



an affiliate of LMHPCO

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Hospice (Medicare) in Mississippi (2018)

- Beneficiaries Served: 19,969
- Average Daily Census 4,372
- Mean Length of Stay 80 days
- Average Length of Stay 31 days
- Routine Home Care 1,577,175 days
- Inpatient Care 20,089 days
- Medicare Payments \$231,971,164

End of Life in Mississippi (2017)

• Total Population	2,986,530
• Total Deaths	31,356
• Population 65+	474,475
• Medicare Beneficiaries	619,948
• Beneficiaries Deaths	25,250
• Hospice Admits	17,601
• Hospice Deaths	11,411
• Beneficiaries without Hospice	13,839
• Hospice Admits/Beneficiaries Death	69.7%
• Hospice Utilization	45.2%

Election Notice Form



Applicant Information (to be filled out by Hospice Provider)	
Address:	Date of Birth:
City/State/Zip:	Medicaid ID Number:
County:	Medicare Number:
Guardian/Legal Representative:	Social Security Number:
Hospice Provider:	Name of Nursing Facility, if applicable:
Attending Physician, if any:	Nursing Facility Medicaid Provider Number:
Hospice Physician Contact Number:	

Beneficiary Information	Hospice Medical Provider Number:
Name:	Hospice Contact Number:
Address:	Name of Hospice Interdisciplinary Group (IDG) Physician:

Effective date of the corresponding election period and effective date of election period: _____ Date ____/____/____ to ____/____/____
Election Period # _____

Declaration (To be read and signed by Medicaid Eligible Beneficiary)

I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed towards a cure of my terminal illness. The focus of hospice care is to provide comfort and support to both myself and my family and/or caregivers.

I understand that if I am a Medicare recipient, I must elect the Medicare hospice benefit.

I understand that by signing this election statement I waive all rights to regular Medicaid for the treatment of my terminal illness and related conditions except for payment to my attending physician and for services unrelated to my terminal illness.

If I am under the age of 21, I may receive hospice benefits including curative treatment without foregoing any other service to which a child is entitled under the Medicaid program. I understand that upon turning twenty-one (21), I will no longer be eligible to receive concurrent hospice care and curative treatment services for my terminal illness.

I understand that I will be entitled to Medicaid hospice services as long as I am Medicaid eligible and certified as terminally ill. The benefit periods consist of an initial 90 days, a subsequent 90 days, and subsequent 90-day periods.

I understand that if I reach a point of stability, and am no longer considered terminally ill, I will not be recertified as terminally ill and my benefits will revert to regular Medicaid benefits, if I am still eligible for Medicaid.

I understand that the effective date of the election period cannot be earlier than the date of the election statement.

The hospice provider I have chosen will receive payment for the care of my terminal illness and related conditions as well as my attending physician. I may change the designated hospice care service provider one time per election period without affecting the provision of my hospice benefit by completing a hospice transfer statement.

I may revoke the hospice care benefit at any time during an election period by signing a statement indicating that I'm revoking the hospice election with the date the revocation is to be effective and submitting the statement to the hospice prior to the effective date of the revocation. I may at any time elect to receive hospice coverage for any other hospice election period as long as I am eligible.

I have the right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

Below, I acknowledge the following Election Statement and choose to elect the Medicaid hospice benefit and choose to receive care services from aforementioned Hospice Provider beginning on aforementioned date:

only one:

do not wish to choose an attending physician.

acknowledge that my choice for an attending physician is:

Physician's Name _____	Physician's Individual MVA _____
Physician's Office Address _____	
Signature of Beneficiary or Guardian/Legal Representative _____	Date _____



Recertification/Resertification of Terminal Illness
Notice of the terminal illness must be completed by the Hospice Medical Director or the Hospice Interdisciplinary Group (IDG) Physician, and the attending care, if any, within two (2) calendar days of the initiation of hospice care. Recertification of the terminal illness must be completed by the Hospice Medical Director or IDG physician no later than two (2) calendar days after the beginning of the period. Certifications/resertifications cannot be complete more than three (3) months after the date of each benefit period. A new certification is not allowed to certify or resertify the terminal illness.

Applicant Information	
Address:	Date of Birth:
City/State/Zip:	Medicaid ID Number:
County:	Medicare Number:
Guardian/Legal Representative:	Social Security Number:
Hospice Provider:	Name of Nursing Facility, if applicable:
Attending Physician, if any:	Nursing Facility Medicaid Provider Number:
Hospice Physician Contact Number:	

Beneficiary Information	Hospice Medical Provider Number:
Name:	Hospice Contact Number:
Address:	Name of Hospice Interdisciplinary Group (IDG) Physician:

Effective date of the corresponding election period and effective date of election period: _____ Date ____/____/____ to ____/____/____
Election Period # _____

Recertification/Resertification Statement of Terminal Illness

I am certifying/resertifying the terminal illness of the beneficiary based on my review of the beneficiary's medical record and in consultation and certify that the above named beneficiary is still eligible for a life expectancy of six (6) months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical and/or other information that fails to support the terminal illness will result in removal to the Medicaid Fraud Control Unit.

Face-to-face encounter prior to 30th and subsequent election periods (to be completed by hospice provider or attending physician) for the first 90-day period, subsequent 90-day period, and every subsequent 90-day period (to be completed by hospice provider or attending physician).

Face-to-face encounter performed on _____ Date Time _____

by _____ Certifying physician.

I attest that I performed a face-to-face encounter with the beneficiary and that the clinical findings of the face-to-face encounter were provided to the certifying physician for use in determining continued clinical eligibility for hospice care.

Printed Name/Title _____
Signature _____ Date _____

Recertification/Resertification Statement of Terminal Illness

If explanation supporting terminal illness with six (6) month or less prognosis including guidelines from local coverage determination, is applicable, for each certification/resertification period is narrative contained on attachment: Yes No

I am certifying/resertifying the terminal illness of the beneficiary based on my review of the beneficiary's medical record and in consultation and certify that the above named beneficiary is still eligible for a life expectancy of six (6) months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical and/or other information that fails to support the terminal illness will result in removal to the Medicaid Fraud Control Unit.

do not wish to choose an attending physician.

acknowledge that my choice for an attending physician is:

Physician's Name _____	Physician's Individual MVA _____
Physician's Office Address _____	
Signature of Beneficiary or Guardian/Legal Representative _____	Date _____

Final Verification (within two (2) days of election date)


on the date signed that a verbal certification was obtained from the _____ certifying that the beneficiary's eligibility for a life expectancy of six (6) months or less if the terminal illness runs its normal course.

Printed Name _____	Signature _____	Date/Time _____
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MS
Medicaid
Election
Notices



Medicaid issues

- Duplication of work
 - Redundancy
 - Difficulty in getting family member to resign every election period
- 



Pediatric Concurrent Care

- ACA mandated Concurrent Care (*i.e., Life Prolonging & Hospice Services*) for any person under the age of 21
- If Supreme Court strikes down ACA, PCC mandate no longer stands
- Growing number of State Legislatures are including PCC into law in order to protect families who are dealing with a seriously ill child:
 - [Washington](#)
 - [Oregon](#)
 - [Utah](#)