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437.401: Introduction

130 CMR 437.000 governs the provision of hospice services under MassHealth. All hospices participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations set forth in 130 CMR 437.000 and 450.000.

437.402: Definitions

The following terms used in 130 CMR 437.000 have the meanings given in 130 CMR 437.000 unless the context clearly requires a different meaning.

Attending Physician — a doctor of medicine or osteopathy who is identified by the member at the time of election of hospice services as having the most significant role in the determination and delivery of the member’s medical care.

Election Period — one of three or more periods of care for which a MassHealth member may elect to receive MassHealth coverage of hospice services. The periods consist of an initial 90-day period, a subsequent 90-day period, and an unlimited number of subsequent 60-day extension periods.

Employee — an employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. An employee may also be a volunteer under the jurisdiction of the hospice.

Hospice — a public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals and meets the requirements of 130 CMR 437.000. The hospice model of care is based on a coordinated program of home and inpatient care, employing an interdisciplinary team to meet the special needs of terminally ill patients.

Nursing Facility — an institution that meets all criteria and certification requirements of 130 CMR 456.404 or 456.405.

Representative — a person who is, because of the member’s mental or physical incapacity, authorized in accordance with state law to execute decisions about hospice services or terminate medical care on behalf of the terminally ill member.

Social Worker — a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and is licensed as a social worker in the Commonwealth of Massachusetts.

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Terminally Ill — a condition in which the member has a medical prognosis of a life expectancy of six months or less.

437.403: Eligible Members

- (A) (1) MassHealth Members. The Division covers hospice services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division’s regulations. The Division’s regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
- (2) Members of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

437.404: Provider Eligibility

Payment for the services described in 130 CMR 437.000 will be made only to hospices participating in MassHealth on the date of service.

- (A) In State. To participate in MassHealth, a Massachusetts hospice must:
- (1) be certified as a provider of hospice services under the Medicare program, as defined in 42 CFR 418.50 through 418.100; and
 - (2) be licensed as a hospice program by the Massachusetts Department of Public Health.
- (B) Out of State. To participate in MassHealth, an out-of-state hospice must:
- (1) be certified as a provider of hospice services under the Medicare program, as defined in 42 CFR 418.50 through 418.100;
 - (2) be licensed by the appropriate licensing agency in its state (as applicable); and
 - (3) participate in the medical assistance program in its own state.

437.405: Out-of-State Hospice Services

The Division pays out-of-state hospices in accordance with 130 CMR 450.109.

(130 CMR 437.406 through 437.410 Reserved)

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437.411: Certification of Terminal Illness

(A) Obtaining Certification. The hospice must obtain certification of the member's terminal illness from either the medical director of the hospice or the physician member of the hospice interdisciplinary group, and from the member's attending physician, if the member has an attending physician, within two calendar days after the beginning of hospice services.

(B) Contents of the Certification Statement. The certification must state that the member's life expectancy is six months or less and must be signed by the physicians specified in 130 CMR 437.411(A). This certification is valid for the first 90 days of hospice coverage.

(C) Recertification for Subsequent Periods. For the subsequent 90-day and 60-day extension periods, the hospice must obtain, at the beginning of the period, a new certification statement from either the medical director of the hospice or the physician member of the hospice interdisciplinary group. The new certification must be on file in the patient's clinical record prior to submission of a claim.

437.412: Electing Hospice Services

(A) Eligibility for Hospice Services.

(1) MassHealth members, including members with both Medicare and MassHealth coverage in a nursing facility, but not including those identified in 130 CMR 437.412(A)(2), are eligible for hospice services if :

- (a) their coverage type as set forth in 130 CMR 450.105 covers hospice services; and
- (b) they fulfill the following requirements:
 - (i) are certified as terminally ill in accordance with 130 CMR 437.411;
 - (ii) agree to waive certain MassHealth benefits in accordance with 130 CMR 437.412(B); and
 - (iii) elect to receive hospice services in accordance with 130 CMR 437.412(C).

(2) For members enrolled in a MassHealth-contracted managed care organization (MCO) who choose hospice services, the hospice must comply with the MCO's requirements for the delivery of hospice services. If, however, an MCO member chooses to receive hospice services outside the managed care plan, the member must disenroll from the MCO and meet the eligibility requirements listed in 130 CMR 437.412(A)(1). See also 130 CMR 437.424(D).

