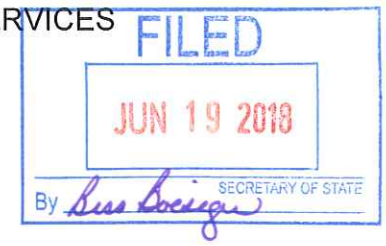
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING



July 30, 2018
10:30 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive additional comments on proposed changes to Title 471, Chapter 36 of the Nebraska Administrative Code (NAC) – *Hospice Services.* This regulation governs the hospice services provided under Nebraska's Medicaid Program. The rewrite mainly consisted of identifying insufficient or inconsistent language, restructuring the regulatory chapters, and performing a compliance review to determine uniformity with State Plan, other NAC chapters, Federal law, and best practices.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8223. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8223. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 471	Prepared by: Catherine Gekas-Steeby
Chapter: 36	Date prepared: 6-7-17
Subject: Hospice Services	Telephone: 402-471-0300

Type of Fiscal Impact:

Please check all that apply

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

PROPOSED REGULATION
POLICY PRE-REVIEW CHECKLIST

Agency: DHHS – Division of Medicaid
Title, Chapter of Regulation: 471 NAC 36
Subject: Hospice Services
Prepared by: Catherine Gekas-Steeby
Telephone: 402-471-0300

A. Policy Changes and Impacts

1. What does the regulation do and whom does it impact? Provide a brief description of the proposed rule or regulation and its impacts on state agencies, political subdivisions, and regulated persons or entities.

   The Department of Health and Human Services (DHHS) recently completed a rewrite of several chapters of Title 471 – Nebraska Medical Assistance Program Services including 471 NAC 36. This regulation governs the hospice services provided under Nebraska's Medicaid Program.

   The proposed regulations do not change the scope of work and there is no additional impact on agency, political subdivisions, and entities.

2. Describe changes being proposed to current policy and briefly provide rationale.

   The rewrite mainly consisted of identifying insufficient or inconsistent language, restructuring the regulatory chapters, and performing a compliance review to determine uniformity with State Plan, other NAC chapters, Federal law, and best practices.

B. Why is the rule necessary? Explain and provide an identification of authorizing statute(s) or legislative bill(s).

1. Update of regulation (repeal of obsolete statutes, reflect current policy, editing or technical language changes, etc.)

   Update of regulation as part of the DHHS regulation cleanup project.

2. Annual changes – cost of living, hunting season schedules, etc.

No

3. Law was changed – federal ___ or state ___ [Cite authorizing statute(s) or legislative bill(s)]

   No change

4. Extension of established policy or program, new initiatives or changes in policy (within statutory authority) No

5. Constituent initiated No

6. Financial needs – increases/decreases in fees No

7. Litigation requires changes in rules No

8. Addresses legal or constitutional concerns of Attorney General's office No

9. Implements federal or court mandate No

10. Other (explain)

C. What happens if these rules are not adopted?

Outdated regulations and inconsistent terminology. Out of compliance and with State Plan, Federal law. and other NAC chapters.

D. Policy Checklist

1. Is this an update or editorial change reflecting essentially no change in policy? Yes.

2. Does the policy in the proposed regulation reflect legislative intent? Yes.

3. Is the policy proposed in the regulation a state mandate on local government? No. Is it funded? No.

4. Is the policy proposed in the regulation a federal mandate on local government? No Is it funded? No.

E. **Fiscal Impact. In addition to completing the required Fiscal Impact Statement (a copy must be attached to this document), the agency must address the following:**

See attached fiscal statement.

1. Will the proposed regulation reduce, increase, or have no change in resources – funds, personnel or FTE? No change.

2. Have initial contacts been made with citizens or organizations that may be impacted by the proposed regulation? Yes.

3. Does the proposed regulation impact another agency? No. Explain the impact.

4. Will the proposed regulation reduce, increase, or have no change on reporting requirements of businesses?

   No change.

5. What is the agency's best estimate of the additional or reduced spending? If there is none, please note. If receipt of federal funds is contingent upon approval of the proposed regulation, then indicate the amount and nature of the federal funds affected, and enclose laws or correspondence from federal officials substantiating the information.

   No change in spending.

6. Include a description of the impact that the proposed regulation will have on the number of state employees and how the agency intends to address proposed increases or decreases in FTE.

   No impact.

F. **Unique problems or issues and recommendations.**

G. **Who is expected to be affected, or to oppose or support the proposed regulation? Explain what initial informal contacts have been made with organizations or citizens who may be affected by the regulation prior to the public hearing.**

DHHS offered stakeholders, deputy directors, and administrators an informal comment period to review the regulations before the Department moved forward with the promulgation process. There is not expected to be any significant support or opposition to the regulations, as they do not change the scope of work and there is no fiscal impact.

DHHS will solicit public comment on the proposed regulations before the public hearing.

H. **Are these proposed rules a likely candidate for negotiated rulemaking? Explain. Has the process been completed? If so, explain how the issues were addressed.**

No.

Agency Director's Verification of Review

I have reviewed these proposals and verify that, at this stage of the regulation's development, these questions have been accurately addressed.

Thomas "Rocky" Thompson
Interim Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services

6/12/2017
Date

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

TO: Executive Board
Room 2108 State Capitol
Legislative Council

FROM: Jaime Hegr, Attorney
Legal Services
Department of Health and Human Services (DHHS)

DATE: June 19, 2018

RE: Notice of Rulemaking under Neb. Rev. Stat. § 84-907.06

The Department of Health and Human Services (DHHS) will be holding a second public hearing on proposed amendments to the following regulations:

TITLE:	471	Nebraska Medicaid Program Services
CHAPTER:	36	Hospice Services

These regulations are scheduled for public hearing on July 30, 2018.

The purpose of this hearing is to receive comments on proposed changes to The purpose of this hearing is to receive additional comments on proposed changes to Title 471, Chapter 36 of the Nebraska Administrative Code (NAC) – *Hospice Services.* This regulation governs the hospice services provided under Nebraska's Medicaid Program. The rewrite mainly consisted of identifying insufficient or inconsistent language, restructuring the regulatory chapters, and performing a compliance review to determine uniformity with State Plan, other NAC chapters, Federal law, and best practices.

The following items are enclosed for your referral to the chair of the relevant standing committee of the Legislature:

1. A copy of the notice of public hearing;
2. A copy of the proposed regulations;
3. A copy of the Policy Pre-Review Checklist; and
4. The estimated fiscal impact of this rulemaking action on state agencies, political subdivisions or persons being regulated.

36-000 MEDICAID HOSPICE SERVICES

36-001 Definitions

Advanced Directive: A legal document, including, but not limited to, a living will, signed by a competent person, to provide guidance for medical and health-care decisions in the event the client becomes incapable to make such decisions.

Assisted Living Facility: A facility licensed as an assisted living facility by the Department of Health and Human Services Division of Public Health.

Attending Physician: A doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by the state in which he or she performs that function, and is identified by the client, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care

Benefit Period: The dates that the certification or recertification request covers.

Bereavement Counseling: Emotional, psychosocial, and spiritual support and services provided before and after the death of the client to assist with issues related to grief, loss, and adjustment.

Caregiver: A friend, family member, or legal guardian who provides ongoing care for a client who is unable to care for him/herself.

Center for Developmental Disabilities: A facility, including a group home, where shelter, food, care, advice, counseling, diagnosis, treatment, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have developmental disabilities.

Client: A Medicaid client who is:

1. Diagnosed as terminally ill; and
2. Admitted into a hospice service, after giving informed consent.

Client Representative: A person who is, because of the client's mental or physical incapacity, authorized in accordance with state law to execute decisions about hospice services, or terminate medical care, on behalf of the terminally ill client.

CMS: The United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Dietary Counseling: Education and interventions provided to the client and family regarding appropriate nutritional intake as the client's condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse, dietitian, or nutritionist, when identified in the client's plan of care.

Election: A decision by the client (or his/her authorized representative) to receive hospice care.

Homemaker: A person employed by, or a volunteer of, a hospice provider to provide domestic services including, but not limited to, meal preparation, laundry, light housekeeping, errands, and chore services.

Hospice or Hospice Provider: A public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care as defined in this section.

Hospice Aide: A person who is employed by a hospice to provide personal care, assistance with activities of daily living, and basic therapeutic care to the clients of the hospice.

Hospice Care: A comprehensive set of services described in 471 NAC 36-003.02, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill client and/or family members, as delineated in a specific client plan of care.

Hospice Inpatient Facility: A facility in which the hospice service provides inpatient care directly for respite and general inpatient care.

Hospice Interdisciplinary Group (IDG): The hospice medical director, nurse practitioner, licensed professional registered nurse, certified social worker, pastoral or other counselor; and, as determined by the interdisciplinary plan of care, providers of special services such as counseling services, pharmacy services, hospice aides, trained volunteers, dietary services, and any other appropriate health services, to meet the physical, medical, psychosocial, spiritual, and emotional needs of clients and families, which are experienced during the final stages of illness, dying, and bereavement.

