CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: May 5, 2025

ALL PLAN LETTER 25-008

SUPERSEDES ALL PLAN LETTER 13-014

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: HOSPICE SERVICES AND MEDI-CAL MANAGED CARE

PURPOSE:

The purpose of this All Plan Letter (APL) is to highlight contractual, regulatory, and statutory requirements applicable to Medi-Cal managed care plans (MCPs) with respect to their responsibilities to provide Medically Necessary hospice services to their MCP Members.

BACKGROUND:

Hospice services, as specified in Title 22 California Code of Regulations (CCR) section 51349, are covered under MCP Contracts and do not affect a Member's eligibility for enrollment in an MCP.[1] Health and Safety Code (H&S) section 1368.2[2] requires hospice care provided in California by licensed health care service plans to be at least equivalent to the hospice benefits provided under the Medicare program, as defined in Title 42 United States Code (USC) section 1395x(dd).[3]

POLICY:

I. General

Under existing Contract requirements and state law, MCPs are required to provide hospice services upon Member election to start and receive such care services.[4] Hospice coverage is provided in benefit periods: Two 90-day periods, beginning on the date of hospice election; followed by unlimited 60-day periods. A benefit period starts the day the Member receives hospice care and ends when the 90-day or 60-day period ends.[5] Members who qualify for and elect to receive hospice care services remain enrolled in an MCP while receiving such services. To avoid problems caused by late referrals, MCP policies and procedures (P&Ps) should

[1] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[2] State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
[3] The USC is searchable at: https://uscode.house.gov/browse.xhtml.
[4] Title 22 CCR 51349(c) and (d).
[5] Medicare Hospice Benefits booklet, U.S. Department of Health and Human Services-Centers for Medicare & Medicaid Services, CMS Product No. 02154, March 2023. Booklet is available at: https://www.medicare.gov/publications/02154-medicare-hospice-benefits.pdf.

clarify and detail how Members may access hospice care services in a timely manner, preferably within 24 hours of the request from in-Network hospice Providers. Consistent with contractual requirements for covered Medi-Cal benefits, MCPs may restrict coverage to in-Network Providers, unless Medically Necessary services are not available in-Network.

Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness.[6]

For out-of-Network hospice Providers, the MCP should seek an agreement, such as a single case agreement or a letter of agreement, to cover hospice care services. Agreements with the out-of-Network hospice Provider require the Provider to submit necessary documentation (see Certification of Terminal Illness and Necessary Documentation, section II. and Member Election of Hospice Services and Revocation Rights, section III. below) for the MCP to ensure that hospice services are provided in accordance with coverage policy, including Medical Necessity. While Prior Authorization for hospice services is restricted, based on the level of care,[7] MCPs are required to review documentation to avoid Fraud, Waste, and Abuse. To avoid possible delays in hospice care services while the MCP processes requests from out-of-Network hospice Providers, MCP P&Ps should clarify and detail how Members may access hospice care services in a timely manner after the MCP confirms qualifications and/or agreement with the out-of-Network hospice Provider, or transfer to an in-Network hospice Provider. For out-of-Network hospice Providers, MCPs must ensure the hospice Provider has Medicare certification, is licensed by the California Department of Public Health (CDPH), and has a National Provider Identifier prior to payments of claims.[8]

II. Certification of Terminal Illness and Necessary Documentation

Requirements for the initiation of outpatient hospice services include a certification by the attending physician and/or the hospice medical director[9] that a Member has a terminal illness with a life expectancy of six months or less, and the Member's election of hospice services in lieu of curative care for the terminal illness. Election of

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[6] Ibid.
[7] Title 22 CCR section 51349.
[8] Information regarding CDPH hospice agency licensing and certification is available at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AppPacket/Hospice-Initial.aspx.
[9] Title 42 Code of Federal Regulations (CFR) section 418.22(b). The CFR is searchable at: https://www.ecfr.gov/.

