Hospice

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Instructions for Use

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Related Policies
None

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

California Health and Safety Code 1368.2 Hospice Care Coverage

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1368.2.

(a) On and after January 1, 2002, every group health care service plan contract, except a specialized health care service plan contract, which is issued, amended, or renewed, shall include a provision for hospice care.

(b) The hospice care shall at a minimum be equivalent to hospice care provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(c) The hospice care provided under this section is not required to include preliminary services set forth in subdivision (d) of Section 1749. However, an enrollee who receives those preliminary services shall remain eligible for coverage of curative treatment by a health care service plan during the course of preliminary services and prior to the election of hospice services.

(d) The following are applicable to this section and to paragraph (7) of subdivision (b) of Section 1345:
  (1) The definitions in Section 1746, except for subdivisions (o) and (p) of that section.
  (2) The "federal regulations" which means the regulations adopted for hospice care under Title XVIII of the Social Security Act in Title 42 of the Code of Federal Regulations, Chapter IV, Part 418, except Subparts A, B, G, and H, and any amendments or successor provisions thereto.

(e) The director no later than January 1, 2001, shall adopt regulations to implement this section. The regulations shall meet all of the following requirements:
  (1) Be consistent with all material elements of the federal regulations that are not by their terms applicable only to eligible Medicare beneficiaries. If there is a conflict between a federal regulation and any state regulation, other than those adopted pursuant to this section, the director shall adopt the regulation that is most favorable for plan subscribers, members or enrollees to receive hospice care.
  (2) Be consistent with any other applicable federal or state laws.
  (3) Be consistent with the definitions of Section 1746, except for subdivisions (o) and (p) of that section.

(f) This section is not applicable to the subscribers, enrollees, or members of a health care service plan who elect to receive hospice care under the Medicare program.

1300.68.2 Barclays Official California Code of Regulations 28 CCR § 1300.68.2

https://govt.westlaw.com/calregs/Document/I9643DB334C8A11ECA45D000D3A7C4BC3?viewType=FullText&listSource=Search&originationContext=Search+Result&transitionType=SearchItem&contextData=(sc.Search)&navigationPath=Search%2fv1%2fresults%2fnavigation%2fi0ad62d3400000188fad959db6259183c%3fppcid%3deb1a7be9dac1499e8fc2968493b19dd4%26Nav%3dREGULATION_PUBLICVIEW%26fragmentIdentifier%3dI9643DB334C8A11ECA45D000D3A7C4BC3%26startIndex%3d1%26transitionType%3dSearchItem%26contextData%3d%2528sc.Default%2529%26originationContext%3dSearch%2520Result&list=REGULATION_PUBLICVIEW&rank=1&t_T2=1300.68.2&t_S1=CA+ADC+s

(a) For purposes of this section, the following definitions shall apply:

1) "**Bereavement services**" means those services available to the surviving family members for a period of at least one year after the death of the enrollee. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the enrollee.
2) "**Hospice service" or "hospice program**" means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of an enrollee who is experiencing the last phases of life due to the existence of a terminal disease, to provide supportive care to the primary care giver and the family of the hospice patient, and which meets all of the following criteria;
   A. Considers the enrollee and the enrollee's family, in addition to the enrollee, as the unit of care.
   B. Utilizes an interdisciplinary team to assess the physical, medical, psychological, social and spiritual needs of the enrollee and the enrollee's family.
   C. Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those enrollees who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.
   D. Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.
   E. Provides for bereavement services following the enrollee's death to assist the family to cope with social and emotional needs associated with the death of the enrollee.
   F. Actively utilizes volunteers in the delivery of hospice services.
   G. To the extent appropriate based on the medical needs of the enrollee, provides services in the enrollee's home or primary place of residence.
3) "**Hospice" or "Hospice Agency**" means an entity which provides hospice services to terminally ill persons and holds a license, currently in effect, as a hospice pursuant to Health and Safety Code section 1747 or a home health agency with federal medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1.
4) "**Home health aide services**" means those services providing for the personal care of the terminally ill patient and the performance of related tasks in the patient's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home health aide services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 (Section 1725 et seq.) of the Health and Safety Code.
5) "**Homemaker services**" means services that assist in the maintenance of a safe and healthy environment and services to enable the enrollee to carry out the treatment plan.
6) "**Interdisciplinary team**" means the hospice care team that includes, but is not limited to, the enrollee and the patient's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.
7) "**Medical direction**" means those services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the interdisciplinary team, a consultant to the enrollee's attending physician and surgeon, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these services shall be referred to as the "medical director."
8) "**Plan of care**" means a written plan developed by the attending physician and surgeon, the medical director or physician and surgeon designee, and the interdisciplinary team that addresses the needs of an enrollee and family admitted to the hospice program. The hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered. However, nothing in this section shall be construed to limit a health care service plan's obligations with respect to its QA program as required under Section 1300.70.
9) "**Skilled nursing services**" means nursing services provided by or under the supervision of a registered nurse under a plan of care developed by the interdisciplinary team and the enrollee's physician and surgeon to an enrollee and his or

