PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Hospice Services</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 12/12/1995</td><td colspan="3">Next Review Date: 01/14/2027
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 01/14/2026</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MPUP3039 - Direct Members
C. MPUP3137 - Palliative Care: Intensive Program (Adult)
D. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21
E. MCCP2022 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
F. MCCP2024 - Whole Child Model For California Children's Services (CCS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Authorized Representative: An adult Member has the right to designate a friend, family Member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
B. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
C. Terminal Illness: A condition caused by injury, disease, or illness from which, to a reasonable degree of certainty, there can be no restoration of health, and which, absent artificial life-prolonging procedures, will inevitably lead to natural death.
D. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with a CCS-eligible condition(s) insured by Partnership.

IV. ATTACHMENTS:

A. Medi-Cal Hospice Program Election Notice *DHCS 8052* (07/2023)
B. Patient Notification of Hospice Non-Covered Items, Services, and Drugs *DHCS 8053* (07/2023)

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Policy/Procedure Title: Hospice Services		☒ **External Policy** ☐ **Internal Policy**	
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Applies to:	☒ **Medi-Cal**	☐ **Employees**	

V. PURPOSE:

The purpose of the guideline is to delineate the requirements for a Member to be admitted to a hospice program and to outline compensation structures for hospice services.

VI. POLICY / PROCEDURE:

A. Criteria for Admission to a Hospice Program

1. A patient will be admitted to the hospice program when the following conditions are met:
   a. The patient has a limited life expectancy of 6 months or less, if the terminal illness follows its normal course.
      1) The patient's physician or the hospice medical director must certify that the Member has a terminal illness by providing specific clinical findings or other documentation to support a life expectancy of 6 months or less.
   b. A member may elect hospice services in lieu of curative care for the terminal illness. (For specific pediatric hospice guidelines, please see VI.C.4. below.)
   c. The primary goal for the patient is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
   d. It is appropriate to direct treatment to improve the quality of the remaining days for the patient and family.
   e. It is agreed by doctor and patient and/or family that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations they would otherwise suffer.
   f. The patient, family, and physician are all willing to participate in the program with the understanding that withdrawal from the hospice program is possible at any time.
2. Election of hospice care for Partnership Medi-Cal Members occurs when the Member (or authorized representative) voluntarily completes and signs the Department of Health Care Services (DHCS) Medi-Cal Hospice Program Election Notice *DHCS 8052* (Attachment A) and selects a hospice provider. Signing this form indicates the Member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.
   a. Members who qualify for and elect to receive hospice care services, remain enrolled in Partnership while receiving hospice services.
   b. Hospice care services may be initiated or continued in a home or clinical setting. Partnership will 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.
   c. A Member who is a resident of a skilled nurse facility (SNF) or an Intermediate Care Facility (ICF) may elect hospice care, and Partnership will provide payment to the hospice for hospice care services at the appropriate level of care.
   d. Partnership does not deny any completed Hospice Program Election Notices nor deny any late referrals to hospice.
   e. Upon receipt of a completed hospice election form, or the member is flagged by DHCS in data sent to the health plan that the member is receiving hospice services, the member is placed into HP 6; a restricted Direct Member designation category. This designation in Partnership's system and online provider portal informs the Member's primary care provider and/or other contracted providers, that the member is currently enrolled in hospice and receiving those services. For more information, see Partnership policy MPUP3039 Direct Members.

B. Hospice Provider Requirements

1. Consistent with contractual requirements for covered Medi-Cal benefits, and Continuity of Care provisions, hospice coverage is restricted to hospice providers who are contracted with Partnership. If medically necessary services are not available in-Network, or if a member is currently receiving

hospice care at the time they become a Partnership member, Partnership will seek an agreement with an out-of-network provider to cover hospice services.

a. An agreement with an out-of-network hospice provider will require the hospice provider to submit necessary documentation for Partnership to ensure that hospice services are provided in accordance with coverage policy, including medical necessity.
b. For out-of-network hospice providers, Partnership will ensure the hospice provider has Medicare certification, is licensed by the California Department of Public Health (CDPH), and has a National Provider Identifier (NPI) prior to payments of claims.
c. To avoid possible delays in hospice services with out-of-network hospice providers, while Partnership confirms hospice provider qualifications and enters into an agreement with the serving hospice provider, Partnership shall ensure the agreement start date commences with the start of services for those providers who meet necessary criteria.
    1) For providers who are not deemed eligible, a referral to Partnership's Care Coordination department shall occur so that Members are referred timely to an in-network hospice provider.
d. A Partnership Member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate as described in policy MPUP3137 Palliative Care: Intensive Program (Adult).