hospice care occurs when the Member or Authorized Representative[10] voluntarily files an election statement with the hospice Provider. The hospice Provider is responsible for the coordination of hospice services and must submit the appropriate Department of Health Care Services' (DHCS) election form (Medi-Cal Hospice Program Election Notice) to the Member's respective MCP within five calendar days of certification and election of hospice care.[11,12,13] In instances where the hospice Provider does not timely submit the election form to the MCP, the MCP is not obligated to cover and pay for the days of hospice care from the hospice admission date to the date the election form is submitted to, and accepted by the MCP. These non-covered days are a hospice Provider's liability, and the hospice Provider cannot bill the Member for them.[14] DHCS and MCPs may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of its claims processing and Utilization Management functions regarding a Member's certification and election, including supporting documentation.[15]

Title 22 CCR section 51349 requires that Medi-Cal implement the certification procedures for hospice in accordance with those specified in Medicare (Title 42 Code of Federal Regulations (CFR) Part 418, Subpart B). A hospice Provider must obtain written certification of terminal illness for each hospice benefit period. For the initial 90-day benefit period, the hospice Provider must obtain written certification statements from the medical director of the hospice, the physician designee (as

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[10] Authorized Representative as defined as "Representative" in Title 42 CFR section 418.3. "Representative means an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian."

[11] Information regarding the DHCS election form, including links to the form, and other resources are included in the Medi-Cal Provider Manual: Hospice Care, section New Hospice Election Notice and Addendum Forms and is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/C1FF6E40-FE8C-4DAB-AFFA-0A479763B3DD/hospic.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO.

[12] Contact information for MCPs can be found on the Medi-Cal Managed Care Health Plan Directory webpage at: https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx.

[13] For Fee-For-Service (FFS) Members, the hospice Provider is responsible for completion of the DHCS election form and submission to DHCS. Submission instructions are available in the Medi-Cal Provider Manual: Hospice Care, section New Hospice Election Notice and Addendum Forms.

[14] Medicare Claims Processing Manual (Chapter 11) - Processing Hospice Claims, section 20.1.1 - Notice of Election. The Claims Processing Manual is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf.

[15] Title 22 CCR section 51159(b); MCP Contract, Exhibit A, Attachment III, 3.3.5 Claims Processing; H&S section 1371(a)(3); Title 28 CCR section 1300.71(d)(2); MCP Contract, Exhibit A, Attachment III, 2.3 Utilization Management Program. The MCP Contract boilerplate is available at: https://www.dhcs.ca.gov/provgovpart/Documents/2024-Managed-Care-Boilerplate-Contract.pdf.

defined in 42 CFR 418.3), or the physician member of the hospice interdisciplinary group; as well as the Member's attending physician (generally the Member's Primary Care Physician and/or referring physician), if the Member has an attending physician. For subsequent benefit periods, the certification must be done by the medical director of the hospice, the physician designee, or the physician member of the hospice interdisciplinary group.[16] "Terminally ill" means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course.[17] Federal law requires that the physician certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.[18] MCPs must not deny hospice care to Members certified as terminally ill.[19] The Centers for Medicare & Medicaid Services (CMS) provided guidance for reference by hospice Providers and MCPs in determining terminal status.[20] The guidelines are not wholly restrictive and/or inclusive for MCP Members to receive hospice care services. The guidelines are a tool and are not exclusive to determining eligibility for hospice care and do not replace a physician's professional judgement, as some Members may not meet these guidelines, yet still have a life expectancy of six months or less.

