



<b>Policy and Procedure No: UM 56.5</b>		<b>Revision No: 5</b>
<b>Division: Care Management</b>		
<b>Department: Utilization Management</b>		
<b>Title: PHC-CA Hospice Care Benefit</b>		
<b>Effective Date: 2/28/2018</b>		
<b>Supersedes Policy No: UM 56.0, UM 56.1, UM 56.2, UM 56.3, UM 56.4</b>		
<b>Reviewed/Revised by: Sandra Holzner</b>		<b>Review/Revision Date: 11/28/2025</b>
<b>Approving Committee: Utilization Management Committee</b>		<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>		

**Purpose:**

This policy outlines how PHC California (the Health Plan) provides medically necessary hospice services to enrollees.

**Policy:**

1. Under existing Contract requirements and state law, the Health Plan is required to provide hospice services upon member election to start and receive such care services.
2. Hospice coverage is provided in benefit periods: Two ninety (90) day periods, beginning on the date of hospice election; followed by unlimited sixty (60) day periods. A benefit period starts the day the enrollee receives hospice care and ends when the ninety (90) day or sixty (60) day period ends.
3. The Health Plan cannot deny hospice care to enrollees certified as terminally ill.
4. Enrollees who qualify for and elect to receive hospice care services remain enrolled in the Health Plan while receiving such services.
5. Enrollees who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness.
6. To avoid problems caused by late referrals, the Health Plan clarifies and details how enrollees may access hospice care services in a timely manner, preferably within twenty-four (24) hours of the request from in-network hospice providers.
7. Consistent with contractual requirements for covered Medi-Cal benefits, the Health Plan may restrict coverage to in-network providers, unless medically necessary services are not available in-network.
8. For out-of-network hospice providers, the Health Plan seeks agreements, such as single case agreements or letters of agreement, to cover hospice care services. Agreements with out-of-network hospice providers require the providers to submit necessary documentation (see Certification of Terminal Illness and Necessary Documentation, section II) and enrollee Election of Hospice Services and Revocation Rights, section III.) to ensure that hospice services are provided in accordance with coverage policy, including medical necessity.
9. The Health Plan ensures that out-of-network hospice providers have Medicare certification, are licensed by the California Department of Public Health (CDP) and have National Provider Identifiers prior to payments of claims.

10. 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, the Health Plan adheres to the same Utilization Review standards as required by federal law (Title 42 CFR section 438.210(a)).
11. While prior authorization for hospice services is restricted, based on the level of care, the Health Plan reviews documentation to avoid Fraud, Waste, and Abuse.
12. Health Plan procedures facilitate enrollee election of hospice care services by engaging in practices that avoid unnecessary delays and complications, as well as placing appropriate safeguards to validate enrollee elections and to prevent Fraud, Waste, and Abuse as outlined in DHCS APL 25-008.
13. To avoid possible delays in hospice care services while the Health Plan processes requests from out-of-network hospice providers, the Health Plan clarifies and details how enrollees may access hospice care services in a timely manner after the Health Plan confirms qualifications and/or agreement with the out-of-network hospice provider, or transfer to an in-Network hospice provider.
14. The initiation of outpatient hospice services requires certification by the attending physician and/or the hospice medical director that an enrollee has a terminal illness with a life expectancy of six months or less, and the enrollee's election of hospice services in lieu of curative care for the terminal illness.
15. DHCS and the Health Plan 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 an enrollee's certification and election, including supporting documentation.

## Procedure

1. Election and Initiation of Hospice Services
  - a. Election of hospice care occurs when the enrollee or Authorized Representative voluntarily files an election statement with the hospice provider.
  - b. 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 enrollee's respective Health Plan within five (5) calendar days of certification and election of hospice care.
    - i. In instances where the hospice provider does not timely submit the election form to the Health Plan, the Health Plan 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 Health Plan.
    - ii. These non-covered days are a hospice provider's liability, and the hospice provider cannot bill the enrollee for them.
  - c. A hospice provider must obtain written certification of terminal illness for each hospice benefit period.