2. The hospice Provider is responsible for the coordination of hospice services. To ensure proper hospice claim processing and reimbursement, all licensed and certified hospice providers must submit the Medi-Cal Hospice Program Election Notice form *DHCS 8052* (Attachment A) to Partnership **within five calendar days** of a Medi-Cal Member's certification and election of hospice services.
    a. In instances where the hospice provider does not timely submit the election form to Partnership, Partnership 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 Partnership. These non-covered days are a hospice provider's liability, and the hospice provider cannot bill the Member for them.
    b. DHCS and Partnership may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of our claims processing and Utilization Management functions regarding a Member's certification and election, including supporting documentation.
    c. While no Treatment Authorization Request (TAR) is required to elect hospice care, Partnership will conduct a prepayment review of each claim to verify that the appropriate documentation has been received in order to avoid fraud, waste, and abuse.
        1) See section VI.E. below for further clarification of TAR requirements for inpatient care.

C. Hospice Benefit
    1. Members who elect hospice become case managed Direct Members at Partnership as described in policy MPUP3039 Direct Members.
        a. The status change effective date is the date the hospice election form was signed by the Member or Authorized Representative.
    2. All services related to the terminal illness must then be provided or authorized by the hospice provider.
        a. Note that palliative items or services in the context of medical hospice benefits are defined separately from palliative care services as referenced in the DHCS Palliative Care guidelines *(palli care)* or as defined in DHCS APL 18-020 *Palliative Care* (or subsequent revisions).
    3. Partnership facilitates Member election of hospice care services by engaging in practices that avoid unnecessary delays and complications, while also placing appropriate safeguards to validate Member elections and to prevent Fraud, Waste, and Abuse.

4. Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness. Services not related to the terminal illness are the responsibility of Partnership. The Member can continue to obtain services that are unrelated to the terminal illness from any Medi-Cal provider subject to Partnership's Treatment Authorization Request (TAR) processes. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a list of services that require a TAR.)
5. A Member under 21 years of age may be eligible for hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018. For more information on services under EPSDT see Partnership policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.
    a. Hospice and palliative care is available for California Children's Services (CCS)-eligible children as detailed in CCS Numbered Letter (NL) 06- 1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care and in CCS NL 12-1119 Palliative Care Options for CCS Eligible Children.
        1) For more information on CCS services for Partnership Members, see policy MCCP2024 Whole Child Model For California Children's Services (CCS).
        2) For more information on pediatric palliative care services, see policy MCUP3140 Palliative Care: Pediatric Program for Members Under the Age of 21
        3) Partnership will facilitate Continuity of Care as described in policies MCCP2024 Whole Child Model For California Children's Services (CCS) and MCCP2014 Continuity of Care.
    b. Hospice care, if elected, for children with terminal illnesses requires close consultation and coordination between Partnership (the Managed Care Plan), local CCS programs (when applicable), and/or other caregivers. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition and will be provided as part of hospice care services as described below at VI.C.6.
6. The following services are part of the hospice benefit and separate payment is not made. The hospice provider is responsible for having contracts with the appropriate providers and for paying the rate agreed upon in the contract for the service. Payment for these services comes out of the hospice per diem. The hospice provider must authorize all of the services related to care of the terminal illness. Physician, and or other Medi-Cal benefits and services not described below must be billed to Partnership separately.
    a. Nursing services
    b. Physical, occupational, and speech therapy
    c. Medical social services under the direction of a physician
    d. Home health aide and homemaker services
    e. Medical supplies and durable medical equipment
    f. Medications and infusion therapy (based on the Hospice Formulary)
    g. Hospice physician services
    h. Counseling services related to the adjustment of the Member's approaching death, including bereavement, grief, dietary, and spiritual counseling
    i. Continuous Nursing services which 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.
    j. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, SNF or hospice facility
    k. Short-term in-patient care for pain control or symptom management in a hospital, SNF or hospice facility (Note that general inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit)
    l. Nutritionist services
    m. Medical transportation

7. Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group to plan, provide, and/or supervise the care and services offered by the hospice provider.
8. 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.
9. Hospice services are not categorized as long term care (LTC) services, regardless of the Member's expected or actual length of stay in a nursing facility while also receiving hospice care.
10. 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.

D. Services Not Covered by a 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 Nursing Facility 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

E. Treatment Authorization Requests (TARs) for Inpatient Care
1. A Partnership TAR is <u>not</u> required for the following services:
   a. Hospice physician services
   b. Routine home care
   c. Continuous home care*
   d. Respite Care*
   e. Hospice Care room and board provided in a SNF or ICF
      1) If a Member currently resides in an Intermediate Care Facility-Developmentally Disabled (ICF-DD) facility or is admitted to an ICF-DD facility, Partnership continues to be financially responsible for the ICF-DD per diem payment.

   *Note: Although no TAR is required, Partnership may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care. If documentation does not support the levels of care, reimbursement may be reduced to the rate for routine home care, in which case the hospice provider may submit an appeal for reconsideration of payment with additional documentation of the medical necessity for the increased level of care.
2. Only general inpatient care is subject to prior authorization, regardless of whether the services are to be rendered by an in-network and out-of-network provider, and the following documents must be submitted to Partnership with the TAR:
   a. A written prescription signed by the Member's attending physician
   b. Justification for the general inpatient care level of care
   c. A copy of the certification of the Member's terminal condition
   d. A copy of the written initial plan of care; AND
   e. A copy of the Member's signed election form
3. Because 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, Partnership adheres to the same utilization review standards as required by federal law. Hospice providers must submit the Medi-Cal Hospice Program Election form DHCS 8052 (Attachment A) and addendum forms containing the necessary information and appropriate signatures to Partnership as previously outlined at VI.B.2.
4. For non-emergency inpatient care related to the terminal illness, the Hospice provider must submit a TAR using an appropriate inpatient code and attach a copy of the Hospice Inpatient Information Form.