Hospice Volunteer: An individual specifically trained and supervised to provide support and supportive services to the client and client's family under the supervision of a designated hospice employee. This does not apply to any volunteers working on behalf of a hospice provider licensed under the Health Care Facility Licensure Act who, as part of their volunteer duties, provide care. Volunteers are unpaid persons who supplement other covered services. Volunteer services include, but are not limited to, caregiver relief, short term client companionship or running errands.

Initial Assessment: An evaluation of the client's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the client's immediate care and support needs.

Institution for Mental Diseases: A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. For the purposes of this chapter, whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Intermediate Care Facility for the Developmentally Disabled (ICF/DD): A facility, licensed by the Department of Health and Human Services Division of Public Health and certified to participate in Medicaid, where shelter, food, and training or habilitation services, advice, counseling, diagnosis, treatment, care, nursing care, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have intellectual disability or related conditions, including epilepsy, cerebral palsy, or other developmental disabilities.

Licensed Nurse: A person licensed as a Registered Nurse or as a Practical Nurse under the provisions of the Nurse Practice Act, Neb. Rev. Stat. §§ 38-2201 to 38-2236.

Licensed Professional: A person licensed to provide patient care services by the state in which services are delivered.

Medicaid: The Nebraska Medical Assistance Program established by Neb. Rev. Stat. § 68-903 and Title XIX of the Social Security Act.

Medicaid Representative: The client's services coordinator or case manager.

Medical Director: A hospice provider employee, or contracted person, who is a doctor of medicine or osteopathy who is responsible for the overall coordination of medical care in the hospice.

Medication: Any prescription or non-prescription drug or biological intended for treatment or prevention of disease or to affect body functions in humans.

Nurse Practitioner: A registered nurse who performs such services as legally authorized to perform under the provisions of the Nurse Practice Act, Neb. Rev. Stat. §§ 38-2201 to 38-2236.

Nursing Facility: A facility, or a distinct part of a facility, licensed by the Department of Health and Human Services Division of Public Health and certified for participation in the Medicaid program under Title XIX of the Social Security Act, where medical care, rehabilitation, or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled.

On-Call Services: Nursing services, physician services, and drugs and biologicals must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the client and family.

Palliative Care: Client and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate client autonomy, access to information, and choice.

Physician: Any person licensed to practice medicine as provided in Neb. Rev. Stat. §§ 38-2001 to 38-2062.

Physician Designee: A doctor of medicine or osteopathy designated by the hospice provider who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

Respite Care: Short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.

Revocation: The choice by the client (or his/her representative) to discontinue hospice services. Hospice services may be revoked in writing at any time.

Social Worker, Certified: A person who has received a baccalaureate or masters degree in social work from an approved educational program, and holds a current certificate issued by the Department of Health and Human Services Division of Public Health.

Terminally Ill or Terminal Illness: The client is diagnosed with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course.

Treatment: A therapy, modality, product, device, or other intervention used to maintain well-being or to diagnose, assess, alleviate, or prevent a disability, injury, illness, disease or similar condition.

36-002 Provider Requirements

36-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), hospice providers shall comply will all applicable provider participation requirements codified in 471 NAC Chapters 2 and 3. In the event that participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 36, the participation requirements in 471 NAC Chapter 36 shall govern.

36-002.02 Service Specific Provider Requirements: Hospice providers shall be certified to participate in Medicare, and meet the licensure and certification requirements of the Nebraska Department of Health and Human Services, Division of Public Health.

36.002.02A Standards of Care: The hospice provider shall deliver services in accordance with the following standards:

1. A hospice provider must be primarily engaged in providing the scope of services outlined in 471 NAC 36-003.02, and must do so in a manner that is consistent with accepted standards of practice;

2. The hospice provider must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice. When the medical director is not available, a physician designated by the hospice provider assumes the same responsibilities and obligations as the medical director;

3. Maintain clinical records containing past and current findings for each hospice client for the longer of 6 years, or the time period identified in 175 NAC 16-006. The clinical record must contain correct clinical information that is available to the client's attending physician and hospice staff. The clinical record may be maintained electronically;

4. Medical supplies and appliances, durable medical equipment, and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice provider while the client is under hospice care;

5. The needs, preferences, cultural diversity, values and expectations of client/caregiver are reflected in all aspects of service delivery;

6. All service provision is done in a manner that is empowering to the client/caregiver;

7. The client/caregiver feels safe and confident that their right to privacy is protected;

8. The client/caregiver is treated with dignity and respect at all times;

9. The hospice provider must assume full responsibility for the professional management of the client's hospice care;

10. The hospice provider must conduct and document, in writing or electronically, a client-specific comprehensive assessment that identifies the client's need for hospice care and services, and the client's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions (See 471 NAC 36-003.01C);

11. The hospice provider must maintain a certification that the client is terminally ill based on the clinical judgment of the hospice provider medical director or the physician member of the hospice IDG, or the client's attending physician if the client has an attending physician (See 471 NAC 36-003.01A and 36-003.01B2a);

12. Maintain the signed election statement in its files (See 471 NAC 36-003.01B);

13. The hospice provider must designate an interdisciplinary group or groups as defined in 471 NAC 36-001 which, in consultation with the client's attending physician, must prepare a written plan of care for each client. The plan of care must specify the hospice care and services necessary to meet the client and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions (See 471 NAC 36-003.01C and 36-003.01E);

14. Provide on-call services 24 hours a day, seven days a week;

15. Allow the Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place;

16. Agree and assure that any suspected abuse or neglect shall be reported to law enforcement and/or appropriate Department staff;

17. A hospice provider must routinely provide all core services directly by hospice provider employees. Any hospice employee or volunteer who is or will be ordering, referring or prescribing items or services to clients, must be enrolled as a Medicaid provider in accordance with the provisions of 471 NAC Chapter 2;

18. All professionals who furnish services directly, under an individual contract, or under arrangements with a hospice provider, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his/her State license, or State certification, or registration. All personnel qualifications must be kept current at all times;

19. The hospice provider must organize, manage and administer its resources to provide the hospice care and services which are reasonable and necessary for the palliation and management of the terminal illness and related conditions;

20. The hospice provider shall have a signed, written, non-resident-specific contract with each certified nursing facility or ICF/DD; and

21. The hospice provider must maintain and document an effective infection control program that protects clients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.

36-002.02B Provider Agreement and Enrollment: The hospice provider shall complete and submit Form MC-19, "Medical Assistance Provider Agreement." When the client resides in a facility, a copy of the hospice provider's contract with the facility shall be attached.

36-002.002C Quality Assurance: The Department of Health and Human Services may refuse to execute or may cancel a contract/provider agreement with a hospice provider when the hospice provider:

1. Does not meet the hospice requirements in this chapter;
2. Consistently admits clients who do not meet the eligibility requirements for terminal illness or consistently exceed the six-month prognosis;
3. Consistently refuses to provide, or is unable to provide, services identified in the assessment and on the hospice plan of care;
4. Consistently bills the majority of claims at the "Continuous Home Care" rate (See 36-004.02B4); or
5. Consistently discharges clients in conflict with 471 NAC 36-003.01G1.

36-002.02D Hospice Aide and Homemaker Competency and Qualifications: All hospice aide and homemaker services must be provided by individuals who meet the personnel

requirements specified in 42 CFR §418.76. The hospice must maintain documentation that demonstrates the requirements of this standard are being met.

1. A hospice aide provides services that are:
   a. Ordered by the IDG;
   b. Included in the plan of care;
   c. Permitted to be performed under State law by such hospice aide; and
   d. Consistent with the hospice aide training.

2. The duties of a hospice aide include the following:
   a. The provision of hands-on personal care;
   b. The performance of simple procedures as an extension of therapy or nursing services;
   c. Assistance in ambulation or exercises; and
   d. Assistance in administering medications that are ordinarily self-administered.

3. Hospice aides must report changes in the client's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.

4. Standard: Supervision of hospice aides:
   a. A registered nurse must act as the supervising nurse for hospice aides;
   b. The supervising nurse must make an on-site visit to the client's home no less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the client's needs;
   c. The hospice aide does not have to be present during this visit;
      i. If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the client is receiving care in order to observe and assess the aide while he or she is performing care;
      ii. If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation in accordance with hospice federal regulations.

   d. The supervising nurse must make an annual on-site visit to the location where a client is receiving care in order to observe and assess each aide while he or she is performing care; and
   e. The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to:
      i. Following the client's plan of care for completion of tasks assigned to the hospice aide by the registered nurse;
      ii. Creating successful interpersonal relationships with the client and family;
      iii. Demonstrating competency with assigned tasks;
      iv. Complying with infection control policies and procedures as outlined in 175 NAC 16; and
      v. Reporting changes in the client's condition.

36-002.02E Attending Physician Requirements: Services of an attending physician who is not an employee of the hospice are covered, billed and reimbursed in accordance with 471 NAC Chapter 18. An attending physician who is not an employee of the hospice must be enrolled as a Medicaid provider in accordance with the provisions of 471 NAC Chapters 2 and 18.