Only general inpatient care is subject to Prior Authorization regardless of whether the services are to be rendered by an in-Network or out-of-Network Provider.[21] The below documents must be submitted to the MCP for Prior Authorization of general inpatient care:

1) A written prescription signed by the Member's attending physician;
2) Justification for the general inpatient care level of care;
3) A copy of the certification of the Member's terminal condition;
4) A copy of the written initial plan of care; and
5) A copy of the Member's signed election form.[22]

MCPs must not require Prior Authorization for routine home care, continuous home care and respite care, or hospice physician services. Hospices must notify the MCP

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[16] Title 42 USC section 1395f(a)(7)(A); 42 CFR section 418.22(c).
[17] Title 42 CFR section 418.3.
[18] 42 CFR section 418.22(b).
[19] MCP Contract, Exhibit A, Attachment III, 5.3.7 Services for All Members.
[20] CMS, Local Coverage Determination (LCD) Hospice Determining Terminal Status (LCD ID L34538) is available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34538&ver=16&contractorName=9&contractorNumber=236|2&lcdStatus=A&sortBy=title&bc=AAAAgAAAIAAAAAAA&=.
[21] Title 22 CCR section 51349.
[22] Department of Health Care Services Manual of Criteria for Medi-Cal Authorization (R-16-00, August 5, 2004), section Criteria for Authorization of Hospice Care (Chapter 11). The Manual of Criteria is available at: https://www.dhcs.ca.gov/formsandpubs/publications/Documents/Medi-Cal_PDFs/Manual_of_Criteria.pdf.

of general inpatient care placements that occur after normal business hours on the next business day. An MCP may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care.[23] If the documentation does not support the continuous home care or respite home care levels of care, or if the documentation included is inadequate, reimbursement may be reduced to the rate for routine home care. The hospice Provider may submit an appeal for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care.[24] Payment and/or hospice care services coverage may be denied if it is determined, based on documentation, that the hospice care services are not medically necessary or the Member is not terminally ill, with liability placed on the hospice Provider.[25]

III. Member Election of Hospice Services and Revocation Rights

A. Election of Hospice Care Services

MCP procedures must facilitate Member election of hospice care services by engaging in practices that avoid unnecessary delays and complications, as well as placing appropriate safeguards to validate Member elections and to prevent Fraud, Waste, and Abuse as outlined in this APL. The Member's election of hospice care services must include the following on the appropriate DHCS hospice election form:[26]

1) The identification of the hospice Provider.
2) The Member's or Authorized Representative's acknowledgement that:
    a) They have full understanding that the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature. Palliative care as defined in H&S section 1339.31(b) means interventions that focus primarily on reduction or abatement of pain and other disease-related symptoms, rather than interventions aimed at investigation and/or interventions for the purpose of cure or prolongation of life.
    b) Certain specified Medi-Cal benefits are waived by the election.
3) The effective date of the election.
4) The signature of the Member or Authorized Representative.
5) All hospice Providers must complete the appropriate DHCS hospice election form and addendum and submit them within five calendar days to the Member's

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[23] Medi-Cal Provider Manual: Hospice Care: General Billing Instructions is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7DC2ACC8-37BB-4E93-B47F-10D8BDBF7689/hospicge.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
[24] Ibid.
[25] Title 42 USC section 1395y; Title 42 USC section 1395pp; 42 CFR Part 411, Subpart A.
[26] Title 22 CCR section 51349(d).

respective MCP.[27]

A Member may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.[28]

B. Hospice Services Benefit

Upon Member election of hospice services, MCPs must ensure provision of, and payment for, hospice care services (listed below) provided by a hospice Provider. MCPs may require that the Member use an in-Network hospice Provider, unless Medically Necessary services are not available in-Network. Hospice care services include, but are not limited to, the following:[29]

1) Nursing services.
2) Physical, occupational, or speech-language pathology.
3) Medical social services under the direction of a physician.
4) Home health aide and homemaker services.
5) Medical supplies and appliances.
6) Drugs and biological.
7) Physician services (see below).
8) Counseling services related to the adjustment of the Member's approaching death; counseling, including bereavement, grief, dietary, and spiritual counseling.
9) Continuous nursing services may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill Member at home. A period of crisis is defined as a period in which a Member requires continuous care for as much as 24 hours to achieve palliation or management of acute medical symptoms.[30] The Medicare Benefit Policy Manual (Chapter 9 - Coverage of Hospice Services Under Hospital Insurance (Rev. 11056, 10-21-21)) section 40.2.1 - Continuous Home Care[31] states care provided requires a minimum of eight hours of nursing care, a minimum of 51 percent of time must be by a licensed nurse, within a 24-hour period commencing at midnight and terminating on the following midnight. Nursing care includes either homemaker or home health aide services. The eight hours of care does not need to be