(B) Waiver of Other Benefits. Upon electing to receive hospice services, a member waives all rights to MassHealth benefits for the following services for the duration of the election of hospice services:

- (1) hospice services provided by a hospice other than the one designated by the member on the hospice form submitted to the Division;
- (2) any MassHealth services that are related to the treatment of the terminal condition for which hospice services were elected, not including room and board in a nursing facility (see 130 CMR 437.424(B)); and

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(3) any MassHealth services that are equivalent to or duplicative of hospice services, except for physician services provided by the member's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

(C) Hospice Form. Each time a MassHealth member who meets the requirements of 130 CMR 437.412(A) seeks to elect hospice services, revoke hospice services, or change hospices, the hospice must complete the Division's hospice form according to the instructions on the form and submit the hospice form to the Division.

(1) Hospice Election. When a MassHealth member elects to receive hospice services, the hospice must ensure that the member or the member's representative signs and dates the hospice form. The hospice must inform the member that hospice services are palliative rather than curative and that access to some MassHealth services will be limited to those provided through the hospice.

(2) Hospice Revocation. The member or the member's representative may revoke the election of hospice services at any time during the election period. The hospice must ensure that the member or the member's representative signs and dates the hospice form. Upon revocation of hospice services for a particular election period, the member:

(a) resumes coverage for the MassHealth benefits waived upon election of hospice services; and

(b) may at any time elect to receive hospice services for any other election periods for which the member is eligible.

(3) Hospice Change. A member may change hospices once in each election period. To change hospices, a hospice form must be submitted to the Division according to the instructions on the hospice form. A member does not revoke election of hospice services by changing hospices.

(D) Effective Date for Hospice Services.

(1) The effective date for hospice election, hospice revocation, or changing hospices is the effective date entered by the hospice on the hospice form submitted to the Division.

(2) The effective date for hospice services may not be earlier than the date the member or the member's representative signed the hospice form.

(E) Duration of Hospice Services. Election periods for hospice services correspond to the certification periods in 130 CMR 437.411. The two 90-day election periods must be used before the subsequent 60-day extension periods. A member may continue to receive hospice services through the initial election period and the subsequent election periods without interruption if the member remains in the care of the hospice and does not revoke the election under 130 CMR 437.412(C)(2).

(130 CMR 437.413 through 437.420 Reserved)

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437.421: Administration and Staffing Requirements

(A) Governing Body. The hospice must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the hospice's total operation. The governing body must designate a person who is responsible for the day-to-day management of the hospice program.

(B) Medical Director. The medical director must be a doctor of medicine or osteopathy and assume overall responsibility for the medical component of the hospice's patient care program.

(C) Interdisciplinary Group. The hospice must designate an interdisciplinary group or groups composed of hospice personnel to provide or supervise the care and services offered by the hospice.

(1) Composition of Group. The interdisciplinary group must include at least the following individuals who are employees of the hospice, except in the case of the physician described in 130 CMR 437.421(C)(1)(a), who may be under contract with the hospice:

- (a) a doctor of medicine or osteopathy;
- (b) a registered nurse;
- (c) a social worker; and
- (d) a pastoral or other counselor.

(2) Role of Group. The interdisciplinary group is responsible for:

- (a) participating in the establishment of a plan of care for each member;
- (b) providing or supervising hospice services;
- (c) reviewing and updating the plan of care for each member; and
- (d) establishing the policies governing the day-to-day provision of hospice services.

(D) Contracted Services. A hospice may arrange for the provision of certain services on a contract basis. These services may not include the nursing services, medical social services, and counseling services specified in 130 CMR 437.000. If the other covered services listed in these regulations (physician services; physical, occupational, and speech/language therapy; homemaker/home health aide services; drugs; durable medical equipment and supplies; and short-term inpatient care) are provided by contract personnel, the hospice must meet the following requirements.

(1) Written Agreement. The hospice must have a written agreement with the contractor that:

- (a) identifies the services to be provided on a contract basis;
- (b) stipulates that services may be provided only with the express authorization of the hospice;
- (c) states how the contracted services will be coordinated, supervised, and evaluated by the hospice;
- (d) delineates the role of the hospice and the contractor in the admission process, patient/family assessment, and the interdisciplinary group-care conferences;
- (e) specifies requirements of documenting that the contracted services are furnished in accordance with the agreement; and
- (f) details the required qualifications for contract personnel.

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(2) Professional Management Responsibility. The hospice must ensure that contracted services are furnished in a safe and effective manner by qualified personnel in accordance with each member's plan of care.

(3) Financial Responsibility. The hospice is responsible for paying contract personnel who have provided hospice-approved services according to the member's plan of care.

