

**NEW YORK STATE  
MEDICAID PROGRAM**

**HOSPICE PROGRAM**

**POLICY GUIDELINES**

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## Section I – Description of Program

Hospice is a coordinated program of home and inpatient care which treats a terminally ill individual and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration. Hospice care may be provided by a hospice agency certified under Article 40 of the Public Health law and approved by Medicare.

The hospice program provides the individual and family with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness, and during dying and bereavement.

The interdisciplinary team is responsible for providing care and services offered by the hospice and supervising and coordinating the individual's care needs. At minimum the team must consist of a Doctor of Medicine or Osteopathy who is employed by or contracted with the hospice, a registered nurse, a social worker, and a pastoral or other counselor. A hospice provider must ensure that the services provided through an existing plan of care, and any new services added after the hospice election, will meet the needs of the hospice patient.

### Eligibility

To be eligible for Medicaid hospice care, the individual's physician and the hospice medical director or designee must certify the individual as having a terminal illness with a life expectancy of fewer than twelve months per benefit period. Individuals must voluntarily elect to receive hospice care which precludes usage of other Medicare and/or Medicaid services for the terminal illness and related conditions.

The hospice program is available through Medicaid, Medicare, private payment, and some health insurers to persons who have a medical prognosis of twelve or fewer months to live if the terminal illness runs its normal course.

Individuals have the ability to rescind this election and subsequently reapply for hospice benefits at a later date.

Medicaid recipients who have elected hospice care are to have a recipient restriction/exception (RR/E) code of C2-HOSPICE-MM placed on their file in eMedNY. The C2 RR/E code is systematically added to a dual eligible Medicaid recipient's record and returned on the ePACES eligibility response when a hospice election period is received on the Medicare Modernization Act (MMA) file of Dual Eligible Beneficiaries. The MMA file includes Medicare Parts A, B, C, and D eligibility and enrollment data including the hospice election date period. For non-dual Medicaid recipients, the C2 RR/E code must be manually entered by submitting a completed Hospice Care Recipient Restriction/Exception (RR/E) Code Update Form to [hospicebilling@health.ny.gov](mailto:hospicebilling@health.ny.gov).

## Medicaid Coverage

The Medicaid hospice benefit includes all services necessary to meet the needs of the patient related to the terminal illness. It is the responsibility of the hospice to provide those services required under the Medicaid hospice benefit.

Medicaid hospice services required by federal regulations are:

- nursing and physician services
- medical social services
- nutrition counseling
- spiritual and bereavement counseling
- home health aide
- homemaker services
- volunteer services
- medical supplies and appliances
- physical therapy
- occupational therapy
- speech therapy
- short-term inpatient care

Personal Care Services (PCS) and Consumer Directed Personal Assistance Services (CDPAS), above those provided by Hospice, may be authorized by the local department of social services/managed care organization only if:

- determined necessary and part of the plan of care unrelated to the terminal illness, or
- services preceded the terminal illness and
- the individual meets the PCS eligibility criteria.

Medicaid reimburses for hospice care as follows:

- For routine home care, including personal care services, using an all-inclusive daily reimbursement rate;
- Continuous home care during periods of crisis;
- General inpatient care for pain or symptom management;
- Inpatient respite to relieve caregivers; and
- Room and board for individuals receiving hospice care in a skilled nursing facility or hospice residence.

## Allowed Services

Services may be provided in the home, a nursing home, assisted living facility, free standing hospice, hospital, or hospice residence; and must be provided according to a written plan of care and are focused on easing the symptoms rather than curing the disease. The individual and family receive medical, psychological and social services, and bereavement and pastoral care related to the individual's terminal diagnosis.

State regulation requires hospice to include the following services as the needs of the patient dictate:

- Nursing;
- Physical Therapy;
- Speech and Language Pathology;
- Home Health Aide and Homemaker;
- Pastoral Care;
- Social Work;
- Psychological;
- Physician;
- Occupational Therapy;
- Medical Supplies and Equipment;
- Bereavement;
- Pharmaceutical/Laboratory;
- Nutrition;
- Audiology; and
- Respiratory Therapy.

### Disallowed Services

The following Medicaid services/programs are not allowed in combination with the hospice benefit:

- Private Duty Nursing;
- Certified Home Health Agency Services; and
- Adult Day Health Care service.

Overpayment resulting from duplication of services will be recouped from the hospice provider.