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[27] For more information, and copies of the DHCS "Medi-Cal Hospice Program Election Notice" form and "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum, please visit the DHCS Hospice Care website at: https://www.dhcs.ca.gov/services/medi-cal/Pages/Hospice-Information.aspx.
[28] Title 42 USC section 1395d(d)(1); Title 42 CFR section 418.21.
[29] Title 42 USC 1395x(dd)(1); Title 22 CCR 51180; Title 22 CCR 51349.
[30] Title 42 CFR section 418.204.
[31] The Medicare Benefit Policy Manual (Chapter 9) is available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf.

continuous within the 24-hour period, but an aggregate of eight hours of primarily nursing care is required.

10) Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, skilled nursing, or hospice facility.
11) Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility.
12) Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the hospice plan of care.

Physician services include: (1) general supervisory services of the hospice medical director; and (2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician of the hospice interdisciplinary team.[32] Physician services not described above must be billed to the MCP separately and include services of the Member's attending physician or consulting physician(s) if they are not an employee of the hospice or providing services under arrangements with the hospice. Physician visits by a hospice-employed physician, medical director, or consultant are billable separately to the MCP. Note that palliative items or services in the context of Medi-Cal hospice benefits are defined separately from the services referenced in Medi-Cal Palliative Care, as defined in APL 18-020, or subsequent APLs.

C. Revocation of Hospice Election and Re-election of Services

A Member's voluntary election may be revoked or modified at any time during a benefit period. To revoke the election of hospice care, the Member or Authorized Representative must file a signed statement with the hospice Provider revoking the individual election for the remainder of that benefit period, including the effective date of the revocation. The hospice Provider must submit the MCP Member's signed hospice revocation statement to the Member's respective MCP within five calendar days.[33,34] The revocation effective date may not be retroactive. At any time after revocation, or a discharge by the hospice for cause, a Member may execute a new election, if they meet hospice coverage eligibility requirements.[35] If the Member is still eligible, and makes a hospice election, and is readmitted to the same or different hospice Provider, the 90/90/unlimited 60--day benefit periods of care restart. If the

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[32] Title 42 CFR section 418.304; Title 22 CCR section 51544.
[33] Medi-Cal Provider Manual: Hospice Care. The signed revocation statement must be submitted to the same MCP department as the hospice election and addendum forms were submitted to, unless otherwise instructed by the MCP.
[34] Medicare Benefit Policy Manual, section 20.2.4 - Hospice Notice of Termination or Revocation.
[35] Medicare Benefit Policy Manual, section 20.2.3 – Hospice Discharge.

Member re-elects hospice care, the hospice Provider must submit a new hospice election form to the Member's respective MCP. A Member or Authorized Representative may change the designation of a hospice Provider once in each benefit period from the original hospice Provider with which the election was made. This change of the designated hospice Provider is not a revocation of the hospice benefit.[36]

D. Special Considerations in Hospice Election

1) In the event that a Member wishes to elect a hospice that is out-of-Network, DHCS encourages MCPs to consider the individual cases of each Member. The MCP has the option of immediately initiating a contract (i.e., Network Agreement, LOA, or single case agreement) with the hospice Provider or referring the Member to an MCP Network Provider for hospice care services. On occasion, Members receiving hospice at the time they become MCP Members may not be able to change their hospice Provider, if requested, due to the limitation of one designation change during a benefit period.[37] MCPs are reminded of a Member's right to request Continuity of Care if they were receiving hospice care services at the time of their MCP enrollment.[38] In addition, the MCP may determine that such a change would be disruptive to the Member's care, or would not for some other reason be in the Member's best interest. In such instances, the MCP should consider entering into an agreement with the established hospice Provider until the new benefit period, or until the end of hospice care services.
2) Hospice care services may be initiated or continued in a home or clinical setting. MCPs remain responsible for the provision or payment of all Medi-Cal covered services not related to the terminal illness, including those of the Member's Primary Care Physician.
3) Members who move their legal residence out of the service area must disenroll from the MCP.
4) Hospice Providers must provide transferring Members with a transfer summary including essential information relative to the Member's diagnosis, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan, which must be signed by the physician.[39] Consequently, upon enrollment in a new MCP, a "change in designated hospice" must be initiated.[40] This may be done only