36-003 Service Requirements

36-003.01 General Requirements

36-003.01A Client Eligibility: The Medicaid Hospice Benefit is available to clients who meet the following criteria:

1. The client is currently eligible for Medicaid; OR provide proof of submission of application for Medicaid Eligibility;
2. The client is diagnosed as terminally ill by the hospice provider medical director or the physician member of the hospice provider IDG, or the attending physician (if any); and
3. The client is an adult and has elected to receive palliative/comfort care to manage symptoms of terminal illness, and has chosen not to receive curative treatment or disease management; or
4. The client is a child and has elected to receive palliative/comfort care to manage symptoms of terminal illness. Such election by a child shall not constitute a waiver of any rights of the child to be provided with, or receive Medicaid payment for, concurrent services related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

36-003.01B Election of Hospice Services: A client, or the client's representative, shall file a voluntary, written expression to choose hospice care, called an election statement designating the Medicaid Hospice Benefit as the care preference for terminal illness. The election statement shall include:

i. The effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care. This date may not be earlier than the date the election is made;
ii. The name of the hospice provider;
iii. The individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care;
iv. The individual's or representative's acknowledgement that he or she understands that the Medicaid services listed in 471 NAC 36-003.01B3 are waived by the election; and
v. The client's signature. If the individual is physically or mentally incapacitated, his/her representative may file the election statement. If signed by the client's representative, the reason the client cannot sign the election statement shall be documented.

36-003.01B1 Hospice's Responsibilities at Election: When a client elects to receive hospice services, the hospice program shall:

a. Explain the scope of benefits the client shall receive as a part of the hospice program;
b. Explain the benefits the client is waiving;
c. Give the client or legal representative a copy of the signed statement;
d. Retain the signed statement in its files; and
e. The client must be informed of his/her rights, and the hospice must protect and promote the exercise of these rights.

36-003.01B2 Benefit Periods: Medicaid provides two 90-day benefit periods during the client's lifetime. If additional benefit periods are needed, Medicaid provides an unlimited number of 60-day benefit periods as elected by the client. The benefit periods may be used consecutively or at intervals. An election to receive hospice care will be considered to continue through the initial certification period and the subsequent election periods without a break in care as long as the client remains in the care of the hospice and does not revoke the election in accordance with 471 NAC 36-003.01B4.

36-003.01B2a Certification: The client shall be certified as terminally ill by the hospice medical director, or the physician member of the IDG, or the attending physician (if any) at the beginning of the first benefit period, and by the hospice medical director for all subsequent benefit periods. The initial certification must be signed by both the medical director (or physician member of the IDG), and the attending physician. Subsequent certifications must include a new statement regarding life expectancy, and be signed by the attending physician.

The initial written certification must be made within 2 calendar days of the start of hospice care; however, if verbal certification is provided within the first 2 calendar days, written certification may be provided within 8 days after hospice care is initiated. Additionally, the initial certification may be completed no more than 15 calendar days prior to the effective date of the election. If these time periods are not met, coverage will not be provided for hospice care rendered before certification. For subsequent benefit periods, written certification must be made within 2 calendar days of the start of the subsequent period. Additionally, the certification for subsequent benefit periods may be completed no more than 15 calendar days prior to the start of each subsequent benefit period.

36-003.01B2a(i) Decline in Clinical Status: Clients shall be considered to have a life expectancy of six months or less only when there is documented evidence of a decline in clinical status. A requirement of the certification process for hospice is the physician narrative explanation of the clinical findings that support a life expectancy of 6 months or less. This brief narrative is to be part of the certification and recertification forms or as an addendum to the certification and recertification forms. Baseline data is established on admission to hospice through nursing assessment in addition to utilization of existing information from records. It is essential that baseline and follow-up determinations are documented thoroughly to establish a decline in clinical status.

Coverage of hospice care for clients not meeting the guidelines may be denied.

36-003.01B2b Concurrent Care for Children under the age of 21: Terminally ill children who are enrolled in a Medicaid or state Children's Health Insurance Plans (CHIP) hospice benefit, may receive curative and hospice services related to their terminal health condition.

36-003.01B2c Guidelines for 180-day Recertification of Hospice Services: A hospice physician must have a face-to-face encounter with each hospice client prior to, but no more than 30 days prior to, the beginning of the client's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements specified in this section results in a failure by the hospice to meet the client's recertification of terminal illness eligibility requirement. The client would cease to be eligible for the benefit until the face-to-face visit is completed.

36-003.01B3 Waiver of Medicaid Benefits for Adult Clients: Upon signing the hospice election statement, an adult client shall be deemed to have waived all rights to the following:

a. Medicaid payment for treatment associated with the terminal illness;
b. Hospice care provided by a hospice provider that was not designated by the client; and
c. All services that are equivalent to, or duplicative of, hospice care

This waiver remains in effect for the duration of the election of hospice care. Medicaid services provided for conditions/illnesses that are unrelated to the terminal illness may be covered by Medicaid separate from the hospice benefit. These services shall be based on individual assessed need and medical necessity as specified in the appropriate chapters of Title 471. If the client/representative revokes election of the Medicaid Hospice Benefit, Medicaid coverage of the benefits deemed to have been waived is restored.

36-003.01B4 Revocation of Election of Hospice Benefit: A client or representative may revoke election of hospice care at any time. To revoke the election of hospice care, the client must file a document with the hospice that includes a signed statement that he or she revokes the election for Medicaid coverage of hospice care, and the date the revocation is to be effective. The client may not designate an effective date prior to the date the revocation document is signed. The individual forfeits coverage for any remaining days in that election period.

The client may initiate re-election of the Medicaid Hospice Benefit if eligibility criteria are met.

When the hospice election is ended due to revocation, the hospice must file a notice of termination/revocation of election with Nebraska Medicaid within 5 calendar days after the effective date of the revocation, unless it has already filed a final claim for that beneficiary.

36-003.01B5 Change of Hospice: The client/representative may choose to change from one hospice provider to another hospice provider. A change of hospice may occur only once in each benefit period. To change the designation of hospice providers, the individual must file, with the hospice from which he or she has received

care and with the newly designated hospice, a signed statement that includes the following information: the name of the hospice from which the individual has received care, the name of the hospice from which the individual plans to receive care, and the date the change is effective.

36-003.01B6 Dually Eligible: A client who is dually eligible (Medicare and Medicaid) must elect and revoke hospice care simultaneously under both the Medicare and the Medicaid program.

36-003.01B7 Admission to Hospice Care: The hospice admits a client only on the recommendation of the medical director in consultation with, or with input from, the client's attending physician (if any).

36-003.01C Initial Assessment: An initial assessment shall be completed within 48 hours after Medicaid eligibility is established and the election statement is signed, unless the physician, client, or representative requests that the initial assessment be completed in less than 48 hours. The nurse completes the assessment to collect comprehensive information concerning the client's preferences, goals, health status, and to determine strengths, priorities, and resources. The assessment shall be completed by a designated registered nurse from the hospice provider and coordinated with the client's Medicaid representative. Ongoing assessments shall be completed and updated with each client visit.

36-003.01D Prior Authorization: All hospice services shall be prior authorized. The hospice shall submit prior authorization requests to the Department within 72 hours of the initial assessment. Prior authorization may be retroactive for up to seven days, based on the client's entry date into the hospice program. To request prior authorization, the hospice shall submit:

i. Agency name and provider number;
ii. The client Medicaid number; OR indicate the submission of application for Medicaid eligibility. The hospice agency must resubmit the request for prior authorization form only once the client has obtained his or her Medicaid eligibility;
iii. Signed election statement;
iv. Physician certification of terminal illness;
v. Hospice plan of care; and
vi. List of all medications, biologicals, supplies, and equipment for which the hospice is responsible.

Claims may be denied when prior authorization is not completed.

Re-authorization is required for each subsequent benefit period.

36-003.01E Individualized Hospice Plan of Care: An individualized hospice plan of care shall be written to identify specific individual services to be provided in a coordinated and organized manner. The hospice shall have up to 5 days from the date of admission to develop the plan of care, with involvement from the client/caregiver, attending physician, medical director, and IDG. Authorization requires the hospice plan of care to be submitted prior to services being provided.

The hospice plan of care shall be culturally appropriate, and identify in detail the services that shall address the needs identified in the assessment. The hospice plan of care shall state in detail the scope and frequency of services that shall meet the client's and family's needs. The care provided shall be in accordance with the written plan of care. In the event of disagreement between the client and in-home caregiver, the client shall make the final decision about care, service needs, preferences, and choices. The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the client's condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the client's updated comprehensive assessment and must note the client's progress toward outcomes and goals specified in the plan of care.

36-003.01F Coordination of Care: The hospice provider shall designate a registered nurse to coordinate the implementation of the hospice plan of care with the client's Medicaid representative. Coordination of care shall include connections to needed services and resources, and shall ensure that client choices and concerns are represented. Coordination requires sharing of information to prevent gaps in service, duplication of services and duplication of payment. A request for additional Medicaid services, or a determination of denial of hospice services, for a Medicaid client by the hospice provider shall be coordinated with the client's Medicaid representative. The hospice provider shall notify the client's Medicaid representative when a Medicaid client elects hospice services.