- i. For the initial ninety (90) day benefit period, the hospice provider must obtain written certification statements from the medical director of the hospice, the physician designee (as defined in 42 CFR 418.3), or the physician member of the hospice interdisciplinary group; as well as the enrollee's attending physician (generally the enrollee's Primary Care Physician and/or referring physician), if the enrollee has an attending physician.
  - ii. Guidance provided by the Centers for Medicare & Medicaid Services (CMS) for reference by hospice providers and The Health Plan in determining terminal status is not wholly restrictive and/or inclusive for Health Plan enrollees to receive hospice care services.
    - 1. 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 enrollees may not meet these guidelines, yet still have a life expectancy of six months or less.
  - iii. 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.
- d. The enrollee's election of hospice care services must include the five elements listed below on the appropriate DHCS hospice election form. All hospice providers must complete the hospice election form and addendum and submit them within five calendar days to the Health Plan.
- i. The identification of the hospice provider.
  - ii. The enrollee's or Authorized Representative's acknowledgement that they have full understanding that the hospice care given as it relates to the enrollee'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.
  - iii. The enrollee's or Authorized Representative's acknowledgement that certain specified Medi-Cal benefits are waived by the election.
  - iv. The effective date of the election.
  - v. The signature of the enrollee or Authorized Representative.
- e. An enrollee may elect to receive hospice care during one or more of the following periods:
- i. An initial ninety (90) day period;
  - ii. A subsequent ninety (90) day period; or
  - iii. An unlimited number of subsequent sixty (60) day periods.

## 2. Provision of Hospice Services

- a. Physician services include:
  - i. General supervisory services of the hospice medical director
  - ii. 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.
- b. Physician services not described above must be billed to the Health Plan separately and include services of the enrollee's attending physician or consulting physician(s) if they are not an employee of the hospice or providing services under arrangements with the hospice.
- c. Physician visits by a hospice-employed physician, medical director, or consultant are billable separately to the Health Plan
- d. 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 DHCS APL 18-020, or subsequent DHCS APLs.

## 3. Provision of Hospice Services by Hospice Interdisciplinary Group

- a. Due to the highly specialized services provided by hospices, federal law mandates that the hospice designates an interdisciplinary group(s) to plan, provide, and/or supervise the care and services offered by the hospice provider.
  - i. 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.
  - ii. 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).

4. The Health Plan must assure coordination of care between the Health Plan and hospice providers and allow for the hospice interdisciplinary team to professionally manage the care of the enrollee as outlined in law.

## 5. Documentation Requirements

- a. The Health Plan may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care.
- b. 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.
- c. 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.
- d. 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 enrollee is not terminally ill, with liability placed on the hospice provider.

## 6. Payment / Reimbursement of Hospice Services

- a. Upon enrollee election of hospice services, the Health Plan ensures provision of, and payment for, the following hospice care services as provided by a hospice provider:
  - i. Nursing services
  - ii. Physical, occupational, or speech-language pathology
  - iii. Medical social services under the direction of a physician
  - iv. Home health aide and homemaker services
  - v. Medical supplies and appliances
  - vi. Drugs and biologicals
  - vii. Physician services (see below)
  - viii. Counseling services related to the adjustment of the Member's approaching death; counseling, including bereavement, grief, dietary, and spiritual counseling
  - ix. Continuous nursing services provided on a twenty-four (24) hour basis during periods of crisis (see Definitions) and only as necessary to maintain the terminally ill Member at home
  - x. 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
  - xi. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing, or hospice facility
  - xii. 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
- b. The Health Plan may require that the enrollee use an in-network hospice provider, unless medically necessary services are not available in-network.
- c. Refer to PHC California Policy and Procedure CL 14, Provider Reimbursement, for more information concerning hospice rates and claims from hospice providers.

## 7. Special Considerations in Hospice Election

- a. In the event that an enrollee wishes to elect a hospice that is out-of-Network, DHCS encourages the Health Plan to consider the individual cases of each enrollee.
  - i. The Health Plan has the option of immediately initiating a contract (i.e., Network

Agreement, LOA, or single case agreement) with the hospice provider or referring the enrollee to a Health Plan Network provider for hospice care services.

- ii. On occasion, enrollees receiving hospice at the time they become Health Plan enrollees may not be able to change their hospice provider, if requested, due to the limitation of one designation change during a benefit period.
  - iii. The Health Plan maintains the enrollee's right to request Continuity of Care if they were receiving hospice care services at the time of their Health Plan enrollment.
  - iv. The Health Plan may determine that such a change would be disruptive to the enrollee's care or would not for some other reason be in the enrollee's best interest. In such instances, the Health Plan considers entering into an agreement with the established hospice provider until the new benefit period, or until the end of hospice care services.
- b. Hospice care services may be initiated or continued in a home or clinical setting. The Health Plan remains responsible for the provision or payment of all Medi-Cal covered services not related to the terminal illness, including those of the enrollee's Primary Care Physician.
  - c. Enrollees who move their legal residence out of the service area must disenroll from the Health Plan.
  - d. Hospice providers must provide transferring enrollees with a transfer summary including essential information relative to the enrollee's diagnosis, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan, which must be signed by the physician. Consequently, upon enrollment in a new Health Plan, a "change in designated hospice" must be initiated. This may be done only once per benefit period.

