NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

October 4, 2023
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level
Meadowlark Conference Room
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 36 of the Nebraska Administrative Code (NAC) – *Hospice Services.* These regulations govern services provided under the Medical Assistance Act, Neb. Rev. Stat. §§ 68-901 et seq. The proposed changes set the regulations' scope and authority; update definitions; clarify authorization language; update references to acute medical crisis and payment; update section headings and formatting; update terminology; remove direction to agency staff; remove duplicate statutory and inconsistent language from the regulations; and restructure the regulatory chapter.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7) and § 68-908.

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 (fax) 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) 471-8417. 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) 471-8417. Individuals who are deaf or hard of hearing may call DHHS via 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: Erin Noble
Chapter: 36	Date prepared: April 17, 2023
Subject: Hospice Services	Telephone: 531-530-7154

Type of Fiscal Impact:

	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:

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 36 HOSPICE SERVICES

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

002.01 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.

002.02 ASSISTED LIVING FACILITY. A facility licensed as an assisted living facility by the Department of Health and Human Services, Division of Public Health.

002.03 ATTENDING PHYSICIAN. A doctor of medicine or osteopathy who is legally authorized to practice medicine or surgery by the state in which they perform that function, and is identified by the client, at the time they elect to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care.

002.04 BENEFIT PERIOD. The dates that the certification or recertification request covers.

002.05 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.

002.06 CAREGIVER. A friend, family member, or legal guardian who provides ongoing care for a client who is unable to care for themself.

002.07 CENTER FOR THE DEVELOPMENTAL DISABILITIES (CDD). 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.

002.08 CLIENT. A Medicaid client who is:

(A) Diagnosed as terminally ill; and

(B) Admitted into a hospice service, after giving informed consent.

002.09 CLIENT REPRESENATIVE. 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.

002.10 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 (RN), dietitian, or nutritionist, when identified in the client's plan of care.

002.11 ELECTION. A decision by the client, or client's representative, to receive hospice care.

002.12 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.

002.13 HOSPICE OR HOSPICE PROVIDER. A public agency, private organization, or subdivision of a public agency or private organization that is primarily engaged in providing hospice care as defined in this section.

002.14 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.

002.15 HOSPICE CARE. A comprehensive set of services described in this chapter, identified and coordinated by a hospice interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill client and family members, as delineated in a specific client plan of care.

002.16 HOSPICE INPATIENT FACILITY. A facility in which the hospice service provides inpatient care directly for respite and general inpatient care.

002.17 HOSPICE INTERDISCIPLINARY GROUP (IDG). The hospice medical director, nurse practitioner, licensed professional registered nurse (RN), 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.

002.18 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.

002.19 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.

002.20 INSTITUTION FOR MENTAL DISEASES (IMD). A hospital, nursing facility (NF), 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.

002.21 INTERMEDIATE CARE FACILITY FOR INVIDUALS WITH DEVELOPMENTAL DISABILITIES (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 24 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.

002.22 LICENSED NURSE. A person licensed as a registered nurse (RN) or as a practical nurse under the provisions of the Nurse Practice Act, Neb. Rev. Stat. §§ 38-2201 to 38-2238

002.23 LICENSED PROFESSIONAL. A person licensed to provide patient care services by the state in which services are delivered.

002.24 MEDICAID REPRESENTATIVE. The client's services coordinator or case manager.

002.25 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.

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

002.27 NURSE PRACTITIONER. A registered nurse (RN) who performs such services as legally authorized to perform under the provisions of the Nurse Practice Act, Neb. Rev. Stat. §§ 38-2201 to 38-2238.

002.28 NURSING FACILITY (NF). 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.

002.29 ON-CALL SERVICES. Nursing services, physician services, and drugs and biologicals must be made routinely available on a 24-hour basis, seven 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.

002.30 PALLIATIVE CARE. As defined in Neb. Rev. Stat. § 71-424.04.

002.31 PHYSICIAN. Any person licensed to practice medicine as provided in Neb. Rev. Stat. §§ 38-2001 to 38-2063.

002.32 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.

002.33 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.

002.34 REVOCATION. The choice by the client, or client's representative, to discontinue hospice services. Hospice services may be revoked in writing at any time.