### Plan of Care

The hospice provider develops an individualized plan of care (POC), established by an interdisciplinary group (IDG) and overseen by a registered nurse (RN) coordinator. The POC must include all services necessary for the palliation and management of the terminal illness and related conditions of the individual. Hospices must identify needs in the comprehensive assessment that are not related to the terminal illness and related conditions. The assessment should document that the hospice is aware of these needs and identify who is addressing them. The hospice should identify what durable medical equipment (DME) is needed and the services to be provided to address the terminal illness and related conditions. The POC should include all diagnoses related to the terminal illness and include those diagnoses directly related to the services the patient is receiving from non-hospice healthcare providers. The hospice must provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

In accordance with [DHCBS 22-15](#), DOH-5778 *Entity/Facility Notification of Hospice Non-Covered Items, Services, and Drugs* is to be completed by the hospice provider and shared with other medical providers and/or facilities who provide services to the patient including local departments of social services and Medicaid Managed Care Organizations (MMCOs). In Section II of DOH-5778, the hospice is to provide the patient's diagnoses information, and identify whether the diagnoses are related (Section

II.A.) or unrelated (Section II.B.) to the patient's terminal illness and its associated conditions. It is expected that the field will not include a code (e.g., C25.9) but rather will include appropriate terminology reflective of the diagnosis.

The above criteria applies to all Medicaid recipients (i.e., Medicaid Fee-for-Service, Mainstream Managed Care and Managed Long Term Care).

## Section II – Managed Care

### Mainstream Managed Care

Hospice services were added as a covered benefit as of October 1, 2013 to the Mainstream managed care benefit package, including Health and Recovery Plan (HARP). This means that individuals who are enrolled in a Mainstream managed care and elect hospice can remain enrolled in Mainstream managed care. Whereas individuals enrolled in the Medicaid fee-for-service program and elect hospice would not be eligible for managed care and would remain under the Medicaid fee-for-service program (per diem reimbursement) for the duration of their approved hospice services.

More information on the Mainstream managed care hospice coverage can be found at: [https://www.health.ny.gov/health\\_care/medicaid/redesign/trans\\_hospice\\_manage\\_care.htm](https://www.health.ny.gov/health_care/medicaid/redesign/trans_hospice_manage_care.htm)

### HIV Special Needs Plan

Under the HIV Special Needs Plan, the hospice benefit is carved out and paid through the Medicaid fee-for-service program. The managed care organization is responsible for helping to coordinate the carved out hospice services. More information on the HIV Special Needs Plan hospice coverage can be found at: <https://www.health.ny.gov/diseases/aids/general/resources/snps/>

### Managed Long Term Care

The Managed Long Term Care (MLTC) program, which includes Partial Capitation, Medicaid Advantage Plus (MAP), and Program for All-Inclusive Care for the Elderly (PACE), provides long term services and supports to hospice electees in different ways.

Individuals enrolled in the Medicaid fee-for-service program and elect hospice are not eligible to enroll in MLTC and would remain under the Medicaid fee-for-service program (per diem reimbursement) for the duration of their approved hospice services.

Individuals enrolled in the MLTC program who decide to elect hospice can remain enrolled in the Partial Capitation, MAP, and Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD). Individuals enrolled in PACE are not eligible for hospice, because PACE plans have an alternate end of life program. If the individual would rather a hospice program, they must be disenrolled from PACE prior to enrollment in hospice.

Information on hospice coverage for children under age 21 can be found at:  
[DOH Medicaid Update January 2011 Vol. 27, No. 1, Office of Health Insurance Programs \(ny.gov\)](#)

Information on hospice coverage in Partial Capitation and MAP can be found at:  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/2015-12-31\\_hospice\\_mltc\\_faq.htm](https://www.health.ny.gov/health_care/medicaid/redesign/2015-12-31_hospice_mltc_faq.htm)

Information on hospice coverage in PACE can be found at:  
[https://www.health.ny.gov/health\\_care/medicaid/redesign/mltc\\_policy\\_13-18.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_13-18.htm)

Information on FIDA-IDD can be found at:  
<https://opwdd.ny.gov/location/partners-health-planfida-idd>

Hospice regulations can be found at:  
<https://regs.health.ny.gov/content/article-9-hospice-operation>

## Section III – Definitions

For the purposes of the Medicaid Program, and as used in this manual, the following terms are defined:

### Hospice Program

Hospice is a coordinated program of home and inpatient care which treats a terminally ill individual and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration.

### Terminal Illness

A terminal illness is a medical prognosis caused by injury, disease, or illness from which there is no reasonable medical probability of recovery.

### Palliative Care

Palliative care means the active, interdisciplinary care of patients with advanced, life-limiting illness, focusing on relief of distressing physical and psychosocial symptoms and meeting spiritual needs. Its goal is achievement of the best quality of life for patients and families.

Palliation is the easing of the severity of a pain or disease without removing the cause.