#### 8. Face-to-Face Encounter

- a. A hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice enrollee to determine the continued eligibility of that enrollee starting with the third benefit period. The face-to-face encounter requirement is satisfied when the following criteria are met:
  - i. 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) an enrollee 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.
  - ii. The hospice physician or NP must attest in writing that they had a face-to-face encounter with the enrollee.
- b. For more information on face-to-face encounter requirements, please see the Medi-Cal Provider Manual: Hospice Care.

## 9. Transition to Hospice Services

- a. The Health Plan instructs staff, subcontractors, downstream subcontractors, network providers, other programs, and out-of-network providers of the importance of timely recognition of an enrollee's eligibility for hospice care services and their election of hospice care services. Once an enrollee has elected hospice care services, Health Plan network providers and case management staff must work closely with hospice providers to facilitate the transfer of services for the enrollee from those directed toward cure and/or prolongation of life, to those directed toward palliation. The Health Plan provides ongoing care coordination to ensure that services necessary to diagnose, treat, and follow-up on conditions unrelated to the terminal illness continue or are initiated as necessary.

## 10. Long-Term Care

- a. Pursuant to the Health Plan Contract, hospice services are Covered Services and are not categorized as Long-Term Care (LTC) services regardless of the enrollee's expected or actual length of stay in a nursing facility (NF) while also receiving hospice care. The Health Plan cannot require authorization for room and board for enrollees 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.
- b. An enrollee who is a resident of a SNF or ICF may elect hospice care. Payment from the Health Plan will be provided to the hospice for hospice care services (at the appropriate level of care).
- c. 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 Health Plan, less the enrollee'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 Health Plan if the enrollee had not been enrolled in hospice.
- d. LTC enrollees who elect the Medi-Cal hospice benefit are not disenrolled from the Health Plan. Hospices must bill the Health Plan using specific revenue codes as described in PHC California Policy and Procedure CL 14, Provider Reimbursement.

## 11. Dually Eligible Medicare and Medi-Cal

- a. The Health Plan cannot require authorization for the hospice provider to bill the Health Plan for the room and board covered by Medi-Cal while the patient is receiving hospice services under Medicare. Additionally, the Health Plan cannot require a copy of an Explanation of Benefits, Remittance Advice, or denial letter from Medicare to accompany room and board claims.
- b. The hospice provider must submit the DHCS election form to both DHCS and the enrollee's respective Health Plan (if enrolled in a Health Plan) for dual eligibles when an enrollee elects the Medicare hospice benefit (see Certification of Terminal Illness and Necessary Documentation, section II. and enrollee Election of Hospice Services and Revocation Rights, section III. above). The Health Plan 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 Health Plan. The nursing home continues to remain responsible for collecting the LTC share of cost, if applicable.

## 12. Physician Services

- a. Refer to PHC California Policy and Procedure CL 14, Provider Reimbursement, for information about billing for physician services for pain and symptom management related to an enrollee's terminal condition and provided by a physician employed by, or under arrangements made by, the hospice provider.

## 13. Utilization Review

### a. Prior Authorization

- i. 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.
  - ii. The five listed documents must be submitted to the Health Plan for Prior Authorization of general inpatient care:
    1. A written prescription signed by the enrollee's attending physician.
    2. Justification for the general inpatient care level of care
    3. A copy of the certification of the enrollee's terminal condition
    4. A copy of the written initial plan of care
    5. A copy of the enrollee's signed election form
  - iii. Prior Authorization is not required for routine home care, continuous home care and respite care, or hospice physician services.
  - iv. Hospices must notify the Health Plan of general inpatient care placements that occur after normal business hours on the next business day.
- b. 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 an enrollee 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.
- i. For example, a brief period of general inpatient care may be needed in some cases when an enrollee elects the hospice benefit at the end of a covered hospital stay. In this circumstance, if an enrollee continues to need pain control or symptom management, which cannot be appropriately provided in other settings while the enrollee prepares to receive hospice home care, general inpatient care is

appropriate. Other examples of appropriate general inpatient care include an enrollee in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring, or an enrollee whose family is unwilling to permit needed care to be furnished in the home.

- c. Hospice providers must submit the DHCS hospice election and addendum forms containing the necessary information and appropriate signatures to the enrollee's respective Health Plan, as outlined above in the "enrollee Election of Hospice Services and Revocation Rights" section.