002.35 SOCIAL WORKER, CERTIFIED. A person who has received a baccalaureate or master's degree in social work from an approved educational program, and holds a current certified social worker certificate issued by the Department of Health and Human Services Division of Public Health.

002.36 TERMINALLY ILL OR TERMINAL ILLNESS. The client is diagnosed with a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

002.37 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.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. Providers must comply with all applicable provider participation requirements codified in 471 Nebraska Administrative Code (NAC) 2 and 3. In the event that participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this chapter, the participation requirements in this chapter will govern.

003.02 SERVICE SPECIFIC PROVIDER REQUIREMENTS. Hospice providers must participate in Medicare, and meet the licensure and certification requirements of the Nebraska Department of Health and Human Services Division of Public Health.

003.02(A) STANDARDS OF CARE. The hospice provider must deliver services in accordance with the following standards:

(i) A hospice provider must be primarily engaged in providing the scope of services outlined in this chapter, and must do so in a manner that is consistent with accepted standards of practice;

(ii) 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;

(iii) The hospice provider must maintain clinical records containing past and current findings for each hospice client for the longer of six years, or the time period identified in 175 NAC 16. 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;

(iv) 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;

(v) The needs, preferences, cultural diversity, values, and expectations of client and caregiver are reflected in all aspects of service delivery;

(vi) All service provision is done in a manner that is empowering to the client and caregiver;

(vii) The client and caregiver feels safe and confident that their right to privacy is protected;

(viii) The client and caregiver is treated with dignity and respect at all times;

(ix) The hospice provider must assume full responsibility for the professional management of the client's hospice care;

(x) 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 as outlined in this chapter;

(xi) The hospice provider must maintain a certification that the client is terminally ill based on the clinical judgment of the hospice medical director or the physician member of the hospice interdisciplinary group (IDG), or the client's attending physician if the client has an attending physician;

(xii) Maintain the signed election statement in its files;

(xiii) The hospice provider must designate a hospice interdisciplinary group (IDG) or groups as defined in this chapter 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;

(xiv) Provide on-call services 24 hours a day, seven days a week;

(xv) Allow the Department staff to review agency policies regarding hiring and reporting to ensure that appropriate procedures regarding abuse, neglect, and law violations are in place;

(xvi) Agree and assure that any suspected abuse or neglect must be reported to law enforcement and appropriate Department staff;

(xvii) 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 2;

(xviii) 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 or her state license, or state certification, or registration. All personnel qualifications must be kept current at all times;

(xix) 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;

(xx) The hospice provider must have a signed, written, non-resident-specific contract with each certified nursing facility (NF), intermediate care facility for individuals with developmental disabilities (ICF/DD), institution for mental diseases (IMD), assisted living facility (ALF), or center for the developmental disabilities (CDD); and

(xxi) 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.

003.02(B) PROVIDER AGREEMENT AND ENROLLMENT. The hospice provider must complete and submit Form MC-19, Service Provider Agreement. When enrollment by hospice is done to provide inpatient services in a facility, a copy of the hospice provider's contract with the facility must be attached.

003.02(C) QUALITY ASSURANCE. The Department may refuse to execute or may cancel a contract or provider agreement with a hospice provider when the hospice provider:

(i) Does not meet the hospice requirements in this chapter;

(ii) Consistently admits clients who do not meet the eligibility requirements for terminal illness or consistently exceed the six-month prognosis;

(iii) Consistently refuses to provide, or is unable to provide, services identified in the assessment and on the hospice plan of care;

(iv) Consistently bills the majority of claims at the continuous home care (CHC); or

(v) Consistently discharges clients in conflict within this chapter.