36-003.01G Discharge from Hospice: Coverage of the Medicaid Hospice Benefit depends on a physician's certification that a client is terminally ill. The client shall be discharged from the Medicaid Hospice Benefit when the client improves or stabilizes enough that he/she no longer meets the definition of a terminal illness. The client may be re-enrolled for a new benefit period when a decline in the clinical status leads to a new certification that the client is terminally ill.

36-003.01G1 Discharge by the Hospice: A hospice provider may discharge a client if:

i. The client moves out of the hospice's service area or transfers to another hospice;
ii. The hospice determines that the client is no longer terminally ill; or
iii. The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the client's (or other persons in the client's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the client, or the ability of the hospice to operate effectively, is seriously impaired. The hospice must do the following before it seeks to discharge a client for cause:
    a. Advise the client that a discharge for cause is being considered;
    b. Make a serious effort to resolve the problem(s) presented by the client's behavior or situation;
    c. Ascertain that the client's proposed discharge is not due to the client's use of necessary hospice services; and
    d. Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

36-003.01G1a Discharge Order: Prior to discharging a client for any reason listed in this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If a client has an attending physician involved in his/her care, this physician should be consulted before discharge and his/her review and decision included in the discharge note.

36-003.01G2 Effect of Discharge: A client, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice:

a. Is no longer covered under Medicaid for hospice care;
b. Resumes Medicaid coverage of benefits waived; and
c. May at any time elect to receive hospice care if he or she is again eligible for the hospice benefit.

36-003.01H Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

36-003.01I HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

36-003.02 Covered Services: A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:

1. Nursing services;
2. Physician services;
3. Medical social services;
4. Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling;
5. Hospice aide, volunteer, and homemaker services;
6. Medical supplies (including drugs and biologicals) and medical appliances;
7. Physical therapy, occupational therapy, and speech language pathology services; and,
8. Short-term inpatient care.

These services are offered based on individually assessed needs and choices of terminally ill clients and their families for palliative care and support. The client has the right to be informed of his/her rights, and the hospice must protect and promote the exercise of these rights.

36-003.02A Nursing Services: The hospice provider shall assure that nursing services require the skills of a registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of a registered nurse, and must be reasonable and necessary for the palliation and management of the client's terminal illness and related conditions. Services shall be provided in accordance with recognized standards of practice.

Nursing services include, but are not limited to:

1. Required visits by a registered nurse (RN) or licensed practical nurse (LPN) to monitor condition, provide care, and maintain comfort based on assessment of individual needs and as identified in the hospice plan of care;
2. At a minimum, the required visits by an RN/LPN occur weekly, or more frequently as needed. The registered nurse shall visit at least every two weeks;

3. Education based on the needs of the client/caregiver and family about the changes to be expected with the dying process; the appropriate use of medications, therapies, equipment, and supplies; what hospice does and does not do; and emphasis on the importance of realistic goals;
4. An initial assessment (see 471 NAC 36-005.01C);
5. An individualized hospice plan of care (see 471 NAC 36-005.01E); and
6. Coordination of care (see 471 NAC 36-005.01F).

A nurse practitioner may serve as an attending physician. If the nurse practitioner serves as the attending physician, the nurse practitioner must comply with the requirements outlined in 471 NAC 36-002.02E. The nurse practitioner may not serve as or replace the medical director or physician designee.

36-003.02B Hospice Aide/Homemaker: The hospice provider shall assure that hospice aide/homemaker services are provided to promote client care and comfort, and are completed at the direction of the client/caregiver based on client's individualized hospice plan of care. Services shall be available and adequate to meet the needs of the client. Hospice aide/homemaker services include:

1. Personal care services, for example, bathing, dressing, assisting with bowel and bladder requirements, assisting with ambulating, hair care, nail care, as indicated in the client's individualized hospice plan of care and at the direction of the client/caregiver; and
2. Hospice aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the client, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the client. Hospice aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the client's family to carry out the plan of care.

36-003.02C Medical Social Services: The hospice provider shall assure that medical social services are provided by a certified social worker for the client/caregiver, and family under the direction of the physician. Medical social services include:

1. Crisis intervention for the client, caregiver, and/or family;
2. Psychosocial assessment to address needs identified by the client/caregiver and to develop plans for intervention;
3. Counseling to assist the client/caregiver/family, including children, to cope with serious illness/death;
4. Client advocacy to assure the client/caregiver has choices in care, and understands their right to refuse treatment;
5. Act as a liaison between client and needed community resources;
6. Fostering human dignity and personal worth; and
7. Coordination of services with the Medicaid representative, when applicable.

36-003.02D Medical Equipment and Supplies including Drugs and Biologicals: The hospice provider shall assure that medical equipment and supplies, including drugs, are provided for

relief of pain and symptom control related to the client's terminal illness and related conditions. This includes both prescription and over-the-counter drugs. All equipment, supplies, medications, and biologicals shall be provided as prescribed by the client's physician, as needed, and at the direction of the client/caregiver, as indicated in the client's individualized hospice plan of care. These services include:

1. Medication for the relief of pain and related symptoms; and
2. Durable medical equipment related to palliation~~; and~~.
~~3. Personal comfort items such as preferred pillows and/or blankets, lotions, and any other items needed for client comfort and management of terminal illness.~~

The hospice is responsible for providing any and all services indicated in the plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions.

36-003.02E Other Counseling Services: The hospice provider shall assure that other counseling services are available for the client, caregiver, and family. Services include:

1. Dietary counseling;
2. Spiritual counseling: The hospice must:
   a. Advise the client and family of the service;
   b. Provide an assessment of the client's and family's spiritual needs.
   c. Provide spiritual counseling to meet these needs in accordance with the client's and family's acceptance of this service, and in a manner consistent with client and family beliefs and desires; and
   d. Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the client's spiritual needs to the best of its ability.
3. Bereavement counseling provided through an organized program of bereavement services under the supervision of a qualified professional. Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Ensure that bereavement services reflect the needs of the bereaved. It is the choice of the family to accept bereavement services.

36-003.02F Volunteer Services: The hospice provider shall sponsor a volunteer program and shall assure that volunteers participate in an initial volunteer education program. Opportunities for ongoing education shall be available for volunteers.

36-003.02G Physician Services: Physician services must be performed in accordance with 471 NAC Chapter 18. The services of the hospice medical director or the physician member of the interdisciplinary team must be performed by a doctor of medicine or osteopathy. Nurse practitioners may not serve as a medical director or as the physician member of the interdisciplinary group. The hospice face-to-face encounter is an administrative requirement related to certifying the terminal illness.

36-003.02H Physical Therapy, Occupational Therapy, and Speech Language Pathology Services: The hospice provider shall assure that physical therapy, occupation therapy, and

speech language/pathology services are provided to control symptoms, or to enable the client to maintain activities of daily living and basic functional skills. These services shall be provided under the direction of the attending physician or medical director, and shall be included in the hospice plan of care. The client/caregiver makes the final decision regarding acceptance/refusal of a therapy program.

36-003.02I Short-Term Inpatient Care: May be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than 5 days. (See 471 NAC 36-004.02B5)

36-003.02J Medical Interventions: The hospice provider shall assure that medical interventions are provided when the interventions related to the terminal illness, either in use or planned, have been evaluated by the attending physician, hospice medical director, hospice team, client/caregiver, and family, based on the quality of life, value of the treatment to the client, and the service's congruence with the palliative care goals of the client/caregiver, family, and hospice. Planned interventions shall be included in the hospice plan of care.

~~36-003.02K Special Modalities:~~ A hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the client's condition and the individual hospice's care-giving philosophy. No additional Medicaid payment may be made regardless of the cost of the services.

36-003.02K Hospice Services in Certain Facilities: A client who meets the eligibility requirements in 471 NAC 36-003.02A and resides in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), a Nursing Facility (NF), an Institution for Mental Disease (IMD), an Assisted Living Facility (ALF), or a Center for the Developmental Disabilities (CDD) may elect to receive hospice services where s/he lives. The Medicaid Hospice Benefit is available to Medicaid eligible persons in an IMD who are age 20 or younger or 65 or older. The facility shall agree to the provision of hospice services, and the hospice provider shall have a signed contract with the facility before provision of hospice services.

36-003.02K1 Facility's Responsibilities: The facility shall:

a. Provide room and board for the client;
b. Perform personal care;
c. Assist with activities of daily living;
d. Administer medications;
e. Provide social activities;
f. Provide housekeeping;
g. Supervise and assist with the use of durable medical equipment and prescribed therapies; and
h. Develop a plan of care in collaboration with the hospice provider, client/caregiver and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the plan.

36-003.02K2 Hospice Responsibilities: The hospice provider shall:

a. Assess the client's needs in coordination with the designated facility representative and client/caregiver;
b. Develop a hospice plan of care in collaboration with client/caregiver, facility caregivers and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the hospice plan of care;
c. Assume the professional management responsibility for ensuring the implementation of the hospice plan of care at the direction of the client/caregiver;
d. In collaboration with the facility representative, coordinate the responsibilities of the facility and the responsibilities of the hospice provider, and document these responsibilities in all client records;
e. Involve family and facility personnel in assisting with provision of services as designated by the hospice plan of care, and at the direction of the client/caregiver. The same level of services that would be provided in the home shall be provided in the facility; and
f. Provide social services and counseling utilizing hospice personnel. This service may not be delegated to the facility's personnel.