5. Emergency admission related to the terminal illness is reviewed for medical necessity by the Partnership Utilization Management (UM) nurse and if appropriate, a length of stay assigned. Partnership must be notified within 24 hours of any emergency admission related to the terminal illness. The hospice provider must submit a TAR using an appropriate inpatient code and attach a copy of the Hospice Inpatient Information Form.
    a. The hospice provider is financially responsible for emergency room services related to complications of the terminal illness if the Hospice provider authorized the service.
    b. Partnership continues to authorize and be financially responsible for outpatient, inpatient and emergency medical services not related to the terminal illness.
6. For Members with Medicare/Medi-Cal coverage, Medicare is the first payer for the hospice daily care. Medi-Cal (Partnership) is financially responsible for medications not related to the hospice diagnosis[1] and the room and board per diem if the Member resides in a LTC facility (bed code 658 for SNF or ICF). The claim must include a copy of the Medicare Explanation of Medical Benefits (EOMB) that shows that Medicare payment was made for hospice services during the period covered.
    a. For Members with Medicare/Medi-Cal coverage, the hospice provider must submit the Medi-Cal Hospice Program Election form *DHCS 8052* (Attachment A) and addendum forms containing the necessary information and appropriate signatures to both DHCS and Partnership when a dual eligible Member elects the Medicare hospice benefit.
7. For Members with other coverage, Medi-Cal is the secondary payer and the hospice must submit a copy of the Explanation of Benefits (EOB) from the other insurer when billing Medi-Cal.

F. Hospice Periods of Care
1. Hospice is a covered Medi-Cal benefit with the following periods of care:
    a. Two 90-day periods, beginning on the date of hospice election
    b. Followed by unlimited 60-day periods
2. A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends.
3. 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.

G. Patient Certification and Recertification Required
1. After a Member has met criteria for admission to a hospice program (section VI.A. above), the hospice provider must maintain an initial certification for the first 90-day period that the patient is terminally ill. Written certification statements must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group, AND the Member's primary care physician)
2. At the start of each subsequent period of care, the hospice provider must maintain a recertification that the patient is terminally ill. For recertification, a written certification statement must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group.
    a. 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, a hospice physician or

[1] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 25-013, "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage," and all medications (Rx and OTC) which are dispensed from pharmacies and covered under Medi-Cal Rx must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria:
http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. When an NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less.

H. Revocation of Hospice Care Services
   1. An individual's voluntary election may be revoked or modified at any time during a benefit period.
      a. To revoke the election of hospice care, the Member or Authorized Representative must file a signed statement with the hospice agency revoking the individual election for the remainder of the benefit period, including the effective date of the revocation. The effective date may not be retroactive.
      b. The hospice provider must submit the Member's signed hospice revocation statement to Partnership within five calendar days.
      c. 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, and the 90/90/unlimited 60-day benefit periods of care will restart.
         1) If the Member re-elects hospice care, the hospice provider must submit a new hospice election form to Partnership.
      d. A Member or Authorized Representative may change the designation of a hospice provider once in each benefit period; this is not a revocation of the hospice benefit.
      e. Members who move their legal residence out of Partnership's service area must notify the hospice provider and shall be disenrolled from Partnership.
         1) If members are transferring care to a new managed care plan, Hospice providers must provide transferring members with a transfer summary, including essential information relative to the members' diagnoses, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan, which must be signed by the physician.
         2) Consequently, upon enrollment in a new managed care plan, a "change in designated hospice" must be initiated. This may be done only once per benefit period.

VII. REFERENCES:

A. Medi-Cal Guidelines - Hospice Care *(hospic)*
B. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
C. Title 22, CCR ICF Sections 51118, 51120 and 51510; SNF 51121, 51123, 51124, 51215, 51511
D. Title 42 Code of Federal Regulations (CFR) Sections 418.28 and 418.30
E. Social Security Act 1812(d)(1)
F. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
H. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care (05/05/2025)
I. DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (09/18/2025)
J. California Children's Services (CCS) Numbered Letter (NL) 06-1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care (10/07/2011)
K. CCS NL 12-1119 Palliative Care Options for CCS Eligible Children (11/18/2019)
L. Centers for Medicare and Medicaid Services (CMS) Letter 10-018 Hospice Care for Children in Medicaid and CHIP (09/09/2010)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/21/00; 11/28/01; 01/15/03; 02/01/03 vs. code changes; 09/15/04; 09/21/05; 08/20/08; 04/21/10; 03/20/13 – effective 04/01/13; 03/18/15; 03/16/16; 03/15/17; 06/21/17; *09/12/18; 08/14/19; 08/12/20; 01/13/21; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 01/14/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.