003.02(D) 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 Code of Federal Regulations (CFR) § 418.76. The hospice must maintain documentation that demonstrates the following requirements of this standard are being met:

(i) A hospice aide provides services that are:

(1) Ordered by the hospice interdisciplinary group (IDG);

(2) Included in the plan of care;

(3) Permitted to be performed under state law by such hospice aide; and
(4) Consistent with the hospice aide training;
(ii) The duties of a hospice aide include the following:
(1) The provision of hands-on personal care;
(2) The performance of simple procedures as an extension of therapy or nursing services;
(3) Assistance in ambulation or exercises; and
(4) Assistance in administering medications that are ordinarily self-administered;
(iii) Hospice aides must report changes in the client's medical, nursing, rehabilitative, and social needs to a registered nurse (RN), 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;
(iv) Supervision of hospice aides must meet the following requirements:
(1) A registered nurse (RN) must act as the supervising nurse for hospice aides;
(2) 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 (IDG) meet the client's needs;
(3) The hospice aide does not have to be present during this visit:
(a) 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; and
(b) 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;
(4) 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
(5) 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:
(a) Following the client's plan of care for completion of tasks assigned to the hospice aide by the registered nurse (RN);
(b) Creating successful interpersonal relationships with the client and family;
(c) Demonstrating competency with assigned tasks;
(d) Complying with infection control policies and procedures as outlined in 175 NAC 16; and
(e) Reporting changes in the client's condition.

003.02(E) 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 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 2 and 18.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

004.01(A) CLIENT ELIGIBILITY. The Medicaid hospice benefit is available to clients who meet the following criteria:

(i) The client is currently eligible for Medicaid;

(ii) The client is diagnosed as terminally ill by the hospice medical director or the physician member of the hospice interdisciplinary group (IDG), and the attending physician, if any; and

(iii) The client is an adult and has elected to receive palliative or comfort care to manage symptoms of terminal illness, and has chosen not to receive curative treatment or disease management; or

(iv) The client is a child and his or her parent or guardian has elected to receive palliative or comfort care to manage symptoms of terminal illness. Such election by a child's parent or guardian must 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.

004.01(B) ELECTION OF HOSPICE SERVICES. A client, or the client's representative, must 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 must include:

(1) 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;

(2) The name of the hospice provider;

(3) The client's or representative's acknowledgement that he or she has been given a full understanding of hospice care;

(4) The client's or representative's acknowledgement that he or she understands that the Medicaid services listed in this chapter are waived by the election; and

(5) The client's signature. If the client is physically or mentally incapacitated, his or her representative may file the election statement. If signed by the client's representative, the reason the client cannot sign the election statement must be documented.

004.01(B)(i) HOSPICE RESPONSIBILITIES AT ELECTIONS. When a client elects to receive hospice services, the hospice program must:

(1) Explain the scope of benefits the client must receive as a part of the hospice program;

(2) Explain the benefits the client is waiving;

(3) Give the client or legal representative a copy of the signed statement;

(4) Retain the signed statement in its files; and

(5) Inform the client of his or her rights, and the hospice must protect and promote the exercise of these rights.

004.01(B)(ii) 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 this chapter.

004.01(B)(ii)(1) CERTIFICATION. The client must be certified as terminally ill by the hospice medical director, or the physician member of the hospice interdisciplinary group (IDG), and 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 hospice interdisciplinary group (IDG), and the attending physician. Subsequent certifications must include a new statement regarding life expectancy, and be signed by the attending physician.

004.01(B)(ii)(1)(a) INITIAL CERTIFICATION AND SUBSEQUENT BENEFIT PERIODS. The initial written certification must be made within two calendar days of the start of hospice care; however, if verbal certification is provided within the first two calendar days, written certification may be provided within eight 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 two 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.

004.01(B)(ii)(1)(b) DECLINE IN CLINICAL STATUS. Clients will 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 six 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.

004.01(B)(ii(2) 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.

004.01(B)(ii)(3) 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.

004.01(B)(iii) WAIVER OF MEDICAID BENEFITS FOR ADULT CLIENTS. Upon signing the hospice election statement, an adult client must be deemed to have waived all rights to the following:

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

004.01(B)(iii)(1) WAIVER DURATION. This waiver remains in effect for the duration of the election of hospice care. Medicaid services provided for conditions or illnesses that are unrelated to the terminal illness may be covered by Medicaid separate from the hospice benefit. These services must be based on individual assessed need and medical necessity as specified in the appropriate chapters of Title 471 NAC. If the client or representative revokes election of the Medicaid hospice benefit, Medicaid coverage of the benefits deemed to have been waived is restored.