The hospice provider may not require the client to move from the facility as long as the client's needs can be appropriately and safely met.

36-003.02L Home and Community-Based Waiver Services: Clients who elect the hospice benefit while receiving home and community-based (HCB) waiver services may continue to receive HCB waiver services that are based on assessed need and medical necessity. All medical services related to the terminal illness or the hospice plan of care are the responsibility of the hospice, and all services shall be coordinated with the waiver services coordinator. The waiver services coordinator retains full responsibility for waiver planning and service authorization.

36-004 Billing and Payment for Hospice Services

36-004.01 Billing

36-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 36, the billing requirements in 471 NAC Chapter 36 shall govern.

36-004.01B Specific Billing Requirements: The hospice provider shall bill for services provided using Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For claim submission instructions, see the Claim Submission Table at 471-000-49, and billing instructions at Appendix 471-000-81 and 471-000-71.

HCPCS/CPT procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Fee Schedule (see 471-000-536).

36-004.02 Payment

36-004.02A General Payment Requirements: Nebraska Medicaid will reimburse the Provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with payment regulations outlined in this 471 NAC Chapter 36, the payment regulations in 471 NAC Chapter 36 shall govern.

36-004.02B Specific Payment Requirements: Medicaid pays for services provided under the Medicaid Hospice Benefit using the Medicaid hospice payment rates established by CMS.

~~36-004.02B1 For Adult Clients: Medicaid pays the inpatient respite care rate to the Hospice provider for each day the client is in an inpatient facility (hospital or nursing facility) and receiving respite care (see 471 NAC 36-004.02B5).~~

~~Medicaid pays the general inpatient care rate to the Hospice provider during a period of acute medical crisis (See 471 NAC 36-004.02B6). Payment shall be made only when the care is provided in a hospital or a contracted hospice inpatient facility. The hospice must have a written contract and retain professional management of hospice services and care.~~

~~In accordance with 471 NAC Chapter 10, Medicaid pays all costs for hospital services provided when a client receiving the Medicaid Hospice Benefit is hospitalized for an acute medical condition that is not related to the terminal illness and/or complications secondary to the terminal illness.~~

~~Determination of the cause of hospitalization shall be made by the IDG with consultation from the Medicaid Hospice Program Specialist. Payment for hospital services shall be made directly to the hospital.~~

~~36-004.02B2 For Child Clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility, including Inpatient Respite Care (see 471 NAC 36-004.02B5) and General Inpatient Care (see 471 NAC 36-004.02B6).~~

36-004.02B1 Routine Home Care (RHC): Medicaid pays the RHC rate to the hospice provider for every day the client is at home, under the care of hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of RHC services provided on any given day. Medicaid pays two separate rates for RHC depending on the length of stay. For the first 60 days of care RHC will be paid at an increased rate, with a reduced RHC rate applicable to for service provided on day 61 and greater.

36-004.02B1a Service Intensity Add-On (SIA): In addition to the per diem rate for RHC level of care, Medicaid will include a SIA payment for direct client care services provided by a RN or social worker during the last seven days of a client's life. The SIA payment will equal the Continuous Home Care (CHC) hourly rate multiplied by

the hours of nursing/social work service (for at least 15 minutes and up to 4 hours total) that occurred on a RHC day during the last seven days of life.

36-004.02B2 Continuous Home Care (CHC): A CHC day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility (hospital, SNF, or hospice inpatient unit) and receives hospice care consisting predominantly of nursing care on a continuous basis at home. CHC is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill client at home. Medicaid pays the CHC rate to the hospice provider to maintain a client at his/her place of residence when a period of medical crisis occurs. A period of medical crisis is a time when a client requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. A RN or LPN shall provide nursing care. A nurse shall be providing more than one half (51% or greater) of care given in a 24-hour period. A minimum of eight hours of care shall be provided in a 24-hour period, which begins and ends at midnight. When the number of hours is less than 24, Medicaid pays the hourly rate. The hours may be split over the 24 hours to meet the needs of the client. RHC shall be billed when fewer than eight hours of nursing care are provided.

36-004.02B3 Inpatient Hospital or Nursing Facility Respite Care: Medicaid pays the inpatient respite care rate to the hospice provider for each day the client is in an inpatient facility (hospital or nursing facility) and receiving respite care.

Medicaid pays the general inpatient care rate to the hospice provider during a period of acute medical crisis (See 471 NAC 36-004.02B4). Payment shall be made only when the care is provided in a hospital or a contracted hospice inpatient facility. The hospice must have a written contract and retain professional management of hospice services and care.

In accordance with 471 NAC Chapter 10, Medicaid pays all costs for hospital services provided when a client receiving the Medicaid Hospice Benefit is hospitalized for an acute medical condition that is not related to the terminal illness and/or complications secondary to the terminal illness.

Determination of the cause of hospitalization shall be made by the IDG with consultation from the Medicaid Hospice Program Specialist. Payment for hospital services shall be made directly to the hospital.

For adult clients, Medicaid pays the inpatient respite care rate to the hospice provider for each day the client is in an inpatient facility and receiving respite care. Payment may be made for a maximum of five days per month counting the day of admission but not the day of discharge. The discharge day for inpatient respite care is billed as routine home care unless the client is discharged as deceased. When the client dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Inpatient respite care is not paid when the client is residing in a facility listed in 471 NAC 36-003.02L.

36-004.02B4 General Inpatient Care: For adult clients, Medicaid pays the general inpatient care rate to the hospice provider during a period of acute medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management that cannot be provided in any other setting. Care shall be provided in a hospital or a contracted hospice inpatient facility that meets the hospice standards regarding staffing and client care.

For child clients, Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility, including Inpatient Respite Care and General Inpatient Care.

A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:

1. Standard: Staffing. The hospice is responsible for ensuring that staffing for all services reflects its volume of clients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided; and
2. Standard: Twenty-four hour nursing services. The hospice facility must provide 24-hour nursing services that meet the nursing needs of all clients and are furnished in accordance with each client's plan of care. Each client must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

When a severe breakdown in caregiving occurs, the general inpatient care rate shall be paid until other arrangements can be made, up to a maximum of ten days per month. The discharge day for general inpatient care is billed as routine home care unless the client is discharged as deceased. When the client dies under general inpatient care, the day of death is paid at the general inpatient care rate.

36-004.02B5 Services Received in Facilities:

36-004.02B5a For Adult Clients: Medicaid pays the hospice provider for both the hospice services provided, and for the residential services provided by the facility.

36-004.02B5a(i) Payment for the Medicaid Hospice Benefit When Provided in an ICF/DD, Nursing Facility, or IMD: Residential payment is 95% of the rate that would have been paid to the facility for residential services.

36-004.02B5a(ii) Payment and Medicaid Managed Care: Except for clients residing in a nursing facility, when the Medicaid Hospice Benefit is elected by a client who is participating in Medicaid Managed Care, services not covered in the Medicaid Hospice Benefit are covered as part of the benefits of the managed care plan, as provided in Title 471 and 482.

36-004.02B5b For Child Clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility.

36-004.02B6 Medicare Coverage: A client who has Medicare coverage shall use Medicare coverage as primary payer until Medicare benefits are exhausted. Medicaid pays the Medicare co-insurance and deductible when the client is covered by both Medicare and Medicaid. See 471 NAC 3-004.

36-004.02B7 Nursing Facility or ICF/DD: See 471 NAC 12-015.

36-000 MEDICAID HOSPICE BENEFIT

36-001 HOSPICE SERVICES: These regulations govern the Medicaid Hospice Benefit, a comprehensive package of services available to current Medicaid clients of all ages. Clients may voluntarily choose hospice services as the care option for their terminal illness. Hospice services include nursing services, physician services, medical social services, counseling services, home health aide/homemaker, medical equipment, medical supplies, drugs and biologicals, physical therapy, occupational therapy, speech language pathology, volunteer services and pastoral care services. These services are offered based on individually assessed needs and choices of terminally ill clients and their families for palliative care and support.

36-002 DEFINITIONS:

Assisted living facility means a facility licensed as an assisted living facility by the Department of Health and Human Services Division of Public Health.

Attending physician means physician named by the client/representative in the hospice records. The attending physician has primary responsibility for the client's care and treatment.

Caregiver means a friend, family member, or legal guardian who provides ongoing care for an individual who is unable to care for him/herself.

Center for developmental disabilities means a facility, including a group home, where shelter, food, and care, advice, counseling, diagnosis, treatment, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have developmental disabilities.

Client representative means a person who is, because of the client's mental or physical incapacity authorized in accordance with state law to execute decisions about hospice services or terminate medical care on behalf of the terminally ill client.

CMS means the federal Centers for Medicare and Medicaid.

Home health aide means a person who is employed by a hospice to provide personal care, assistance with activities of daily living, and basic therapeutic care to the clients of the hospice.

Homemaker means person employed by, or a volunteer of, a hospice to provide domestic services including, but not limited to, meal preparation, laundry, light housekeeping, errands, and chore services as defined by hospice policy.

