Government Business Division
Policies and Procedures

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Utilization Management</td><td colspan="2"><u>SUBJECT (Document Title)</u>
Hospice Care - CA</td></tr>
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12/11/1997</td><td>Date of Last Review
02/08/2024</td><td>Date of Last Revision
01/25/2023</td><td>Dept. Approval Date
02/08/2024</td></tr>
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Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Medicaid (Anthem) provides and reimburses for hospice care services. Any Anthem recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal program coverage for services related to the terminal condition. However, for a member under age 21, who voluntarily chooses hospice care may continue to be provided with treatment for the condition for which a diagnosis of terminal illness has been made. For individuals who have elected hospice care, Anthem will arrange for continuity of medical care, including maintaining established patient-provider relationships to the greatest extent possible and will continue to provide for all medical care not related to the member's terminal condition.

Medicare certified facilities provide the appropriate level of care for members in need of hospice care. Admission to a nursing facility of a Member who has elected covered hospice services does not affect their eligibility for enrollment with Anthem. Hospice services are considered covered services with Anthem and are not long-term care services regardless of the Member's expected or actual length of stay in a nursing facility.

Members are informed of the availability of hospice care as a covered benefit through the receipt of their Evidence of Coverage.

DEFINITIONS:

Hospice care: Hospice care is multi-disciplinary care designed to meet the needs of a terminally ill individual. It is the provision of palliative and supportive items and services as described below by a hospice provider or by arrangements made by the hospice provider for an individual who has voluntarily elected to receive such care in lieu of curative treatment related to terminal condition. A physician must certify that the member's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

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Hospice services include:

- Nursing services;
- Physical, occupational and speech therapy;
- Medical social services under the direction of a physician;
- Home health aide and homemaker services;
- Medical supplies and appliances;
- Drugs and biological;
- Physician services (see below);
- Short term inpatient care;
- Counseling services related to the adjustment of the member's approaching death; counseling, including bereavement, grief, dietary and spiritual counseling;
- Continuous nursing services may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill member at home. A crisis can be defined as the period in which a member requires continuous care for as much as 24-hours to achieve palliation or management of acute medical symptoms. Care provided requires a minimum of eight hours of nursing care, a minimum of 51 percent of time must be by a licensed nurse, within a 24-hour period commencing at midnight and terminating on the following midnight. Nursing care includes either homemaker or home health aide services. The eight hours of care does not need to be continuous within the 24-hour period, but an aggregate of eight hours of primarily nursing care is required.
- Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing or hospice facility.
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility.
- Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the hospice plan of care.

Note: Physician services include: (1) general supervisory services of the hospice medical director; and, (2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician of the hospice interdisciplinary team (Title 42, Code of Federal Regulations (CFR), Section 418.304 and Title 22, California Code of Regulations (CCR), Section 51544). Physician services not described above shall be billed to the MCP separately and include services of the member's attending physician or consulting physician(s) if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Physician visits by a hospice-employed physician, medical director, or consultant are billable separately to Anthem.

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Hospice care is palliative in nature and is used to alleviate pain and suffering, and to treat symptoms rather than cure the illness. Care is directed toward the physical, psychological, social and spiritual needs of the patient/family unit. Medical and nursing services are designed to maximize the patients' comfort. Hospice services are made available 24 hours a day on an as needed basis. Hospices also provide bereavement counseling for the immediate family and significant others.

Levels of Hospice Care: These include the following:

- Routine Home Care: Care received at the patient's home and includes routine nursing service, social work, counseling services, durable medical equipment, supplies, drugs, home health aide/homemakers, personal care attendants, physical therapy, occupational therapy and speech language pathology therapy. Payment is made on an all-inclusive per diem basis without regard to the volume or intensity of services on any given day.
- Continuous Home Care: Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. A period of crisis is a time when a patient requires continuous care (primarily professional nursing care) to achieve palliation or the management of acute medical symptoms. Nursing care must be provided by an RN or a Licensed Vocational nurse (LVN). The RN/LVN must be providing care for more than half of the period of care. A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. The care need not be continuous (i.e., four hours may be provided in the morning and another four hours be provided in the evening of that day). Homemaker and home health aide services may also be provided to supplement the nursing care.
- Respite Care: Occurs when the patient receives care in an approved inpatient facility on a short-term basis to provide relief for the family member's or others caring for the individual.
- Inpatient Care: When the patient receives general care in an inpatient facility for pain control, or acute/chronic symptom management that cannot be managed in the patient's residence, or other settings such as chemotherapy/radiation for pain palliation by reducing tumor growth. Response time for Inpatient Hospice Care is 24 hours.