004.01(B)(iv) 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.

004.01(B)(iv)(1) REVOCATION OF ELECTION. When the hospice election is ended due to revocation, the hospice must file a notice of revocation of election with Medicaid within five calendar days after the effective date of the revocation, unless it has already filed a final claim for that beneficiary.

004.01(B)(v) CHANGE OF HOSPICE. The client or representative may choose to change from one hospice provider to another hospice provider. A change of hospice provider 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:

(1) Name of the hospice from which the individual has received care;
(2) Name of the hospice from which the individual plans to receive care; and

(3) Date the change is effective.

004.01(B)(vi) DUALLY ELIGIBLE. A client who is Medicare and Medicaid eligible must elect and revoke hospice care simultaneously under both the Medicare and the Medicaid program.

004.01(B)(vii) 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.

004.01(B)(viii) ADVANCE DIRECTIVES. Medicaid-participating hospice agencies must comply with applicable state and federal requirements.

004.01(C) INITIAL ASSESSMENT. An initial assessment must 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 must be completed by a designated registered nurse (RN) from the hospice provider and coordinated with the client's Medicaid representative. Ongoing assessments must be completed and updated with each client visit.

004.01(D) PRIOR AUTHORIZATION. All hospice services must be prior authorized. The hospice must submit prior authorization requests to the Department within three business days 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. Claims may be denied when prior authorization is not completed. Re-authorization is required for each subsequent benefit period. To request prior authorization, the hospice must submit:

(i) Agency name and provider number;
(ii) The client's Medicaid number. When the client's Medicaid eligibility is pending at the time of admission to hospice and the client later becomes eligible, the hospice agency must submit the request for prior authorization once the client is determined Medicaid eligible;
(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.

004.01(E) INDIVIDUALIZED HOSPICE PLAN OF CARE. An individualized hospice plan of care must be written to identify specific individual services to be provided in a coordinated and organized manner. The hospice must have up to three business days from the initial assessment to develop the plan of care, with involvement from the client, caregiver, attending physician, medical director, and hospice interdisciplinary group (IDG). The hospice plan of care must be established prior to services being provided.

004.01(E)(i) ADDITIONAL PLAN OF CARE REQUIREMENTS. The hospice plan of care must be culturally appropriate, and identify in detail the services that will address the needs identified in the assessment. The hospice plan of care must state in detail the scope and frequency of services that will meet the client's and family's needs. The care provided must be in accordance with the written plan of care. In the event of disagreement between the client and in-home caregiver, the client must make the final decision about care, service needs, preferences, and choices. The hospice interdisciplinary group (IDG), in collaboration with the client'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.

004.01(F) COORDINATION OF CARE. The hospice provider must designate a registered nurse (RN) to coordinate the implementation of the hospice plan of care with the client's Medicaid representative. Coordination of care must include connections to needed services and resources, and must 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 must be coordinated with the client's Medicaid representative. The hospice provider must notify the client's Medicaid representative when a Medicaid client elects hospice services.

004.01(G) DISCHARGE FROM HOSPICE. Coverage of the Medicaid hospice benefit depends on a physician's certification that a client is terminally ill. The client must be discharged from the Medicaid hospice benefit when the client improves or stabilizes enough that he or 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.

004.01(G)(i) DISCHARGE BY THE HOSPICE. A hospice provider may discharge a client if:

(a) The client moves out of the hospice's service area or transfers to another hospice;
(b) The hospice determines that the client is no longer terminally ill; or
(c) 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:
    (1) Advise the client that a discharge for cause is being considered;
    (2) Make a serious effort to resolve the problems presented by the client's behavior or situation;
    (3) Ascertain that the client's proposed discharge is not due to the client's use of necessary hospice services; and

(4) Document the problems and efforts made to resolve the problems and enter this documentation into its medical records.

004.01(G)(i)(1) 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 or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

004.01(G)(ii) EFFECT OF DISCHARGE. A client, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice:

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

004.01(H) SERVICES PROVIDED FOR CLIENTS ENROLLED IN NEBRASKA MEDICAID MANAGED CARE. See 471 NAC 1.