(4) Inpatient Care. The hospice must ensure that inpatient care is furnished in a MassHealth-participating facility that meets the requirements specified in 42 CFR 418.98. The hospice must have a written agreement with the facility that specifies:

(a) that the hospice must furnish the inpatient provider with a copy of the member's plan of care that specifies the inpatient services to be provided;

(b) that the inpatient provider has established policies consistent with those of the hospice and agrees to abide by the patient-care protocols established by the hospice for its patients;

(c) that the medical record includes a record of all inpatient services and events and that a copy of the discharge summary and, if requested, a copy of the medical record are provided to the hospice;

(d) the party responsible for the implementation of the provision of the agreement; and

(e) that the hospice retains responsibility for appropriate hospice-services training of personnel providing hospice services under the agreement.

(5) Room and Board in a Nursing Facility. The hospice and the nursing facility must enter into a written agreement under which the hospice takes full responsibility for the professional management of the member's hospice services and the nursing facility agrees to provide room and board to the member. Room and board includes performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the member's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

(E) Volunteer Services. The hospice must use volunteers in administrative or direct patient care roles. The hospice must appropriately train volunteers and document its ongoing efforts to recruit and retain volunteer staff.

(1) Level of Activity. A hospice must document that it maintains a volunteer staff sufficient to provide administrative or direct patient care that, at a minimum, equals five percent of the total staff. The hospice must document continuing level of volunteer activity and must record any expansion of care and services achieved through the use of volunteers, including the type of services and the time worked.

(2) Proof of Cost Savings. The hospice must document:

(a) positions occupied by volunteers;

(b) work time spent by volunteers occupying those positions; and

(c) estimates of the dollar costs that the hospice would have incurred if paid employees occupied the volunteer positions.

(3) Availability of Clergy. The hospice must try to arrange for visits of clergy or other members of religious organizations in the community for members who request such visits. The hospice must also inform members of the availability of this service.

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437.422: Plan of Care

(A) Establishment of Plan. The member's attending physician, the hospice's medical director or physician designee, and the interdisciplinary group must establish a written plan of care for each member before providing hospice services.

(B) Contents of Plan. The plan of care must include an assessment of the member's needs and identify services to be provided to help the member manage discomfort and to relieve symptoms. It must also detail the frequency of services necessary to meet the needs of the member and the member's family.

(C) Review of Plan. The plan of care must be reviewed, updated, and signed at intervals specified in the plan of care, but no longer than 60 days, by the attending physician, the medical director or physician designee, and the interdisciplinary group. These reviews must be documented in the member's clinical record.

437.423: Covered Services

The hospice must provide services for the palliation and management of the terminal illness and related conditions. All services must be performed by appropriately qualified personnel, but the nature of the service, rather than the qualifications of the person who provides it, determines the reimbursement category of the service, as defined in 130 CMR 437.424. The following services are covered hospice services.

(A) Nursing Services. Nursing services must be provided by or under the supervision of a registered nurse. Patient-care responsibilities of nursing personnel must be specified.

(B) Medical Social Services. Medical social services must be provided by a qualified social worker under the direction of a physician. The social worker analyzes and assesses social and emotional factors and the member's capacity to cope with them; helps the member and the member's family follow hospice recommendations; and assists the member's family with personal and environmental difficulties and in using community resources.

(C) Physician Services. In addition to palliation and management of terminal illness and related conditions, physicians employed by or under contract with the hospice, including the physician member of the interdisciplinary group, must also meet the general medical needs of the members to the extent that these needs are not met by the member's attending physician. Physicians may bill MassHealth for services not related to the terminal illness according to the Division's physician regulations at 130 CMR 433.000.

(D) Counseling Services. The following counseling services must be available to the member and member's family or other persons caring for the member at home.

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(1) Bereavement Counseling. An organized plan of care for bereavement counseling must be developed by a qualified professional under the auspices of the hospice. This plan of care must reflect family needs, delineate the services to be provided, and specify the frequency of service delivery. Bereavement counseling is a required hospice service, but is not reimbursable.

(2) Dietary Counseling. When needed, dietary counseling services must be provided by a qualified professional.

(3) Spiritual Counseling. Spiritual counseling must include notice to members of the availability of clergy.

(4) Additional Counseling. Additional counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

(E) Physical, Occupational, and Speech/Language Therapy. The hospice must ensure that physical, occupational, and speech/language therapy services are provided by qualified personnel and in accordance with accepted standards of practice.