her family that pertain to the palliative, supportive services required by an enrollee with a terminal illness. Skilled nursing services include, but are not limited to, enrollee assessment, evaluation and case management of the medical nursing needs of the enrollee, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the enrollee and his or her family, and the instruction of caregivers in providing personal care to the enrollee. Skilled nursing services shall provide for the continuity of services for the enrollee and his or her family. Skilled nursing service shall be available on a 24-hour on-call basis.

10) "**Social service/counseling services**" means those counseling and spiritual services that assist the enrollee and his or her family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.
11) "**Terminal disease**" or "**terminal illness**" means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course. This definition is not intended to limit the ability of health plans and hospices to develop and utilize comprehensive, evidence-based medical and psychosocial criteria or "best practice" guidelines for hospice referrals that are not dependent upon an estimated time of death, that are predictive of the need and appropriateness of palliative care and that are consistent with standards among palliative care professionals.
12) "**Volunteer services**" means those service provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the hospice to provide direction to hospice volunteers. Hospice volunteers may be used to provide support and companionship to the enrollee and his or her family during the remaining days of the enrollee's life and to the surviving family following the enrollee's death.

(b) Hospice services provided pursuant to the requirements of Section 1368.2 shall comply with the following requirements:
1) Only an entity licensed pursuant to the California Hospice Licensure Act of 1990, (Health and Safety Code Section 1745, et seq.) or a licensed home health agency with federal Medicare certification (Health and Safety Code sections 1726 and 1747.1) may provide hospice services to plan enrollees, except that an entity licensed as a hospice may arrange to provide hospice services required to be provided pursuant to this section with appropriately licensed individuals or entities.
2) Plans are required to provide to enrollees with a "terminal illness", through their contractual arrangements with hospices, the following services, at a minimum, when the enrollee qualifies for and chooses hospice care:
   A. Interdisciplinary team care with development and maintenance of an appropriate plan of care.
   B. Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse.
   C. Bereavement Services.
   D. Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
   E. Medical direction with the medical director being also responsible for meeting the general medical needs of the enrollees to the extent that these needs are not met by the attending physician.
   F. Volunteer services.
   G. Short-term inpatient care arrangements.
   H. The following shall be provided to the extent reasonable and necessary for the palliation and management of terminal illness and related conditions: pharmaceuticals, medical equipment and supplies.
   I. Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

(c) Covered services are to be made available on a 24 hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

(d) Special Coverage Requirements:
1) Periods of Crisis: Nursing care services must be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an enrollee at home. Hospitalization must be covered pursuant to 1300.68.2(b)(2)(G), when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24 hour continuous basis during periods of crisis but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the enrollee requires continuous care to achieve palliation or management of acute medical symptoms.
2) Respite Care: Respite care is short-term inpatient care provided to the enrollee only when necessary to relieve the family members or other persons caring for the enrollee. Coverage of respite care may be limited to an occasional basis and to no more than five consecutive days at a time.

(e) Every plan shall include notice of the coverage specified in subdivisions (b), (c) and (d) in the plan's evidence of coverage and disclosure form on or after January 1, 2002.
(f) All contracts between plans and hospices must be in accordance with all federal and state hospice licensure requirements.