004.01(I) HEALTH CHECK SERVICES. See 471 NAC 33.

004.02 COVERED SERVICES. 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 or her rights, and the hospice must protect and promote the exercise of these rights. 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.

004.02(A) NURSING SERVICES. The hospice provider must assure that nursing services require the skills of a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a registered nurse (RN), and must be reasonable and necessary for the palliation and management of the client's terminal illness and related conditions. Services must be provided in accordance with recognized standards of practice. 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 this chapter. The nurse practitioner may not serve as or replace the medical director or physician designee. Nursing services include, but are not limited to:

(i) 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;
(ii) At a minimum, the required visits by a registered nurse (RN) or licensed practical nurse (LPN) occur weekly, or more frequently as needed. The registered nurse (RN) must visit at least every two weeks;
(iii) 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;
(iv) An initial assessment;
(v) An individualized hospice plan of care; and
(vi) Coordination of care.

004.02(B) HOSPICE AIDE and HOMEMAKER. The hospice provider must assure that hospice aide and homemaker services are provided to promote client care and comfort, and are completed at the direction of the client and caregiver based on client's individualized hospice plan of care. Services must be available and adequate to meet the needs of the client. Hospice aide and homemaker services include:

(i) Personal care services, as indicated in the client's individualized hospice plan of care and at the direction of the client and caregiver; and
(ii) Hospice aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the client. Hospice aide services must be provided under the general supervision of a registered nurse (RN). 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.

004.02(C) MEDICAL SOCIAL SERVICES. The hospice provider must 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:

(i) Crisis intervention for the client, caregiver, and family;
(ii) Psychosocial assessment to address needs identified by the client and caregiver and to develop plans for intervention;
(iii) Counseling to assist the client, caregiver, and family including children, to cope with serious illness and death;
(iv) Client advocacy to assure the client and caregiver have choices in care, and understands their right to refuse treatment;
(v) Act as a liaison between client and needed community resources;
(vi) Fostering human dignity and personal worth; and
(vii) Coordination of services with the Medicaid representative, when applicable.

004.02(D) MEDICAL EQUIPMENT AND SUPPLIES INCLUDING DRUGS AND BIOLOGICALS. 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. The hospice provider must 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 must be provided as prescribed by the client's physician, as needed, and at the direction of the client and caregiver, as indicated in the client's individualized hospice plan of care. These services include:

(i) Medication for the relief of pain and related symptoms;
(ii) Durable medical equipment related to palliation; and
(iii) Personal comfort items related to the palliation and management of the client's terminal illness.

004.02(E) OTHER COUNSELING SERVICES. The hospice provider must assure that other counseling services are available for the client, caregiver, and family. Services include:

(i) Dietary counseling;
(ii) Spiritual counseling. The hospice must:
  (1) Advise the client and family of the service;
  (2) Provide an assessment of the client's and family's spiritual needs;
  (3) 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
  (4) 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; and
(iii) Bereavement counseling provided through an organized program of bereavement services under the supervision of a qualified professional. The hospice provider must make bereavement services available to the family and other individuals in the bereavement plan of care up to one year following the death of the patient and ensure bereavement services reflect the needs of the bereaved. It is the choice of the family to accept bereavement services.

004.02(F) VOLUNTEER SERVICES. The hospice provider must sponsor a volunteer program and must assure that volunteers participate in an initial volunteer education program. Opportunities for ongoing education must be available for volunteers.

004.02(G) PHYSICIAN SERVICES. Physician services must be performed in accordance with 471 NAC 18. The services of the hospice medical director or the physician member of the hospice interdisciplinary group (IDG) 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 hospice interdisciplinary group (IDG). The hospice face-to-face encounter is an administrative requirement related to certifying the terminal illness.

004.02(H) PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH LANGUAGE PATHOLOGY SERVICES. The hospice provider must 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 must be provided under the direction of the attending physician or medical director, and must be included in the hospice plan of care. The client and caregiver make the final decision regarding acceptance or refusal of a therapy program.

004.02(I) SHORT-TERM INPATIENT RESPITE CARE. May be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days.

004.02(J) MEDICAL INTERVENTIONS. The hospice provider must 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 must be included in the hospice plan of care. 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 caregiving philosophy. No additional Medicaid payment may be made regardless of the cost of the services.

