for the Medicaid waiver/hospice recipient.
- Waiver providers and hospice providers are expected to communicate with each other any change in their respective plans of care that may impact the other provider's plan of care.
- Under no circumstance should the Medicaid waiver program provide more hours of service for a Medicaid waiver/hospice recipient than the Medicaid waiver program would have provided had that Medicaid waiver recipient not elected hospice.
- The waiver case manager will have to determine the appropriate number of hours of service on a case-by-case basis when the waiver case manager meets with the hospice provider to collaborate in preparation of the individual plans of care prepared by each provider.
- The preparation of each provider's plan of care is impacted by the individual waiver program in which the Medicaid recipient is enrolled and the Medicaid recipient's specific hospice primary diagnosis.

In conclusion, the ongoing communication by hospice providers and waiver case managers is required to ensure that the respective plans of care address the waiver/hospice recipient's overall care because the hospice provider cares for the terminal illness and the waiver provider cares for the nonterminal conditions.

Overview of Hospice/Waiver Services

Services Provided by the Hospice Provider

Once a Medicaid waiver recipient elects the Medicaid hospice benefit, the hospice provider becomes the professional manager (case

manager) of the hospice patient's hospice care. The hospice provider will provide those services outlined in the *hospice covered services and reimbursement rule*. A copy of the *hospice covered services and reimbursement rule* may be obtained by contacting Myers and Stauffer LC, Medicaid's long-term care rate-setting contractor, at (317) 846-9521.

This policy change means that those services related to the terminal condition as well as those services that both programs have in common will be administered and paid for by the hospice provider. Under no circumstances should the Medicaid waiver program provide any of these common services for the care of the terminal condition because this would constitute duplication of the Medicaid recipient's hospice care.

These "common" services include the following:

- Attendant care or personal assistance by qualified home health aides only
- Respite care—Attendant or personal assistance by qualified home health aides only
- Homemaker
- Respite—Homemaker
- Respite care—Nursing facility limited to five days
  - payment at 95 percent of the intermediate level-of-care rate and effective October 1, 1998, payment at 95 percent of the single nursing facility case mix rate
- Physical therapy
- Occupational therapy
- Speech or language therapy

The hospice provider may employ any professional qualified to provide respite care, homemaker services, and attendant or personal care and still be reimbursed at the routine home care rate. This means that the hospice provider can opt to have attendant or personal care services provided by a home health aide rather than a nurse. The hospice provider may use a nurse when the hospice recipient requires more intensive nursing care and is at the continuous care rate.

It is the responsibility of the hospice provider to immediately notify the waiver providers currently delivering these "common" services through the waiver program that the recipient has elected the Medicaid hospice benefit and that claims will not be paid for "common" services

rendered by the waiver provider for dates of service 10 days or later from the hospice election date.

The hospice provider is the only provider that can bill the Indiana Medicaid program for these services for service dates beginning 10 days after the hospice election date. The hospice provider must use a UB92 claim form to bill for these services.

Services Provided By the Waiver Provider

The waiver recipient who elects the Medicaid hospice benefit may still receive waiver services that are NOT RELATED to the terminal illness and are not duplicative of hospice care. These particular waiver services will continue to be authorized by the waiver case manager and will be referred to in this bulletin as "noncommon" services.

These "noncommon" services include the following:

- Case management
- Case management assessment—level-of-care
- Case management assessment—psychological
- Case management assessment—speech evaluation
- Case management assessment—audiological
- Rehabilitative services—independent living support
- Adult day care
- Homemaker for Aged and Disabled Waiver for those services that the hospice provider may not administer, such as grocery shopping, transportation to medical appointments, and picking up the recipient's prescriptions. The waiver will only provide those services not duplicative of the hospice homemaker services.
- Residential-based habilitation and ADL training
- Day habilitation—individual
- Day habilitation—group
- Prevocational services
- Behavior management
- Audiological therapy—home health agency
- Audiological therapy—(Indiana Division of Disability, Aging, and Rehabilitative Services-Habilitation Agency or other)
- Supported employment

- Environmental modifications—initial
- Environmental modifications—maintenance
- Attendant care—(Indiana Division of Disability, Aging, and Rehabilitative Services) for those services that may not be administered by the hospice provider; such as running errands or picking up prescriptions. The waiver provider will only administer those services not duplicative of hospice attendant care.
- Attendant care—(nonagency) for those services that may not be administered by the hospice provider; such as running errands or picking up prescriptions. The waiver provider will only administer those services not duplicative of hospice attendant care.
- Home delivered meals
- Assistive technology—initial
- Assistive technology—maintenance
- Personal emergency response system—installation
- Personal emergency response system—monthly charge
- Minor home modifications—initial
- Minor home modifications—maintenance
- Adaptive aids and devices—initial
- Adaptive aids and devices—maintenance

The waiver providers must continue to bill for these "noncommon" services using a HCFA 1500 claim form.

Contractual Arrangements by the Hospice Provider

As previously mentioned, the hospice provider becomes the professional manager (case manager) of the hospice patient's hospice care. The hospice provider can enter into a contract with other agencies to deliver the hospice core services on behalf of the hospice provider. When the hospice provider enters into such contracts, the hospice provider must ensure that the contracted agency delivers the hospice core services in compliance with Medicare regulations.

