Final Adoption
August 7, 2020

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 343.00: Hospice Services

Section

343.01: General Provisions

(1) Scope, Purpose, and Effective Date. 101 CMR 343.00 governs the rates of payment used by all governmental units to eligible providers for hospice services provided to publicly aided individuals. In accordance with the Social Security Act, sections 1814(i)(1)(C)(ii) and 1814(i)(2)(B), the annual federally mandated hospice rates and hospice cap increases described in 101 CMR 343.00 are effective as specified herein. The rates set forth in 101 CMR 343.00 also apply to individuals covered by M.G.L. c. 152 (the Workers' Compensation Act).

(2) Disclaimer of Authorization of Services. 101 CMR 343.00 is not authorization for or approval of the services for which rates are determined pursuant to 101 CMR 343.00. Governmental units that purchase care are responsible for the definition, authorization, and approval of care and services extended to publicly aided clients.

(3) Coding Updates and Corrections. EOHHS may publish service code updates and corrections in the form of an administrative bulletin. The publication of such updates and corrections will list

(a) codes for which the code numbers only changed, with a corresponding crosswalk;
(b) codes for which the code remains the same but the description has changed;
(c) deleted codes for which there is no crosswalk; and
(d) new codes that require new pricing. For such new codes, EOHHS applies individual consideration in reimbursement until appropriate rates can be developed.

(4) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify the substantive provisions of 101 CMR 343.00 and to notify interested parties of payment updates pursuant to 101 CMR 343.04(3)(b).

343.02: Definitions

A number of common words and expressions are specifically defined in 101 CMR 343.02. Whenever one of them is used in 101 CMR 343.00, it will have the meaning given in the definition, unless the context clearly requires a different meaning. When appropriate, definitions may include a reference to federal and state laws and regulations.

Center. The Center for Health Information and Analysis established under M.G.L. c. 12C.

Compliant Rate. Hospice service rates for eligible providers that are in compliance with federal quality reporting requirements established in accordance with the Social Security Act, sections 1814(i)(5)(A)(i).

Continuous Home Care. Care provided only during a period of crisis in which a patient requires continuous care, predominantly nursing care, at home to achieve palliation or management of acute medical symptoms. Homemaker and/or home health aide services may also be covered on a continuous basis. The continuous home care rate is paid on an hourly rate basis for each day, or portion thereof, that an individual qualifies for and receives such care. A minimum of eight hours must be provided in a 24-hour period to qualify for the continuous home care rate.

Eligible Provider. Any Medicare-certified organization licensed under state law as a provider of hospice services.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

General Inpatient Care. Care provided in a participating hospice inpatient unit, hospital, or skilled nursing facility that additionally meets the Centers for Medicare and Medicaid Services (CMS) special hospice standards for staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be managed in other settings.

Governmental Unit. The Commonwealth; any department, agency, board, or commission of the Commonwealth; and any political subdivision of the Commonwealth.

Hospice. A public agency or private organization or a subdivision of either that is providing care to terminally ill individuals and meets the Medicare conditions of participation specified in 42 CFR 418.52 through 418.116 for hospices. If it is a freestanding hospice that provides inpatient care directly, it must meet the conditions of 42 CFR 418.110.

(a) Core services (provided directly by hospice employees) include
    1. nursing services;
    2. physician services;
    3. medical social services; and
    4. counseling services.

(b) Supplemental services (may be on a contract basis) include
    1. short-term inpatient care;
    2. medical appliances and supplies, including drugs and biologicals;
    3. home health aide and homemaker services;
    4. physical therapy, occupational therapy, and speech-language; and
    5. pathology services.

Inpatient Care Limitation. For Medicaid, the total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for all Medicaid patients for a 12-month period may not exceed 20% of total days for which all Medicaid patients have elected hospice care; however, days to be used by individuals with Acquired Immune Deficiency Syndrome (AIDS) are exempt from the number of inpatient care days counted toward the 20% limitation.

Inpatient Respite Care. Short-term inpatient care provided to the individual in an approved inpatient facility only when necessary to relieve the family members or other persons caring for that individual. Respite care may be provided only on an occasional basis and shall be limited to no more than five consecutive days. Reimbursement for the sixth and any subsequent days is made at the routine home care rate.

Non-compliant Rate. Hospice service rates for eligible providers that are not in compliance with the federal quality reporting requirements established in accordance with the Social Security Act, sections 1814(i)(5)(A)(i).

Publicly Aided Individual. A person who receives medical services for which a governmental unit is liable, in whole or in part, under a statutory program.

Room and Board. An additional *per diem* amount that equals at least 95% of the amount the Commonwealth would pay the facility for a non-hospice Medicaid beneficiary, for routine or continuous-care days in an intermediate care or skilled nursing facility. 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 a resident's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

Routine Home Care. Payment for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. There are two rates for routine home care: one rate for days one through 60 and a lower rate for days greater than 60. Rates for routine home care are paid without regard to the volume or intensity of routine home care services provided on any day.