Hospice or hospice service means a person or legal entity which provides home care, palliative care, or other supportive services to terminally ill persons and their families.

Hospice client means a client who is diagnosed as terminally ill with a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course and who with informed consent is admitted into a hospice program.

Hospice inpatient facility means a facility in which the hospice provides inpatient care directly for respite and general inpatient care.

Hospice interdisciplinary team means the attending physician, hospice medical director, licensed professional registered nurse, certified social worker, pastoral or other counselor, and, as determined by the interdisciplinary plan of care, providers of special services such as counseling services, pharmacy services, home health aides, trained volunteers, dietary services, and any other appropriate health services, to meet the physical, psychosocial, spiritual, and economic needs which are experienced during the final stages of illness, dying, and bereavement.

Hospice volunteer means an individual specifically trained and supervised to provide support and supportive services to the hospice client and hospice client's family under the supervision of a designated hospice volunteer coordinator. This does not apply to any volunteers working on behalf of a hospice licensed under the Health Care Facility Licensure Act who, as part of their volunteer duties, provide care.

Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Intermediate care facility for mentally retarded means a facility, licensed by the Department of Health and Human Services Division of Public Health and certified to participate in Medicaid, where shelter, food, and training or habilitation services, advice, counseling, diagnosis, treatment, care, nursing care, or related services are provided for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who have mental retardation or related conditions, including epilepsy, cerebral palsy, or other developmental disabilities.

Licensed medical nutrition therapist means a person who is licensed to practice medical nutrition therapy pursuant to the Uniform Licensing Law and who holds a current license issued by the Department of Health and Human Services Division of Public Health pursuant to Neb. Rev. Stat. § 38-1813.

Licensed nurse means a person licensed as a Registered Nurse or as a Practical Nurse under the provisions of the Nurse Practice Act, Neb. Rev. Stat. §§ 38-2201 to 38-2236.

Medicaid means the Nebraska Medical Assistance Program established by Neb. Rev. Stat. § 68-903 and Title XIX of the Social Security Act.

Medicaid representative means the client's services coordinator or case manager.

Medical director means a hospice employee or contracted person who is a doctor of medicine or osteopathy who is responsible for the overall coordination of medical care in the hospice.

Medication means any prescription or non-prescription drug or biological intended for treatment or prevention of disease or to effect body functions in humans.

Nursing facility means a facility or a distinct part of a facility, licensed by the Department of Health and Human Services Division of Public Health and certified for participation in the Medicaid program under Title XIX of the Social Security Act, where medical care, rehabilitation, or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled.

Palliative care means treatment directed at controlling pain, relieving other physical and emotional symptoms, and focusing on the special needs of the client and the client's family as they experience the dying process rather than treatment aimed at a cure or prolongation of life.

Physician means any person licensed to practice medicine as provided in Neb. Rev. Stat. §§ 38-2001 to 38-2062.

Social worker, certified means a person who has received a baccalaureate or masters degree in social work from an approved educational program and holds a current certificate issued by the Department of Health and Human Services Division of Public Health.

Terminal illness means that the client is diagnosed with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course.

Treatment means a therapy, modality, product, device, or other intervention used to maintain well being or to diagnose, assess, alleviate, or prevent a disability, injury, illness, disease or similar condition.

Volunteer services means services provided by unpaid persons that supplement other covered services. Services include but are not limited to caregiver relief, short-term client companionship or running errands.

36-003 PROVIDER STANDARDS

36-003.01 Standards for Providing Services: The hospice provider shall deliver services in accordance with the following standards:

1. The needs, preferences, cultural diversity, values and expectations of client/caregiver are reflected in all aspects of service delivery;
2. All service provision is done in a manner that is empowering to the client/caregiver;
3. The client/caregiver feels safe and confident that their right to privacy is protected; and
4. The client/caregiver is treated with dignity and respect at all times.

36-003.02 Hospice Provider Requirements: To participate in the Medicaid program, the hospice provider shall:

1. Be a participant in the Medicare hospice program;
2. Be licensed to provide hospice care by the Department of Health and Human Services Division of Public Health;
3. Assume full responsibility for the professional management of the client's hospice care;
4. Maintain certification by a physician that the client is terminally ill with a life expectancy of six months or less based on the physician's or medical director's clinical judgment regarding the normal course of the client's illness;
5. Maintain the signed election statement in its files;
6. Develop the plan of care and interventions based on the assessment of the needs and choices identified by client/caregiver. All service provision shall be consistent with the plan of care;
7. Provide "on call" services 24 hours a day, seven days a week;
8. Follow all applicable Nebraska Department of Health and Human Services regulations;
9. Bill only for services authorized and actually provided;
10. Comply with the requirements of 471 NAC 3 for the submission of claims for payment;
11. Retain financial and statistical records for four years from date of service provision to support and document claims;
12. Accept Medicaid payment as payment in full from the Department of Health and Human Services plus the client's share of cost;
13. Allow federal and state offices responsible for program administration or audit to review service and financial records. Inspections, reviews and audits may be conducted on site;
14. Operate a drug free work place;
15. Allow the Department of Health and Human Services staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place;
16. Agree and assure that any suspected abuse or neglect shall be reported to law enforcement and/or appropriate Department staff;

17. Not discriminate against any employee, applicant for employment, or program participant or applicant because of race, age, color, religion, sex, handicap, or national origin, in accordance with 45 CFR Parts 80, 84, 90; and 41 CFR Part 60;
18. Agree and understand that any false claims (including claims submitted electronically), statements, documents, or concealment of material facts may be prosecuted under applicable state or federal laws (42 CFR 455.18); and
19. Respect every client's right to confidentiality and safeguard confidential information.

36-003.03 Provider Agreement and Enrollment: The hospice provider shall complete and submit Form MC-19, "Medical Assistance Provider Agreement." When the client resides in a facility, a copy of the hospice provider's contract with the facility shall be attached.

36-004 CLIENT ELIGIBILITY REQUIREMENTS: The Medicaid Hospice Benefit is available to clients who meet the following criteria:

5. The client is currently eligible for Medicaid;
6. The client is diagnosed as terminally ill by the hospice medical director and the attending physician with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course; and
7. The client is an adult and has chosen to receive palliative/comfort care to manage symptoms of terminal illness and has chosen not to receive curative treatment or disease management; or
8. The client is a child and has elected to receive palliative/comfort care to manage symptoms of terminal illness. Such election by a child shall not constitute a waiver of any rights of the child to be provided with, or receive Medicaid payment for, concurrent services related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

36-005 COVERED SERVICES: The Medicaid Hospice Benefit includes coverage for services provided in response to the palliative management of the terminal illness. The hospice provider shall assure the following criteria are met:

1. All services shall be performed by qualified personnel;
2. The cultural requirements of the client/caregiver are identified and appropriate resources are utilized including interpreters; and
3. Services are provided based on the individual needs of client by staff educated in the hospice philosophy.

36-005.01 Nursing Services: The hospice provider shall assure that nursing services are provided by or under the supervision of a registered nurse. Nursing services shall be directed and staffed to assure that the nursing needs of the clients are met. The client care responsibilities of the nursing personnel shall be specified in the hospice plan of care. Services shall be provided in accordance with recognized standards of practice. Nursing services include:

1. Regular visits by a registered nurse (RN) or licensed practical nurse (LPN) to monitor condition, provide care, and maintain comfort based on assessment of individual needs and as identified in the hospice plan of care;

2. Face to face visits, at a minimum weekly by an RN/LPN, or more frequently as needed, and the registered nurse shall visit at least every two weeks;
3. Education based on the needs of the client/caregiver and family about the changes to be expected with the dying process; the appropriate use of medications, therapies, equipment, and supplies; what hospice does and does not do; and emphasis on the importance of realistic goals;
4. An initial assessment (see 471 NAC 36-005.01A);
5. An individualized hospice plan of care (see 471 NAC 36-005.01B); and
6. Coordination of care (see 471 NAC 36-005.01C).

36-005.01A Initial Assessment: An initial assessment shall be completed within 24 hours after Medicaid eligibility is established and the election statement is signed. The nurse completes the assessment to collect comprehensive information concerning the client's preferences, goals, health status, and to determine strengths, priorities, and resources. The assessment shall be completed by a designated registered nurse from the hospice provider and coordinated with the client's Medicaid representative. Ongoing assessments shall be completed and updated with each client visit.

36-005.01B Individualized Hospice Plan of Care: An individualized hospice plan of care shall be written to identify specific individual services to be provided in a coordinated and organized manner. The interdisciplinary team shall be involved in developing the plan of care. The hospice plan of care shall be culturally appropriate and identify in detail the services that shall address the needs identified in the assessment. The hospice plan of care shall state in detail the scope and frequency of services that shall meet the client's and family's needs. The hospice plan of care shall be developed with the client/caregiver within two calendar days of admission to the hospice program. The care provided shall be in accordance with the written plan of care. In the event of disagreement between the client and in-home caregiver, the client shall make the final decision about care, service needs, preferences, and choices. The hospice plan of care shall be reviewed and updated based on client need and a minimum of every two weeks.