As the manager of the hospice patient's care, the hospice provider is the entity that authorizes these hospice services. These hospice services must be billed to Medicaid by the hospice provider on a UB92 claim form. Under these circumstances, the OMPP reimburses the hospice provider who then reimburses the other providers or agencies that serve as contractors to the hospice provider.

Possible Contracts between the Hospice/Waiver Providers

The hospice provider can enter into contracts with other agencies to deliver the hospice core services on behalf of the hospice provider. This section of the bulletin is intended to address possible operational concerns that could be raised by waiver/hospice providers regarding independent contracting arrangements between the two providers for those services held in common to treat the terminal condition of the hospice/waiver recipient. The contracts between hospice/waiver providers would permit for the continuity of providers for the hospice/waiver recipient.

Hospice/waiver providers are under no obligation to enter contracts with each other for the waiver provider to serve as a contractor of the hospice provider to deliver the common services to treat the terminal condition. Under this contractual arrangement, the hospice provider would reimburse the waiver provider from the hospice *per diem*. Indiana Medicaid would not pay any additional monies above the hospice *per diem* to the hospice provider.

The following parameters must be met if a hospice provider enters into a contract with a waiver provider to provide common services to treat the terminal condition:

- The hospice provider would only contract with the waiver provider to deliver those services that both programs hold in common to treat the terminal condition.
- The hospice provider must make sure that the services the waiver provider would deliver are within established Medicare regulations (for example, appropriate level of staff).
- If the services to be delivered by the waiver provider do not meet the Medicare guidelines of hospice care, then the hospice provider must not enter into a contract with the waiver provider to deliver those common services for the care of the terminal condition.
- In this contractual relationship, the waiver provider would serve as an independent contractor to the hospice provider and the hospice provider has the oversight of the individual's hospice care.
- The hospice provider must reimburse its contractor through the hospice *per diem*. Under this contractual arrangement the waiver provider must not bill Medicaid directly.
- Indiana Medicaid will not pay additional funds over the hospice *per diem* to the hospice provider for these contracted services.

- Under this contract, the hospice provider is the entity responsible for the hospice/waiver recipient's hospice care so the contract should include a framework for partnership, identify a conflict resolution mechanism in the event of disputes, a joint plan for continually assessing and improving patient care, and the terms and procedures for formal review and renewal of the relationship on a regular basis.
- Under this contractual arrangement, it is the hospice provider who authorizes these common services and then bills Medicaid for the common services on a UB92 claim form. As previously mentioned, the hospice provider then reimburses the waiver provider in accordance with the contract.

In this situation, the OMPP will pay the hospice provider who then is responsible for reimbursing the waiver provider. Under this contract, the hospice/waiver recipient would have continuity of care and staff support for the "common" services delivered by the waiver provider during the last stages of the hospice/waiver recipient's life. If the hospice provider enters into a contract with the waiver provider to deliver those "common services", then the hospice recipient should be told that these services will continue to be delivered by the same provider who was performing the service delivery under the waiver program, but that the service is authorized by the hospice provider.

Conclusion

The early and ongoing collaboration of both the hospice case manager and the waiver case manager will be instrumental in the smooth coordination and delivery of nonduplicative services to the hospice/waiver recipient through each program. For instance, there may be some overlap between the attendant care and homemaker services offered by each program and the collaboration of both case managers will be imperative to avoid duplication of services. Both case managers will also need to ensure that the hospice recipient does receive additional homemaker (for Aged and Disabled Waiver) and attendant care services available through the waiver program that the hospice provider may not administer. As the hospice recipient has not disenrolled from the waiver program, the recipient may receive those additional homemaker and attendant care services through the waiver program that are not duplicative of hospice care. Finally, if at any time the hospice/waiver recipient wishes to revoke the Medicaid hospice benefit to receive services only through the waiver program, then the recipient may do so with minimal interruption of service because the recipient's waiver slot has been retained. In conclusion, the ongoing

collaboration of both case mangers once the waiver recipient elects hospice, should facilitate the resolution of service delivery issues as they arise.

If the hospice provider elects NOT to enter into an agreement with the waiver provider(s) to deliver the "common" services, then the hospice recipient should be advised that the recipient will retain those "common services" but that the services will be delivered by the hospice provider(s) or through the hospice provider’s contractors. As previously mentioned, it is the responsibility of the hospice provider to immediately notify the waiver providers currently delivering these "common" services through the waiver program that the recipient has elected the hospice benefit and that claims will not be paid for "common" services rendered by the waiver provider for dates of service 10 days or later from the hospice election date. REGARDLESS OF HOW THESE COMMON SERVICES ARE PROVIDED, ONCE THE HOSPICE CARE IS EFFECTIVE, THE WAIVER PROVIDER MUST NOT BILL MEDICAID FOR THE PROVISION OF THE EQUIVALENT WAIVER SERVICES FOR THE TERMINAL CONDITION(S).

Further inquiries regarding the hospice benefit, or questions regarding this bulletin, may be directed to the EDS Provider Assistance Unit at (317) 655-3240 or 1-800-577-1278.