Specialty Physician Services: Services furnished by a physician under arrangement with the hospice for managing symptoms that cannot be remedied by the patient's attending physician because of immediate need; care is outside the primary care physician's scope of practice.

Terminally Ill: Terminally ill as defined in Title 22 CCR Section 51180.2 means that an individual's medical prognosis as certified by a physician, results in a life expectancy of six

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months or less if the disease follows its natural course.'' 42 CFR 541 8.22(b) requires that the physician certification contain the qualifying clause: "the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course." Pursuant to contractual requirements, managed care plans may not deny hospice care services to members certified as terminally ill.

Types of Hospice Providers: Hospice Providers may include the following:

- Hospitals;
- Skilled Nursing Facilities;
- Intermediate Care Facilities;
- Home Health Agencies;
- Any licensed provider certified by Medicare to provide hospice care.

PROCEDURE:

I. Members over the age of 21

A. Prior authorization is not required for in network hospice. This includes inpatient hospice services (hospital, skilled nursing, or inpatient rehab). Prior authorization is required for all Non-Par services. When prior authorization is required:
   1. Hospice shall notify Anthem of general care placement that occurs after normal business hours on the next business day.
   2. Hospice inpatient services are covered services and are not categorized as Long Term Care services regardless of the member’s expected or actual length of stay in a nursing facility (NF) while also receiving hospice care.
   3. The provision of hospice care while an individual is a resident of a skilled nursing facility (SNF) or intermediate care facility is allowed.
   4. If inpatient hospice is being requested, then the authorization and payment will be provided to the hospice agency, which will in turn reimburse the facility for room and board.

B. Once a request for Hospice evaluation is received, the reviewing nurse verifies the following:
   1. Member eligibility
      The member has been diagnosed with a terminal illness, with a life expectancy of six (6) months or less

   Notes: As stated in Section 1812(d)(1) of the Social Security Administration (SSA) and Title 42, CFR, Section 418.21, an individual may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods;

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C. The Utilization Management (UM) or Case Management staff authorizes services for three (3) months (in order to recheck eligibility and participation in the program) and extends the services as necessary.

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D. The UM nurse or Case Management staff notifies the Hospice agency and documents that requests for continuation of hospice care beyond the authorization period is mandatory.

E. A member's voluntary election of hospice care may be revoked or modified at any time during an election period. if the member or member's representative files a statement with the hospice that includes:
   1. A signed statement that the member or representative revokes the election for Medi-Cal coverage for the remainder of the election period;
   2. The effective date, which may not be retroactive
   3. At any time after the revocation, an individual may execute a new election, thus restarting the 90/90/unlimited 60-day certification periods of care. An individual or representative may change the designation of a hospice provider once each benefit period. This change is not a revocation of the hospice benefit (Title 42, CFR, Sections 418.28 and 418.30).
   4. Members who do not meet criteria because their life expectancy is greater than 6 months, or because they continue to receive curative care, may be referred to Palliative Care services in accordance with our palliative care policy and APL-17-015.

   Note: If a member revokes the hospice benefit, or is discharged by the hospice for cause and later elects hospice and is readmitted to the same or different hospice provider, then the 90/90/unlimited 60-day election periods are initiated as if hospice is starting anew. A member's change from one designated hospice to another is not considered a revocation of the hospice election.

II. Members under the age of 21

A. Children with a California Children's Services (CCS) eligible medical condition are eligible to receive case management services through CCS for palliative care in conjunction with services to treat their CCS condition.

   NOTE: CCS does not cover hospice care, including respite care, post death family bereavement counseling, spiritual counseling, individual art, music, activity/play therapists, child life specialists, and traditional hospice care concurrently with curative or life-prolonging treatment. Members with a terminal condition covered by CCS must

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be clearly informed that the election of hospice care will terminate the member's eligibility for CCS services.