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[36] Title 42 CFR sections 418.28 and 418.30.
[37] Title 42 CFR section 418.30.
[38] See APL 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[39] H&S section 1262.5.
[40] Title 42 CFR section 418.30.

once per benefit period.

E. Face-to-Face Encounter

1) A hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice Member to determine the continued eligibility of that Member starting with the third benefit period. The face-to-face encounter requirement is satisfied when the following criteria are met:
    a. Timeframe of the face-to-face encounter occurred no more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter. However, in cases where a hospice newly admits (i.e. transfer/admission to a licensed hospice facility type) a Member in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. Under documented exceptional circumstances, a face-to-face encounter within two calendar days after admission will be considered timely.
    b. The hospice physician or NP must attest in writing that they had a face-to-face encounter with the Member.

For more information on face-to-face encounter requirements, please see the Medi-Cal Provider Manual: Hospice Care.

IV. Transition to Hospice Services

A. General

MCPs must instruct staff, Subcontractors, Downstream Subcontractors, Network Providers, other programs, and out-of-Network Providers of the importance of timely recognition of a Member's eligibility for hospice care services and their election of hospice care services. Once a Member has elected hospice care services, MCP Network Providers and case management staff must work closely with hospice Providers to facilitate the transfer of services for the Member from those directed toward cure and/or prolongation of life, to those directed toward palliation. Ongoing Care Coordination must be provided to ensure that services necessary to diagnose, treat, and follow-up on conditions unrelated to the terminal illness continue to be provided, or are initiated as necessary.[41]

B. Services for Children with Life-Threatening Condition

Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, children receiving hospice care services for a terminal illness and life expectancy of six months or less may receive additional services than are available for

[41] Title 42 CFR section 438.208.

adults. Children can, and often do, live longer with a terminal illness because of aggressive treatment and their natural resilience.

In addition to hospice care services, children and families may benefit from receiving palliative care services. Children are eligible for hospice care under the same criteria as adults (a physician certifies the Member as having a life expectancy of six months or less), although children under 21 years of age also may elect to receive concurrent curative treatment of the hospice related diagnosis and concurrent palliative care. For more information regarding policy guidance, please see the Medi-Cal Provider Manual: Hospice Care.

In addition, hospice and palliative care is available for California Children's Services (CCS) eligible children. For additional information on this subject, please see CCS Numbered Letter (NL): 12-1119: Palliative Care Options for CCS Eligible Children.[42]

For additional information regarding policy guidelines and procedural direction on authorization of Medically Necessary services related to the CCS child's terminal illness for children who have elected hospice care, please see CCS NL: 06-1011.[43]

MCPs should contact their respective CCS county office[44] with questions regarding palliative/hospice services for eligible children. MCPs must work with CCS to facilitate Continuity of Care, including maintaining established patient-provider relationships, to the greatest extent possible. Hospice care, if elected, for children with terminal illnesses requires close consultation and coordination between the MCP, the local CCS program (when applicable), and/or other caregivers. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition. MCPs participating in the CCS Whole Child Model (WCM) Program as a WCM MCP must adhere to program service coverage responsibilities, policies, and requirements, as outlined in APL 24-015, and any subsequent APLs.[45]

C. Concurrent Hospice and Curative Care for Children

Under section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, Medicaid children who have elected to receive hospice services,

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[42] CCS NL: 12-1119 is available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-12-1119.pdf.
[43] CCS NL: 06-1011: Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care is available at: https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl061011.pdf.
[44] A listing of CCS county offices is available at: https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx.
[45] APL 24-015: California Children's Services Whole Child Model Program.

or for whom hospice services have been elected, may continue to receive services to treat their terminal illness.[46,47]

D. Provision of Hospice Services by Hospice Interdisciplinary Group

Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group(s) to plan, provide, and/or supervise the care and services offered by the hospice Provider. A written plan of care must be established by the attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care. The plan of care is then reviewed and updated at intervals specified in the plan of care by the attending physician, the medical director or physician designee, and the interdisciplinary group of the hospice (Title 42 CFR section 418.56).