004.02(K) HOSPICE SERVICES IN CERTAIN FACILITIES. A client who meets the eligibility requirements in this chapter and resides in an intermediate care facility for individuals with developmental disabilities (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 he or she lives. The Medicaid hospice benefit is available to Medicaid eligible persons in an institution for mental diseases (IMD) who are age 20 or younger, or 65 or older. The facility must agree to the provision of hospice services, and the hospice provider must have a signed contract with the facility before provision of hospice services.

004.02(K)(i) FACILITY REPONSIBILITIES. The facility must:

(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 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.

004.02(K)(ii) HOSPICE RESPONSIBILITIES. 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. The hospice provider must:

(1) Assess the client's needs in coordination with the designated facility representative, client, and 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 and caregiver;
(4) 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;
(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 and caregiver. The same level of services that would be provided in the home must 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.

004.02(L) HOME AND COMMUNITY-BASED WAIVER SERVICES (HCBS). Clients who elect the hospice benefit while receiving home and community-based waiver services (HCBS) may continue to receive home and community-based waiver services (HCBS) 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 must be coordinated with the waiver services coordinator. The waiver services coordinator retains full responsibility for waiver planning and service authorization.

005. BILLING AND PAYMENT FOR HOSPICE SERVICES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements in 471 NAC 3. In the event that billing requirements in 471 NAC 3 conflict with billing requirements outlined in this chapter, the billing requirements in this chapter will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS. The hospice provider must bill for services provided using Form CMS-1450 or the standard electronic health care claim. Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes used by Medicaid are listed in the Nebraska Medicaid Fee Schedule.

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 3. In the event that payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the payment regulations in this chapter will govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS. Medicaid pays for services provided under the Medicaid hospice benefit using the Medicaid hospice payment rates established by Centers for Medicare and Medicaid services (CMS).

005.02(B)(i) ROUTINE HOME CARE (RHC). Medicaid pays the routine home care (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 (CHC). This rate is paid without regard to the volume or intensity of routine home care (RHC) services provided on any given day. Medicaid pays two separate rates for routine home care (RHC) depending on the length of stay. For the first 60 days of care, routine home care (RHC) will be paid at an increased rate, with a reduced routine home care (RHC) rate applicable to services provided on day 61 and greater.

005.02(B)(i)(1) SERVICE INTENSITY ADD-ON (SIA). In addition to the per diem rate for routine home care (RHC) level of care, Medicaid will include a service intensity add-on (SIA) payment for direct client care services provided by a registered nurse (RN) or social worker during the last seven days of a client's life. The service intensity add-on (SIA) payment will equal the continuous home care (CHC) hourly rate multiplied by the hours of nursing or social work service, for at least 15 minutes and up to four hours total, that occurred on a routine home care (RHC) day during the last seven days of life.

005.02(B)(ii) CONTINUOUS HOME CARE (CHC). A continuous home care (CHC) day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility, hospital, short term nursing facility, or hospice inpatient unit and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Continuous home care (CHC) is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill client at home. Medicaid pays the continuous home care (CHC) rate to the hospice provider to maintain a client at his or 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 (RN) or licensed practical nurse (LPN) must provide nursing care. A nurse must be providing more than one half of care given in a 24-hour period. A minimum of eight hours of care must 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 (RHC) must be billed when fewer than eight hours of nursing care are provided.

005.02(B)(iii) INPATIENT HOSPITAL OR NURSING FACILITY (NF) RESPITE CARE. Inpatient respite care may be necessary to relieve the caregiver who normally cares for the client at home.

005.02(B)(iii)(1) INPATIENT 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. 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 (RHC) 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.

005.02(B)(iii)(2) INPATIENT RESPITE CARE FOR CHILD CLIENTS. Medicaid payment for hospital and nursing facility (NF) services must be made directly to the hospital or nursing facility (NF) for inpatient respite care.

005.02(B)(iv) GENERAL INPATIENT CARE. General inpatient care may be necessary for pain control or acute or chronic symptom management that cannot be provided in any other setting. Care must be provided in a hospital or a contracted hospice inpatient facility that meets the hospice standards regarding staffing and client care. The hospice must have a written contract and retain professional management of hospice services and care.