B. For questions regarding palliative/hospice services for eligible children, Anthem's Medical Management nurses should contact CCS directly at (916) 327-1400. Continuity of medical care, including maintaining established patient-provider relationships, will be facilitated to the greatest extent possible. The Medical Management nurses will ensure consultation and coordination with the local CCS program (when applicable), and/or other caregivers, when necessary.

<u>REFERENCES</u>:

- Anthem Blue Cross Provider Manual, Last updated January 2023
- CA Health and Safety (H&S) Code, Section1368.2
- Central Valley/Bay Area, Rural Expansion, Tulare, Sacramento, San Benito, and Tri-County Contracts, Exhibit A
- Department of Health Care Services (DHCS) Notification #N.L. 04-0207 "PALLIATIVE CARE OPTIONS FOR CCS ELIGIBLE CHILDREN" (February 2007), retrieved from http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl040207.pdf
- DHCS APL 13-014 "HOSPICE SERVICES AND MEDI-CAL MANAGED CARE" (October 2013), retrieved from http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-014.pdf
- DHCS APL 18-020 "PALLIATIVE CARE" (December 2018), retrieved from https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-020.pdf
- DHCS Notification #06-1011 "AUTHORIZATION OF MEDICALLY NECESSARY CONCURRENT TREATMENT SERVICES FOR CCS CLIENTS WHO ELECT HOSPICE CARE" (October 2011), retrieved from http://www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf
- DHCS Notification #PL 11-004 "THE IMPLEMENTATION OF SECTION 2302 OF THE AFFORDABLE CARE ACT, ENTITLED "CONCURRENT CARE FOR CHILDREN." (February 2011), retrieved from http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-004.pdf
- Medi-Cal Member Services Guide, Evidence of Coverage (EOC), Effective 2023
- Medicare Hospice Manual and Centers for Medicare & Medicaid Services (CMS) Section 230.3, Transmittal A-03-016
- MRMIP EOC, Effective 2023
- SSA Section 1812(d)(1)

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- SSA Section 1861(dd) (1)
- Title 22, California Code of Regulations (CCR), Section 51180, 51349
- Title 42, CFR, Section 438.208
- Title 42, Code of Federal Regulations (CFR), Part 418, Subpart B

RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management (UM)

Secondary Department(s):
Case Management (CM)

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
03/29/12	• Minor revisions made. Verified EOC.s and POM. Needs detailed review by UM CM. DW
02/08/13	• Expanded abbreviations, minor formatting revisions • Updated policy based on current contract language • Updated references.
03/21/14	Changes to this policy made in response to new All Plan Letter received from Compliance. • Moved the verbiage regarding members under 21 from the Policy section to its own section under the Procedure. • Expanded what services are included under Hospice Services in response to updated All Plan Letter. • Changed the Definition of Terminal Illness as per new DHCS requirements that the physician certification contain the qualifying clause: "“the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course." • Changed I.D. to be three months instead of 12 months at a time and added a statement that no auth is required for outpatient hospice • Divided the Procedure section into 2 sections: 1) Members over

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Review Date	Changes
	21 and 2) Members under 21. • Added some general statements under Procedure I.A. • Added language about what's required when a member "elects" hospice services along with what type of election periods members may select. • Updated information about revocation of hospice benefits • Updated references
03/13/15	• Removed Healthy Families • Hyperlinked DHCS websites • Changed and deleted wording under procedure for members over 21 years of age.
02/17/16	• Updated References • Added Medi-Cal Access Program
01/30/17	• Annual review. Updated what auth is required for and what is not. Added that hospice agency will pay the facility
01/30/18	• Annual Review, updated references
01/30/19	• Annual Review, updated references
01/29/20	• Annual Review, updated references
01/27/21	• Annual Review, updated references
02/03/22	• Annual Review, updated references and placed in alphabetical order
01/25/23	• Annual Review • Updated References section • Updated Primary Department section from "Medical Management: Utilization Management (UM) & Case Management (CM)" to "Utilization Management (UM)" to match primary department in header • Added "Case Management (CM)" as a secondary department
02/08/24	• Annual Review—no changes

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