MCPs must assure coordination of care between MCP and hospice Providers, and allow for the hospice interdisciplinary team to professionally manage the care of the Member as outlined in law.

V. Reimbursement

A. Hospice Services

Medi-Cal program payments for hospice services are based upon the level of care provided so that hospice Providers may group the above services into the following revenue codes as outlined in the Medi-Cal Provider Manual. The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare. These rates are authorized by federal law, which also provides for an annual increase in payment rates for hospice care services. MCPs must update their rates annually to coincide with changes to the Medicare rates. (Title 42 USC section 1395f(i)(1)(C)(ii)).

MCPs may pay more, but not less than, the Medicare rate for hospice services.[48] The Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register:

1) Routine home care (service intensity add-on rate), Revenue Code 0552.
2) Routine home care (high rate), Revenue Code 0650.
3) Continuous home care, Revenue Code 0652.
4) Inpatient respite care, Revenue Code 0655.

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[46] Title 42 USC 1396d(o)(1)(C).
[47] Additional information on concurrent care for children can be found in DHCS Managed Care Policy Letter 11-004 and APL 18-020, including any subsequent iterations, at: https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx.
[48] Title 42 USC section 1396a(a)(13)(B).

5) General inpatient care (no respite)/hospice general care, Revenue Code 0656.
6) Physician services, Revenue Code 0657.
7) Routine home care (low rate), Revenue Code 0659.[49]

A hospice day billed at the routine home care level in the first 60 days of a hospice election is paid at the high routine home care rate. A hospice day billed at the routine home care level on day 61 or later of the hospice election is paid at the low routine home care rate. For a hospice Member that is discharged and readmitted to hospice services within 60 days of the discharge, the hospice days will continue to follow the Member at the routine home care rates outlined above (i.e. the first 60 days paid at the high routine home care rate and day 61 or later paid at the low routine home care rate). If the hospice Member is discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the Member's 60-day window, paid at the routine home care high rate upon the new admission.[50] Routine home care days that occur during the last seven days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.[51]

MCPs must pay inpatient rates (general or respite) for the date of admission and all subsequent inpatient days, except the day on which a Member is discharged. For the day of discharge, MCPs must pay the appropriate home care rate (routine or continuous) unless the Member dies as an inpatient. If the Member dies while an inpatient, the MCP must pay the inpatient rate (general or respite) for the discharge day.[52]

B. Long-Term Care

Pursuant to the MCP Contract, hospice services are Covered Services and are not categorized as Long-Term Care (LTC) services regardless of the Member's expected or actual length of stay in a nursing facility (NF) while also receiving hospice care. MCPs cannot require authorization for room and board for Members receiving hospice services and residing in a skilled nursing facility (SNF)/NF or intermediate care facility (ICF) as described in Title 42 USC section 1396a(a)(13)(B) and Title 42 CFR section 418.112.

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[49] Medi-Cal Provider Manual: Hospice Care Billing Codes is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/5274CADF-CF8F-4465-9400-85DF5A8517E9/hospicbilcd.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
[50] Medicare Claims Processing Manual (Chapter 11) - Processing Hospice Claims, section 30.2 - Payment Rates.
[51] Title 42 CFR section 418.302.
[52] Ibid.