005.02(B)(iv)(1) GENERAL INPATIENT CARE FOR ADULT CLIENTS. Medicaid pays the general inpatient care rate to the hospice provider during a period of acute medical crisis.

005.02(B)(iv)(2) GENERAL INPATIENT CARE FOR CHILD CLIENTS. Medicaid payment for hospital and nursing facility (NF) services must be made directly to the hospital or nursing facility (NF) for general inpatient care.

005.02(B)(iv)(3) GENERAL INPATIENT CARE HOSPICE FACILITY REQUIREMENTS. A hospice that provides general inpatient care directly in its own facility must demonstrate compliance with the following standards:

(a) 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

(b) 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.

005.02(B)(iv)(4) GENERAL INPATIENT CARE RATE RESTRICTIONS. When a severe breakdown in caregiving occurs, the general inpatient care rate must be paid until other arrangements can be made, up to a maximum of 10 days per month. The discharge day for general inpatient care is billed as routine home care (RHC) 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.

005.02(B)(v) HOSPITAL SERVICES UNRELATED TO TERMINAL DIAGNOSIS. In accordance with 471 NAC 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 or complications secondary to the terminal illness. Determination of the cause of hospitalization must be made by the hospice interdisciplinary group (IDG) with consultation from the Department. Payment for hospital services must be made directly to the hospital.

005.02(B)(vi) SERVICES RECEIVED IN FACILITIES.

005.02(B)(vi)(1) ADULT CLIENTS. Medicaid pays the hospice provider for both the hospice services provided, and for the residential services provided by the facility.

005.02B(vi)(1)(a) PAYMENT FOR THE MEDICAID HOSPICE BENEFIT WHEN PROVIDED IN AN INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES (ICF/DD), A NURSING FACILITY (NF), OR AN INSTITUTION FOR MENTAL DISEASES (IMD). Payment for the Medicaid hospice benefit can be found in the applicable chapters in Title 471 NAC.

005.02(B)(vi)(1(b) PAYMENT AND MEDICAID MANAGED CARE. When a client permanently residing in a nursing facility (NF) is enrolled in managed care and elects the hospice benefit all services not covered under the Medicaid hospice benefit are covered as part of the benefits of the managed care plan. The Medicaid hospice benefit, services covered under the hospice benefit, and nursing facility (NF) room and board payments will be paid outside of the managed care plan.

005.02(B)(vi)(2) CHILD CLIENTS. Medicaid payment for hospital and nursing facility (NF) services must be made directly to the hospital or nursing facility (NF).

005.02B(vii) MEDICARE COVERAGE. A client who has Medicare coverage must 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 as indicated in 471 NAC 3.

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. Remains in section 4 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

Medication means any prescription or non-prescription drug or biological intended for treatment or prevention of disease or to effect body functions in humans. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

Physician means any person licensed to practice medicine as provided in Neb. Rev. Stat. §§ 38-2001 to 38-2062. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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. Remains in section 2 as modified

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.

Remains in section 3 as modified

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.

Remains in section 3 as modified

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

(i) The client is currently eligible for Medicaid;
(ii) 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
(iii) 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
(iv) 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.

Remains in section 4 as modified

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).

Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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.

Remains in section 4 as modified

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.

Remains in section 4 as modified

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.

Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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.

Remains in section 4 as modified

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. Remains in section 5 as modified

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. 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.

Remains in section 4 as modified

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.
Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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. Remains in section 4 as modified

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.

Remains in section 4 as modified

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.

Remains in section 4 as modified

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. Remains in section 4 as modified

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.

Remains in section 4 as modified

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.

Remains in section 4 as modified

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. Remains in section 4 as modified

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.

Remains in section 3 as modified

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.
Remains in section 5 as modified

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. Remains in section 5 as modified

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:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.
2. 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.
3. If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

    a. 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;
    b. Multiplying excess inpatient care days by the routine home care rate;
    c. 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. Remains in section 5 as modified

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. Remains in section 5 as modified

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).

Remains in section 5 as modified

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.