36-005.01C Coordination of Care: Coordination of care shall include links to needed services and resources, and shall ensure that client choices and concerns are represented. The hospice provider shall designate a registered nurse to coordinate the implementation of the hospice plan of care with the client's Medicaid representative. Coordination shall accomplish sharing of information to prevent gaps in service, duplication of services and duplication of payment. A request for additional Medicaid services or a determination of denial of hospice services for a Medicaid client by the hospice provider shall be coordinated with the client's Medicaid representative. The hospice provider shall notify the client's Medicaid representative when a Medicaid client elects hospice services.

36-005.02 Home Health Aide/Homemaker: The hospice provider shall assure that home health aide/homemaker services are provided to promote client care and comfort and are completed at the direction of the client/caregiver based on client's individualized hospice

plan of care. Services shall be available and adequate to meet the needs of the client. Home health aide/homemaker services include:

1. Personal care services, for example, bathing, dressing, assisting with bowel and bladder requirements, assisting with ambulating, hair care, nail care, as indicated in the client's individualized hospice plan of care and at the direction of the client/caregiver; and
2. Homemaker services to maintain a safe and sanitary environment, for example, meal preparation, changing linens, light housekeeping and laundry for client cleanliness and comfort, as indicated in client's individualized hospice plan of care and at the direction of the client/caregiver.

36-005.03 Medical Social Services: The hospice provider shall assure that medical social services are provided for the client/caregiver and family under the direction of the physician. Medical social services include:

1. Crisis intervention for the client, caregiver, and/or family;
2. Psychosocial assessment to address needs identified by the client/caregiver and to develop plans for intervention;
3. Counseling to assist the client/caregiver/family, including children, cope with serious illness/death;
4. Client advocacy to assure the client/caregiver have choices in care and understand their right to refuse treatment;
5. Liaison between client and needed community resources;
6. Fostering human dignity and personal worth; and
7. Coordination of services with the Medicaid representative, when applicable.

36-005.04 Medical Equipment and Supplies including Drugs and Biologicals: The hospice provider shall assure that medical equipment and supplies, including drugs, are provided for palliation and management of the terminal illness and related conditions. All equipment, supplies, medications, and biologicals shall be provided as prescribed by the client's physician, as needed, and at the direction of the client/caregiver as indicated in the client's individualized hospice plan of care. These services include:

1. Medication for the relief of pain and related symptoms;
2. Durable medical equipment related to palliation; and
3. Personal comfort items needed for client comfort and management of terminal illness.

36-005.05 Other Counseling Services: The hospice provider shall assure that other counseling services are available for the client, caregiver, and family. Services include:

1. Dietary counseling provided by a licensed medical nutrition therapist;
2. Spiritual counseling with a person of the client's choice. The interdisciplinary team shall include pastoral care professionals who are educated in the hospice philosophy;
3. Bereavement counseling provided through an organized program of bereavement services under the supervision of a qualified professional.

Bereavement services shall be offered to the client's family at least quarterly for one year following death of the client. Bereavement services shall identify "at risk" survivors and provide resources for follow-up. It is the choice of the family to accept bereavement services.

36-005.06 Volunteer Services: The hospice provider shall sponsor a volunteer program and shall assure that volunteers participate in an initial volunteer education program. Opportunities for ongoing education shall be available for volunteers.

36-005.07 Physician Services: The client's attending physician or a physician associated with the hospice provider shall provide medical direction. The physician associated with the hospice provider shall ultimately assure the general medical needs are met in all settings, including long term care.

36-005.08 Physical Therapy, Occupational Therapy, and Speech Language Pathology Services: The hospice provider shall assure that physical therapy, occupation therapy, and speech language/pathology services are provided to control symptoms or to enable the client to maintain activities of daily living and basic functional skills. These services shall be provided under the direction of the physician and shall be included in the hospice plan of care. The client/caregiver makes the final decision regarding acceptance/refusal of a therapy program.

36-005.09 Medical Interventions: The hospice provider shall assure that medical interventions are provided when the interventions related to the terminal illness, either in use or planned, have been evaluated by the attending physician, hospice medical director, hospice team, client/caregiver, and family, based on the quality of life, value of the treatment to the client, and the service's congruence with the palliative care goals of the client/caregiver, family, and hospice. Planned interventions shall be included in the hospice plan of care.

36-006 ELECTION OF HOSPICE SERVICES: A client or the client's legal representative shall file a voluntary, written expression to choose hospice care, called an election statement designating the Medicaid Hospice Benefit as the care preference for terminal illness. The election statement shall include:

1. The date that hospice services are to begin;
2. The name of the hospice provider; and
3. The client's signature or the signature of the client's legal representative when client is unable to sign. The reason the client cannot sign shall be documented.

A client who has Medicare coverage shall use Medicare coverage as primary payer until Medicare benefits are exhausted. Medicaid pays the Medicare co-insurance and deductible when the client is covered by both Medicare and Medicaid. See 471 NAC 3-004.

36-006.01 Hospice's Responsibilities at Election: When a client elects to receive hospice services, the hospice program shall:

1. Explain the benefits the client shall receive;
2.

2. Explain the benefits the client is waiving;
3. Give the client or legal representative a copy of the signed statement; and
4. Retain the signed statement in its files.

36-006.02 Benefit Periods: Medicaid provides two 90-day benefit periods during the client's lifetime. If additional benefit periods are needed, Medicaid provides three 60-day benefit periods. Hospice services beyond these benefit periods shall be approved as an exception under the prior authorization provisions in 471 NAC 36-007. The benefit periods may be used consecutively or at intervals.

36-006.02A Certification: The client shall be certified as terminally ill with a six- month life expectancy by the hospice medical director and the attending physician at the beginning of the first benefit period and by the hospice medical director for all subsequent benefit periods.

36-006.03 Waiver of Medicaid Benefits for Adult Clients: An adult client shall be deemed to have waived all rights to Medicaid payment for treatment associated with the terminal illness for the duration of the election of hospice care. Medicaid services provided for conditions/illnesses that are unrelated to the terminal illness may be covered by Medicaid separate from the hospice benefit. These services shall be based on individual assessed need and medical necessity as specified in the appropriate chapters of Title 471. If the client/representative revokes election of the Medicaid Hospice Benefit, Medicaid coverage of the benefits deemed to have been waived is restored.

36-006.04 Revocation of Election of Hospice Benefit: A client/representative may revoke election of the hospice benefit at any time. The days that are remaining in the current benefit period are lost. The client/representative shall initiate the process of revocation and follow through with the hospice provider.

The client may initiate re-election of the Medicaid Hospice Benefit if eligibility criteria are met.

36-006.05 Change of Hospice: The client/representative may choose to change from one hospice provider to another hospice provider. A change of hospice may occur only once in each benefit period.

36-007 PRIOR AUTHORIZATION: All hospice services shall be prior authorized. The hospice shall submit prior authorization requests to the Department within 72 hours of the initial assessment. Prior authorization may be retroactive for up to seven days, based on the client's entry date into the hospice program. To request prior authorization, the hospice shall submit:

1. Agency name and provider number;
2. Signed election statement;
3. Physician certification of terminal illness and 6 month or less life expectancy;
4. Hospice plan of care; and
5. List of all medications, biologicals, supplies, and equipment for which the hospice is responsible.

Claims may be denied when prior authorization is not completed.

Re-authorization shall be requested for clients who surpass the six-month prognosis.

36-007.01 Clinical Criteria for Non-Cancer Diagnosis: Coverage of the Medicaid Hospice Benefit depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. The client shall be discharged from the Medicaid Hospice Benefit when the client improves or stabilizes enough that the six months or less prognosis is no longer accurate. The client may be re-enrolled for a new benefit period when a decline in the clinical status is such that the life expectancy is again six months or less.

36-007.01A Guidelines for Decline in Clinical Status: Clients shall be considered to have a life expectancy of six months or less only when there is documented evidence of a decline in clinical status. Baseline data is established on admission to hospice through nursing assessment in addition to utilization of existing information from records. It is essential that baseline and follow-up determinations are documented thoroughly to establish a decline in clinical status.

Coverage of hospice care for clients not meeting the guidelines may be denied. Some clients may not meet the guidelines, yet still be appropriate for hospice care, because of co-morbidities or decline. Coverage for these clients may be approved through the prior authorization process.

36-008 MEDICAID HOSPICE BENEFIT IN CERTAIN FACILITIES: A client who meets the eligibility requirements in 471 NAC 36-004 and resides in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), a Nursing Facility (NF), an Institution for Mental Disease (IMD), an Assisted Living Facility (ALF), or a Center for the Developmental Disabilities (CDD) may elect to receive hospice services where s/he lives. The Medicaid Hospice Benefit is available to Medicaid eligible persons in an IMD who are age 20 or younger or 65 or older. The facility shall agree to the provision of hospice services and the hospice provider shall have a signed contract with the facility before provision of hospice services.

36-008.01 Facility's Responsibilities: The facility shall:

1. Provide room and board for the client;
2. Perform personal care;
3. Assist with activities of daily living;
4. Administer medications;
5. Provide social activities;
6. Provide housekeeping;
7. Supervise and assist with the use of durable medical equipment and prescribed therapies; and
8. Develop plan of care in collaboration with the hospice provider, client/caregiver and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the plan.