A Member who is a resident of a SNF or ICF may elect hospice care. Payment from the MCP will be provided to the hospice for hospice care services (at the appropriate level of care).[53]

The hospice Provider must reimburse the facility for the room and board at the rate negotiated between the hospice Provider and facility. Payment for the room and board component must be equal to at least 95 percent of the reimbursement the NF/SNF would have been reimbursed by Medi-Cal or the MCP, less the Member's share of cost, if applicable. Payments by a hospice Provider to a nursing home for room and board must not exceed what would have been received directly from Medi-Cal or the MCP if the Member had not been enrolled in hospice.

LTC Members who elect the Medi-Cal hospice benefit are not disenrolled from the MCP. Hospices will bill the MCPs using the following revenue codes:

1) Revenue Code 0658-Facility Type Code 25.
2) Revenue Code 0658-Facility Type Code 26.
3) Revenue Code 0658-Facility Type Code 28.
4) Revenue Code 0658-Facility Type Code 65.
5) Revenue Code 0658-Facility Type Code 81.
6) Revenue Code 0658-Facility Type Code 86.

C. Dually Eligible Medicare and Medi-Cal

For all Members with both Medicare and Medi-Cal coverage (dual eligibles), MCPs must ensure that Medicare remains the primary payor for the hospice care services. MCPs must cover cost sharing for contracted services.

For dually eligible SNF residents, in accordance with the Medicare Benefit Policy Manual (Chapter 9) section 20.3 - Election by Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries, payment for room and board must be made directly to the hospice Provider. The room and board charge billed to the MCP as the hospice benefit under Medicare does not cover room and board.[54] Following payment from Medicare, the hospice Provider then bills the MCP for the Medicare co-payment amount; however, the total reimbursed amount cannot exceed the Medicare rate (Title 22 CCR section 51544). For Medicare Members entitled to only Medicare Part B, benefits will be billed directly to the MCP. No Medicare denial will be required.

MCPs cannot require authorization for the hospice Provider to bill the MCP for the room and board covered by Medi-Cal while the patient is receiving hospice

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[53] Title 42 USC section 1396d(o).
[54] Title 42 USC section 1396d(o); Medicare Hospice Benefits booklet.

services under Medicare. Additionally, MCPs cannot require a copy of an Explanation of Benefits, Remittance Advice, or denial letter from Medicare to accompany room and board claims.

The hospice Provider must submit the DHCS election form to both DHCS and the Member's respective MCP (if enrolled in an MCP) for dual eligibles when a Member elects the Medicare hospice benefit (see Certification of Terminal Illness and Necessary Documentation, section II. and Member Election of Hospice Services and Revocation Rights, section III. above).[55] The MCP will then pay the room and board payment to the hospice Provider according to the rate outlined above, and the hospice must be responsible for paying the nursing home. Eligibility for the Medi-Cal nursing home room and board payment continues to be determined by the nursing home and the MCP. The nursing home continues to remain responsible to collect the LTC share of cost, if applicable.

If hospice services, including room and board services, are covered by a recipient's Other Health Coverage insurance, MCPs must ensure hospice Providers bill the Other Health Coverage prior to billing Medi-Cal. A copy of the Explanation of Benefits, Remittance Advice, or denial letter must accompany each Medi-Cal claim for services.

D. Physician Services

Hospice Providers must use Revenue Code 0657 when billing for physician services for pain and symptom management related to a Member's terminal condition and provided by a physician employed by, or under arrangements made by, the hospice Provider.[56] MCPs are required to reimburse Revenue Code 0657, which is limited to one visit-per-day, per-Member.

Consulting/special physician services Revenue Code 0657 may be billed only for physician services to manage symptoms that cannot be remedied by the Member's attending physician because of one of the following:

1) Immediate need; or
2) The attending physician does not have the required special skills.

E. Utilization Review

The Medi-Cal Fee-For-Service (FFS) program does not permit Prior Authorization of hospice services, except for inpatient admissions, as outlined in state law (22 CCR 51349). Therefore, MCPs adhere to the same Utilization

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[55] Medicare Benefit Policy Manual, section 20.3 – Election by Skilled Nursing Facility and Nursing Facilities Residents and Dually Eligible Beneficiaries and section 20.4 – Election by Managed Care Enrollees.
[56] Medi-Cal Provider Manual: Hospice Care: General Billing Instructions.

