Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter HOS-15
March 2011

TO: Hospice Providers Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: *Hospice Manual* (Revised Hospice Regulations)

This letter transmits revised hospice regulations. MassHealth revised the hospice regulations to reflect changes as a result of the federal Patient Protection and Affordable Care Act (PPACA) enacted in March of 2010. PPACA requires state Medicaid programs to make hospice services available for children under the age of 21 without forgoing curative treatment or any other medically necessary services for which the child is eligible.

PPACA does not change any other criteria for electing hospice services.

PPACA does not change the contractual obligation of MassHealth's participating providers to provide services under the hospice benefit as it relates to the member's terminal illness, as described in 130 CMR 437.400 et seq. The hospice plan of care must identify any curative treatment the member receives.

The MassHealth Hospice Election form has been revised to reflect the changes in the PPACA. Providers can find the new MassHealth Hospice Election form on the MassHealth Website at www.mass.gov/masshealth.

These regulations are effective April 1, 2011.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Hospice Manual

Pages 4-3 through 4-6, 4-9, and 4-10

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Hospice Manual

Pages 4-3 through 4-6, 4-9, and 4-10 — transmitted by Transmittal Letter HOS-14

437.404: Provider Eligibility

Payment for the services described in 130 CMR 437.000 is 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 Part 418; and
(2) be licensed as a hospice program by the Massachusetts Department of Public Health pursuant to M.G.L. c 111, Sec. 57D and 105 CMR 141.000.

(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 Part 418;
(2) be licensed by the appropriate licensing agency in its state (as applicable); and
(3) participate in the Medicaid program in its own state.

437.405: Out-of-State Hospice Services

The MassHealth agency pays for out-of-state hospice services in accordance with the criteria described in 130 CMR 450.109.

437.406: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary hospice services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 437.000, and with prior authorization.

(130 CMR 437.407 through 437.410 Reserved)

437.411: Certification of Terminal Illness

(A) Obtaining Certification. Within two calendar days after the beginning of hospice services, 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 team, and from the member's attending physician, if the member has an attending physician.

(B) 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 written certification statement from either the medical director of the hospice or the physician member of the hospice interdisciplinary team. The new certification must be on file in the member's clinical record before the submission of a claim.

(C) 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) and (B). This certification is valid for the first 90 days of hospice coverage. The certification must include a brief narrative explaining the clinical findings that support a life expectancy of six months or less as part of the certification or recertification as specified in 130 CMR 437.411(A) and (B). The narrative must be located immediately before the physician's signature and must include a statement attesting that by signing, the physician confirms that the narrative was composed personally by the physician based on his or her review of the member's medical record or, if applicable, his or her examination of the member. The narrative must reflect the member's individual clinical circumstances and may not contain checkboxes or standard language used for all members.

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) MassHealth members under age 21 who have elected the hospice benefit will have coverage for curative treatment and all medically necessary services for which they are eligible. For such members, the hospice provider remains responsible for all hospice services as described in 130 CMR 437.423.

(3) 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. However, if 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. With the exception of members described in 130 CMR 437.412(A)(2), 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 MassHealth agency;

(2) any MassHealth services that are related to the treatment of the terminal illness for which hospice services were elected, not including room and board in a nursing facility (see 130 CMR 437.424(B)); and

(3) any MassHealth services that are equivalent to or duplicative of hospice services, except for

(a) the MassHealth Personal Care Attendant Program (130 CMR422.400), when used to the extent that the hospice would routinely use the services of a member's family in implementing the plan of care. PCA services must be coordinated with any in-home support services that the member is receiving or is eligible to receive, from a home and community-based services network; and

(b) 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 MassHealth agency's hospice form according to the instructions on the form and submit the form to the MassHealth agency.

(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 MassHealth agency according to the instructions on the 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 MassHealth agency.

(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)

(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.

437.422: Plan of Care

(A) Establishment of Plan. The hospice interdisciplinary team in collaboration with the attending physician, hospice medical director, physician designee, member or representative, and primary caregiver must establish and follow an individualized written plan of care in accordance with the member's needs.

(B) Scope of Plan. The plan of care must reflect member and family goals and interventions based on problems identified in the comprehensive assessment. The plan must include all services necessary for the palliation and management of the terminal illness and related conditions, including the coordination of all in-home supports. The plan of care must be coordinated with any services the member may be authorized to receive from the MassHealth Personal Care Attendant Program and such services may be used only to the extent that the hospice would routinely use the services of a hospice member's family in implementing the plan of care. For members under age 21, the hospice plan of care must identify any curative treatment the member is receiving.

(C) Review of Plan. The plan of care must be reviewed, revised, and documented at intervals specified in the plan of care, but no longer than 15 days, by the attending physician, the medical director or physician designee, and the hospice interdisciplinary team. 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.

(B) Medical Social Services. Medical social services must be provided by a qualified social worker under the direction of a physician. The social worker is responsible for analyzing and assessing social and emotional factors and the member's capacity to cope with them, helping the member and the member's family follow hospice recommendations, and assisting 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 hospice interdisciplinary team, 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 MassHealth 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.

(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 hospice interdisciplinary team 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) Hospice Aide/Homemaker Services. The hospice must provide hospice aide and homemaker services that are ordered by the hospice interdisciplinary team, and are included in the plan of care in accordance with 42 CFR 418. Hospice aide and homemaker services may include the provision of personal care and household services. A registered nurse must visit the member's home every two weeks to assess the quality of care and services provided by the hospice aide to ensure that services ordered by the hospice interdisciplinary team meet the member's needs.

(G) Drugs and Durable Medical Equipment and Medical Supplies. The hospice must provide and be responsible for all drugs and durable medical equipment and medical 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 MassHealth pharmacy regulations at 130 CMR 406.000 and durable medical equipment regulations at 130 CMR 409.000, as applicable.