#### 14. Services not Covered by Hospice Provider

- a. Private pay room and board or residential care.
- b. Acute in-patient hospitalization unrelated to the terminal illness.
- c. Level A or Level B NF for unrelated issues.
- d. 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.
- e. Other necessary services for conditions unrelated to the terminal illness

#### 15. Fraud, Waste, and Abuse

- a. Given recent audits investigating hospice licensure and oversight and Medicare actions to address hospice care benefit integrity, the Health Plan remains proactive and vigilant regarding program integrity requirements, especially those that address Fraud, Waste, and Abuse, as outlined in the Health Plan Contract and other policy guidance. DHCS expects The Health Plan 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 an enrollee as receiving hospice. Protocols and procedures also include informing the enrollee's PCP to notify them of the enrollee's election to hospice and adding any other system indicators to flag enrollees receiving hospice services. DHCS places an indicator in the Medi-Cal Eligibility Data System to designate enrollees in FFS receiving hospice services. As such, DHCS expects The Health Plan to initiate the same system changes when their enrollees have been designated as hospice with a "900" restricted services code as indicated in the eligibility files provided by DHCS to the Health Plan. In addition, The Health Plan must examine documentation received from the hospice provider to determine the qualification of the enrollee to receive hospice. If appropriate, The Health Plan requests additional documentation for such a determination, to confirm proper and appropriate claim payments and service authorizations are made and not based on fraudulent submissions.
- b. The Health Plan acknowledges contractual obligations to report complete, accurate, reasonable, and timely submission of Encounter Data. DHCS requests, in particular, the Health Plan 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 Health Plan records, documents, and electronic systems to ensure compliance with service delivery and/or claim

payments.

- c. The Health Plan is 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 DHCS APLs and Policy Letters. These requirements are communicated by the Health Plan 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. The Health Plan reviews their Network provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this DHCS APL.

## 16. Revocation of Hospice Services

- a. Enrollee's voluntary election may be revoked or modified at any time during a benefit period.
- b. To revoke the election of hospice care, the enrollee 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.
- c. The hospice provider must submit the Health Plan enrollee's signed hospice revocation statement to the enrollee's respective Health Plan within five calendar days, and the revocation effective date may not be retroactive.
- d. Any time after revocation, or a discharge by the hospice for cause, an enrollee may execute a new election, if they meet hospice coverage eligibility requirements.
  - i. If the enrollee is still eligible, and makes a hospice election, and is readmitted to the same or different hospice provider, the 90/90/unlimited sixty (60) day benefit periods of care restart.
  - ii. If the enrollee re-elects hospice care, the hospice provider must submit a new hospice election form to the enrollee's respective Health Plan
- e. An enrollee 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, and this change of the designated hospice provider is not a revocation of the hospice benefit.

### Definitions:

- 1. **Period of Crisis:** As defined in Title 42 CFR Section 418.204, it means a period in which an enrollee requires continuous care for as much as 24 hours to achieve palliation or management of acute medical symptoms. The Medicare Benefit Policy Manual 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 continuous within the 24-hour period, but an aggregate of eight hours of primarily nursing care is required.
- 2. **Terminally ill:** As defined in Title 42 CFR Section 418.3, it means that the individual has a medical prognosis that his or her life expectancy is six (6) months or less if the illness runs its normal

course. 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.

3. Palliative care: As defined in California Health and Safety (H&S) Code, Section 1339.31(b), it means interventions that focus primarily on reduction or abatement of pain and other disease-related symptoms, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

**Monitoring:**

This policy and procedure is reviewed and updated as often as required and approved annually by the Utilization Management Committee (UMC).

**Reference(s):**

1. Medi-Cal Regulations Title 22, CCR, Sections: 51003, 51180, 51180.0, 51180.2, 51180.3, 51180.4, 51180.5, 51180.6, 51180.7, 51250, 51349, and 51544.
2. Title 42 CFR Section 418.204
3. Title 42 CFR Section 418.3
4. Title 42 CFR Section 418.302 and 304
5. SSA 1812(d)(1), 1814 (i) (1) (C)(ii) and 1902 (a)(13)(B)
6. 42 USC Section 1396d(o)(1)
7. DHCS All Plan Letters (DHCS APLs) 13-014 and 18-020
8. California Welfare and Institutions Code (WIC), Section 14132.75

**Regulatory Approval(s):**

Date	Version	Agency	Purpose	Response
9/10/2025	56.4	Dept. of Health Care Services (DHCS)	DHCS APL 25-008	Approved