State Market Plan Enhancements

Hospice Services provided by an Out-of-Network Hospice agency are not covered except in certain circumstance in counties in California in which there are no Network Hospice agencies and only when prior authorized and arranged by UnitedHealthcare or the Member's Network Medical Group.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine the coverage eligibility.

Hospice services are covered only:

- For members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course.
  (Refer to the *Federal/State Mandated Regulations* section for definition of terminal illness.)
  Note: Should the member continue to live beyond the original Hospice qualifying life expectancy, the member's attending Physician needs to re-evaluate the member's condition and determine the appropriateness of continuing Hospice.
- When provided by an appropriately licensed Hospice Facility directly or indirectly when arrangements are made by the selected Hospice. Hospice care is any service delivered by a licensed Hospice agency, which may be delivered either at home or in an inpatient or outpatient facility.
- If a written plan of care is established by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Physician, a registered nurse, a social worker and a spiritual caregiver.

There are no day limits; however, the member may be under case management or designee.

Respite care is covered only if it is part of an authorized Hospice plan and is necessary to relieve the primary caregiver. It is covered only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

Hospice is responsible for providing any and all services indicated as necessary for the palliation and management of the Terminal Illness and related conditions in the plan of care.

Examples of covered benefits include, but are not limited to:

- Nursing care provided by or under the direct supervision of a qualified registered nurse;
- Medical social services provided by a licensed social worker and under the direction of a physician;
- Physician services performed by a Physician except that the services of the hospice medical director or the Physician member of the interdisciplinary group (the Hospice team) must be performed by a medical doctor (M.D.) or doctor of osteopathy (D.O.);
- Inpatient hospital services in an appropriately licensed hospice facility when the member's Interdisciplinary team has determined that the member's care cannot be managed at home;
- Medical equipment, supplies, and drugs that are used primarily for the relief of pain related to the terminal illness. Equipment includes durable medical equipment and other items related to the management of the terminal illness. Equipment for use in the member's home is provided by hospice;
- Example of supplies: disposable incontinence underpads; adult incontinence garments
- Certified home health aide and home health aide services that must be provided under the general supervision of a qualified registered nurse;
- 24-hour continuous care when required by a member to achieve palliation or management of acute medical symptoms ;

- Physical, occupational, and/or speech therapy if provided for the purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills;
- Counseling and bereavement services;
- Skilled nursing services. Refer to the *Federal/State Mandated Regulations* section for definition.

Note: Covered hospice services are available in the home on a 24-hour basis when medically necessary, during periods of crisis, when a Member requires continuous care to achieve palliation or management of acute medical symptoms.

Not Covered

- Members who do not have a terminal illness. (Refer to the *Federal/State Mandated Regulations* section for the definition of Terminal Illness.)
- Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in non-certified hospice programs).
- Hospice services provided by an out-of-network hospice agency are not covered **except** in certain circumstance in counties in California in which there are no network hospice agencies and only when prior authorized and arranged by UnitedHealthcare or the member's network medical group.
- Respite care is not covered, unless part of an authorized hospice plan and is necessary to relieve the primary caregiver.

Policy History/Revision Information

Date	Summary of Changes

10/01/2023	**Covered Benefits**
	• Revised coverage criteria for hospice services; replaced criterion requiring:
	  ○ "For members *who have been certified by their attending physician* as terminally ill" with "for *those* members with a terminal illness, *defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course*"
	  ○ "When provided by a licensed hospice facility directly or indirectly when arrangements are made by the selected hospice" with "when provided by an *appropriately* licensed hospice facility directly or indirectly when arrangements are made by the selected hospice"
	• Revised list of examples of covered hospice services:
	  ○ Added "24-hour continuous care when required by a member to achieve palliation or management of acute medical symptoms"
	  ○ Removed "continuous home care only as necessary to maintain the Terminally Ill member at home"
	Not Covered
	• Revised list of non-covered services; replaced "members who do not *meet the definition of* terminally il *[defined in the* ***Federal/State Mandated Regulations*** *section of the policy]*" with "members who do not *have a* terminal illness"
	Supporting Information
	• Removed *Definitions* section
	• Archived previous policy version BIP077.M

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.