(F) Homemaker/Home Health Aide Services. Homemaker and home health aide services may include the provision of personal care services, household services essential to the member's comfort and hygiene, and maintenance of a safe and healthy environment to allow the member to implement the plan of care. A registered nurse must visit the home site at least once every two weeks when home health aide services are being provided. The visit must include an assessment of the home health aide services. The registered nurse must prepare the instructions for patient care and ensure that these services are documented.

(G) Drugs and Durable Medical Equipment and Supplies. The hospice must provide and be responsible for all drugs and durable medical equipment and supplies needed for the palliation and management of the terminal illness and related conditions, according to the member's plan of care. Any person permitted by state law to do so may administer drugs. Pharmacy and durable medical equipment providers may bill MassHealth separately only for those services not related to the member's terminal illness, according to the Division's pharmacy regulations at 130 CMR 406.000 and durable medical equipment regulations at 130 CMR 409.000, as applicable.

(H) Short-Term Inpatient Care.

(1) Facilities. Short-term general inpatient care for pain control and symptom management and inpatient respite care must be provided in a facility that meets the criteria specified in 42 CFR 418.98.

(2) Limitations. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate number of days of hospice services provided to all MassHealth members during that same period. Days of inpatient care provided to individuals with AIDS (acquired immunodeficiency syndrome) may be excluded from the days counted toward the 20-percent limitation.

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(I) Other Covered Items and Services. Other covered items and services include those items and services that are specified in the plan of care and for which MassHealth payment may otherwise be made.

437.424: Reimbursement for Hospice Services

(A) Type of Care. The Massachusetts Division of Health Care Finance and Policy establishes the rates of reimbursement for hospice services provided under MassHealth. Reimbursement is based on the type of care provided rather than the qualifications of the person who provided the service. Reimbursement rates correspond to the following four categories of care.

- (1) Routine Home Care. The routine home care rate is paid for each day the member is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.
- (2) Continuous Home Care. The continuous home care rate is an hourly rate paid when a member who has elected to receive hospice services is not in an inpatient facility and receives hospice services consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in 42 CFR 418.204(a) and only as necessary to maintain the member at home. A minimum of eight hours must be provided in a 24-hour period to qualify for the continuous home care rate.
- (3) Inpatient Respite Care. The inpatient respite care rate is paid for each day the member is in an approved inpatient facility and is receiving respite care from the hospice. Reimbursement for inpatient respite care will be made for a maximum of five consecutive days' stay including the date of admission but not counting the date of discharge. Reimbursement for any subsequent days will be made at the routine home care rate.
- (4) General Inpatient Care. The general inpatient care rate is paid for each day the member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings. None of the other fixed reimbursement rates will be applicable for a day on which the member receives inpatient care except for the day of discharge.

(B) Room and Board in a Nursing Facility. The Division pays the hospice a room and board per diem amount for a member residing in a nursing facility in accordance with Division of Health Care Finance and Policy regulations and in addition to either the routine home care rate (130 CMR 437.424(A)(1)) or the continuous home care rate (130 CMR 437.424(A)(2)). These rates are based on the nursing facility rate in effect on the date the hospice service is provided and will not be subject to adjustment in the event of a subsequent change in the nursing facility rate. The Division does not pay the room and board per diem amount for any day that a member receives inpatient respite care or general inpatient care. If a member receiving hospice services is hospitalized, the Division will pay for the medical leave of absence an amount equal to the room and board per diem amount, provided that the conditions for medical leave of absence as set forth in 130 CMR 456.000 are met.

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(C) The Hospice Form. A hospice must complete the Division's hospice form and submit the form to the Division in accordance with 130 CMR 437.412. The Division will not pay for hospice services provided prior to the effective date entered on the hospice form.

(D) MassHealth Members Enrolled in MCOs. A hospice may not bill the Division for a MassHealth member receiving hospice services through a managed care organization (MCO).

(E) Non-Hospice Providers. Non-hospice providers may bill the Division for the treatment of conditions not related to the member's terminal illness according to the applicable MassHealth regulations for that provider type.

437.425: Recordkeeping Requirements

All hospices must maintain a clinical record for each member receiving care and services. The clinical record must include the following information:

- (A) the plan of care;
- (B) the member's name, member identification number (RID), address, sex, age, and next of kin;
- (C) hospice forms as described in 130 CMR 437.412(C);
- (D) pertinent medical history;
- (E) complete documentation of all services and events; and
- (F) the certification of terminal illness, as described in 130 CMR 437.411.

REGULATORY AUTHORITY

130 CMR 437.000: M.G.L. c. 118E, ss. 7 and 12.