Review standards as required by federal law (Title 42 CFR section 438.210(a)). Hospice Providers must submit the DHCS hospice election and addendum forms containing the necessary information and appropriate signatures to the Member's respective MCP, as outlined above in the "Member Election of Hospice Services and Revocation Rights" section.

Per the Medicare Benefit Policy Manual (Chapter 9) section 40.1.5 - Short-Term Inpatient Care, general inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot appropriately be provided in other settings. Skilled nursing care may be needed by a Member whose home support has broken down, making it no longer appropriate to furnish needed care in the home setting. General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit.

For example, a brief period of general inpatient care may be needed in some cases when a Member elects the hospice benefit at the end of a covered hospital stay. In this circumstance, if a Member continues to need pain control or symptom management, which cannot be appropriately provided in other settings while the Member prepares to receive hospice home care, general inpatient care is appropriate. Other examples of appropriate general inpatient care include a Member in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring, or a Member whose family is unwilling to permit needed care to be furnished in the home.

F. Services not Covered by Hospice Provider

1) Private pay room and board or residential care.
2) Acute in-patient hospitalization unrelated to the terminal illness.
3) Level A or Level B NF for unrelated issues.
4) Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
5) Other necessary services for conditions unrelated to the terminal illness.

VI. Fraud, Waste, and Abuse

Given recent audits investigating hospice licensure and oversight,[57] and Medicare actions to address hospice care benefit integrity,[58] MCPs are reminded to remain

[57] California State Auditor Report 2021-123, March 2022 is available at: https://www.auditor.ca.gov/pdfs/reports/2021-123.pdf.
[58] CMS, Blog: "CMS is Taking Action to Address Benefit Integrity Issues Related to Hospice Care" dated August 22, 2023 is available at: https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care.

proactive and vigilant regarding program integrity requirements, especially those that address Fraud, Waste, and Abuse, as outlined in the MCP Contract and other policy guidance.[59] DHCS expects MCPs to apply appropriate compliance review protocols and procedures regarding claim processing and Utilization Management systems upon receipt of a hospice election form and/or hospice claim to identify a Member as receiving hospice. Protocols and procedures also include informing the Member's PCP to notify them of the Member's election to hospice and adding any other system indicators to flag Members receiving hospice services. DHCS places an indicator in the Medi-Cal Eligibility Data System to designate Members in FFS receiving hospice services. As such, DHCS expects MCPs to initiate the same system changes when their Members have been designated as hospice with a "900" restricted services code as indicated in the eligibility files provided by DHCS to the MCPs. In addition, MCPs must examine documentation received from the hospice provider to determine the qualification of the Member to receive hospice. If appropriate, MCPs should request additional documentation for such a determination, to confirm proper and appropriate claim payments and service authorizations are made, and not based on fraudulent submissions.

Additionally, DHCS reminds MCPs of their contractual obligations to report complete, accurate, reasonable, and timely submission of Encounter Data. DHCS requests, in particular, MCPs provide data for the referring Provider (attending physician), rendering Provider (hospice Provider), and the starting day of service data fields to assist DHCS in its program integrity activities.

At any time, DHCS may inspect and audit MCP records, documents, and electronic systems to ensure compliance with service delivery and/or claim payments.[60]

MCPs must review their contractually required P&Ps to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal[61] within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

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[59] MCP Contract, Exhibit A, Attachment III, 1.3 Program Integrity and Compliance Program.
[60] MCP Contract, Exhibit E, 1.1.22 Inspection and Audit of Records and Facilities.
[61] The MCOD-MCP Submission Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx.

MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding administrative and monetary sanctions, see APL 25-007, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original signed by Bambi Cisneros

Bambi Cisneros

Acting Chief, Managed Care Quality and Monitoring Division

Assistant Deputy Director, Health Care Delivery Systems