36-008.02 Hospice Responsibilities: The hospice provider shall:

1. Assess the client's needs in coordination with the designated facility representative and client/caregiver;
2. Develop a hospice plan of care in collaboration with client/caregiver, facility caregivers and providers, including the case manager, service coordinator, and eligibility workers, and adhere to responsibilities outlined in the hospice plan of care;
3. Assume the professional management responsibility for ensuring the implementation of the hospice plan of care at the direction of the client/caregiver;
4. Coordinate, with the facility's representative, the responsibilities of the facility and the responsibilities of the hospice provider and document in all client records;
5. Involve family and facility personnel in assisting with provision of services as designated by the hospice plan of care, and at the direction of the client/caregiver. The same level of services that would be provided in the home shall be provided in the facility; and
6. Provide social services and counseling utilizing hospice personnel. This service may not be delegated to the facility's personnel.

The hospice provider may not require the client to move from the facility as long as the client's needs can be appropriately and safely met.

36-009 WAIVERS: Clients who elect the hospice benefit while receiving home and community-based (HCB) waiver services may continue to receive HCB waiver services that are based on assessed need and medical necessity. All medical services related to the terminal illness or the hospice plan of care are the responsibility of the hospice and all services shall be coordinated with the waiver services coordinator. The waiver services coordinator retains full responsibility for waiver planning and service authorization.

36-010 DISCHARGE GUIDELINES: The hospice provider shall discontinue services for a client when:

1. The home environment is not safe for hospice personnel, caregiver, or client;
2. The client no longer meets admission guidelines;
3. Life expectancy exceeds one year of benefit periods;
4. The client revokes hospice election; or
5. The client is no longer Medicaid eligible.

36-011 QUALITY ASSURANCE: The Department of Health and Human Services may refuse to execute or may cancel a contract/provider agreement with a hospice provider when the hospice provider:

1. Does not meet the hospice requirements in 471 NAC 36-000;
2. Consistently admits clients who do not meet the eligibility requirements for terminal illness or consistently exceed the six-month prognosis;
3. Consistently refuses to provide or is unable to provide services identified in the assessment and on the hospice plan of care;
4. Consistently bills the majority of claims at the “Continuous Home Care” rate; or
5. Consistently discharges clients in conflict with 471 NAC 36-000.

36-012 PAYMENT: Medicaid pays for services provided under the Medicaid Hospice Benefit using the Medicaid hospice payment rates established by CMS.

36-012.01 For adult clients: Medicaid pays the inpatient respite care rate to the Hospice provider for each day the client is in an inpatient facility (hospital or nursing facility) and receiving respite care (see 471 NAC 36-012.03).

Medicaid pays the general inpatient care rate to the Hospice provider during a period of acute medical crisis (See 471 NAC 36-012.04). Payment shall be made only when the care is provided in a hospital or a contracted hospice inpatient facility.

Medicaid pays all costs for hospital services provided when a client receiving the Medicaid Hospice Benefit is hospitalized for an acute medical condition that is not related to the terminal diagnosis and/or complications secondary to the terminal diagnosis.

Determination of the cause of hospitalization shall be made by the Hospice disciplinary team with consultation with the Medicaid Hospice Program Specialist. Payment for hospital services shall be made directly to the hospital.

36-012.02 For child clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility, including Inpatient Respite Care (see 471 NAC 36-012.05) and General Inpatient Care (see 471 NAC 36-012.06).

36-012.03 Routine Home Care: Medicaid pays the routine home care rate to the hospice provider for every day the client is at home, under the care of hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

36-012.04 Continuous Home Care: Medicaid pays the continuous home care rate to the hospice provider to maintain a client at his/her place of residence when a period of medical crisis occurs. A period of medical crisis is a time when a client requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. A registered nurse or a licensed practical nurse shall provide nursing care. A nurse shall be providing more than one half (51% or greater) of care given in a 24-hour period. A minimum of eight hours of care shall be provided in a 24-hour period, which begins and ends at midnight. When the number of hours is less than 24, Medicaid pays the hourly rate. The hours may be split over the 24 hours to meet the needs of the client. Routine home care shall be billed when fewer than eight hours of nursing care are provided.

36-012.05 Inpatient Hospital or Nursing Facility Respite Care: For adult clients, Medicaid pays the inpatient respite care rate to the hospice provider for each day the client is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the client when necessary to relieve the caregiver. Payment may be made for a maximum of five days per month counting the day of admission but not the day of discharge. The discharge day for inpatient respite care is billed at routine home care unless the client is discharged as deceased. When the client dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Inpatient respite care is not paid when the client is residing in a facility listed in 471 NAC 36-008.

36-012.06 General Inpatient Care: For adult clients, Medicaid pays the general inpatient care rate to the hospice provider during a period of acute medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management that cannot be provided in any other setting. Care shall be provided in a hospital or a contracted hospice inpatient facility that meets the hospice standards regarding staffing and client care. When a severe breakdown in caregiving occurs, the general inpatient care rate shall be paid until other arrangements can be made, up to a maximum of ten days per month. The discharge day for general inpatient care is billed as routine home care unless the client is discharged as deceased. When the client dies under general inpatient care, the day of death is paid at the general inpatient care rate.

36-012.06A Limitation On Payments To A Hospice: Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid clients during that same period. Medicaid clients who have been diagnosed with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospice's "cap period" (11/1 -10/31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate are not counted as inpatient days. The Department calculates the limitation as follows:

i. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.
ii. If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment is necessary.
iii. If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made;
2. Multiplying excess inpatient care days by the routine home care rate;
3. Adding together the amounts calculated in a and b; and comparing the amount in c with interim payments made to the hospice for inpatient care during the "cap period." Any excess reimbursement is refunded by the hospice.

36-013 PAYMENT FOR SERVICES RECEIVED IN FACILITIES:

36-013.01 For adult clients: Medicaid pays the hospice provider for both the hospice services provided and for the residential services provided by the facility.

36-013.01A Payment for the Medicaid Hospice Benefit When Provided in an ICF/MR, Nursing Facility, or IMD: Residential payment is 95% of the rate that would have been paid to the facility for residential services.

36-013.01B Payment and Medicaid Managed Care: When the Medicaid Hospice Benefit is elected by the client who is participating in the Nebraska Health Connection (Medicaid Managed Care), services not covered in the Medicaid Hospice Benefit are covered as part of the benefits of the managed care plan, as provided in Title 471 and 482.

36-013.02 For child clients: Medicaid payment for hospital and nursing facility services shall be made directly to the hospital or nursing facility.

36-014 BILLING: The hospice provider shall bill for services provided using Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837). For claim submission instructions, see the Claim Submission Table at 471-000-49.

HCPCS/CPT procedure codes used by Nebraska Medicaid are listed in the Nebraska Medicaid Fee Schedule (see 471-000-536).

36-015 MEDICAID PAYMENT WHEN A MEDICAID CLIENT RESIDING IN A NURSING FACILITY OR ICF/MR ELECTS THE MEDICARE HOSPICE BENEFIT : See 471 NAC 12-015.

Boesiger, Bess

From:	DHHS Regulations
Sent:	Tuesday, June 19, 2018 9:56 AM
To:	Boesiger, Bess
Cc:	DHHS Regulations; Hegr, Jaime; DHHS MLTC Regulations
Subject:	NOTICE OF RULEMAKING -16015 MLTC - MEDICAID HOSPICE SERVICES (471)
Attachments:	Notice of Public Hearing.pdf; FISCAL IMPACT STATEMENT.pdf; 16015 - POLICY PRE-REVIEW CHECKLIST - SIGNED 6.12.17.pdf; 16015 - EXEC BOARD NOTICE OF RULEMAKING.pdf; 16015 -WORKING COPY 11.23.16.pdf

Title: 471
Chapter: 36 (Amend)
Short Description: Hospice Services

Summary:
The purpose of this hearing is to receive additional comments on proposed changes to Title 471, Chapter 36 of the Nebraska Administrative Code (NAC) – *Hospice Services.* This regulation governs the hospice services provided under Nebraska's Medicaid Program. The rewrite mainly consisted of identifying insufficient or inconsistent language, restructuring the regulatory chapters, and performing a compliance review to determine uniformity with State Plan, other NAC chapters, Federal law, and best practices.

Hearing Date: 07-30-2018
Hearing Time: 10:30 AM Central Time
Hearing Address: Nebraska State Office Building, Lower Level Conference Room A, 301 Centennial Mall South
City: Lincoln
State: NE
Zip Code: 68509
Agency Hearing Contact Name: Jeanie Boerger
Agency Hearing Contact Email: DHHS.Regulations@nebraska.gov
Agency Hearing Contact Phone: (402) 471-8223

Please turn on the on-line comments button. Comments should be routed to DHHS.Regulations@nebraska.gov

Agency Name: Health and Human Services
Agency Division: Legal Services
Agency Address: P.O. Box 95026
City: Lincoln
State: NE
Zip Code: 68509-5026
Agency Phone Number: (402) 471-8223

Please find attached the following:

- Notice of Public Hearing – July 30, 2018 (PDF)
- Fiscal Impact Statement for 471 NAC 36 (PDF)