Routine Home Care (Days from One to 60). Payment for each day (one through 60 days) when the member has elected to receive hospice in their home and is not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any day. A 60-day gap in hospice services is required to reset the counter that determines if a patient is qualified for the one through 60 payment category.

Routine Home Care (Days Greater than 60). Payment for each day (61+ days) when the member has elected to receive hospice in their home and is not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any day.

Service Intensity Add-on (SIA). The SIA rate is an addition to the Routine Home Care (RHC) rate, for a minimum of 15 minutes and up to four hours per day (excluding a social worker’s phone calls), when all of the following criteria are met.

(a) The day is a RHC level of care day.
(b) The RHC day occurs during the last seven days of the member’s life, and the member is discharged deceased.
(c) Direct patient care is furnished by a registered nurse (RN) or social worker that RHC day.

Terminally Ill. The individual has a medical prognosis that his/her life expectancy is six months or less.

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343.03: Filing and Reporting Requirements

(1) Cost Reporting. Providers must satisfy the applicable filing and reporting requirements of 957 CMR 6.00: *Cost Reporting Requirements*.

(2) Penalty for Non-compliance. The purchasing governmental unit may reduce the payment rates by 15% for any provider that fails to submit required information to the Center. The purchasing governmental unit will notify the provider in advance of its intention to impose a rate reduction.

343.04: General Rate Provisions

(1) Effect of 101 CMR 343.00. The rates of payment under 101 CMR 343.00 constitute full compensation for hospice services provided to publicly aided individuals, including necessary administration and professional supervision. These established rates of payment for authorized services, with the exception of payment for room and board, shall be set in accordance with Centers for Medicare and Medicaid Services (CMS) regulation 42 CFR 418.302.

(2) Rate Determination. Each payment rate is determined by CMS to reflect the cost incurred by a hospice in efficiently providing the core and supplemental services associated with that type of hospice care to Medicaid beneficiaries. The allowable Medicaid hospice rates are determined in accordance with 42 CFR 418.302. The Medicaid rates are determined by adding the unweighted amount to the wage component, as adjusted to reflect local differences in wages, in accordance with 42 CFR 418.306.

(3) Rates. Allowable rates for hospice services are outlined in 101 CMR 343.04(3)(a) and (b).
(a) Providers shall be paid at the compliant or non-compliant rates established by CMS based on compliance with federal quality reporting requirements.
(b) If CMS amends the amounts listed in 42 CFR 418.306, the Medicaid rates will change accordingly. Said changes will be listed in an EOHHS administrative bulletin.
(c) For those hospice clients residing in nursing facilities, the per diem rate shall equal 95% of the rate that would have been paid by the Commonwealth to a particular nursing facility for a non-hospice Medicaid beneficiary.
(d) The rates of payment for authorized hospice services effective October 1, 2019, are the rates listed in 101 CMR 343.04(3)(d).

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Barnstable			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$229.57	$225.10
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$181.44	$177.90
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$68.57	$67.24
T2043	Continuous Home Care	Per Hour	$68.57	$67.24
T2044	Inpatient Respite	*Per Diem*	$540.52	$529.98
T2045	General Inpatient	*Per Diem*	$1,191.34	$1,168.13

Berkshire			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$206.16	$202.15
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$162.94	$159.76
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$61.58	$60.38
T2043	Continuous Home Care	Per Hour	$61.58	$60.38
T2044	Inpatient Respite	*Per Diem*	$495.67	$486.00
T2045	General Inpatient	*Per Diem*	$1,077.01	$1,056.02

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Bristol			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$199.57	$195.68
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$157.73	$154.65
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$59.61	$58.45
T2043	Continuous Home Care	Per Hour	$59.61	$58.45
T2044	Inpatient Respite	*Per Diem*	$483.02	$473.60
T2045	General Inpatient	*Per Diem*	$1,044.78	$1,024.42

Essex/Middlesex			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$208.47	$204.41
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$164.76	$161.55
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$62.27	$61.06
T2043	Continuous Home Care	Per Hour	$62.27	$61.06
T2044	Inpatient Respite	*Per Diem*	$500.08	$490.32
T2045	General Inpatient	*Per Diem*	$1,088.25	$1,067.05

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Hampden/Hampshire			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$196.62	$192.80
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$155.40	$152.37
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$58.73	$57.59
T2043	Continuous Home Care	Per Hour	$58.73	$57.59
T2044	Inpatient Respite	*Per Diem*	$477.38	$468.07
T2045	General Inpatient	*Per Diem*	$1,030.40	$1,010.32

Norfolk/Plymouth/Suffolk			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$227.21	$222.79
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$179.58	$176.08
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$67.87	$66.55
T2043	Continuous Home Care	Per Hour	$67.87	$66.55
T2044	Inpatient Respite	*Per Diem*	$536.01	$525.55
T2045	General Inpatient	*Per Diem*	$1,179.84	$1,156.85

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Worcester			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$215.85	$211.65
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$170.60	$167.27
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$64.47	$63.22
T2043	Continuous Home Care	Per Hour	$64.48	$63.22
T2044	Inpatient Respite	*Per Diem*	$514.23	$504.21
T2045	General Inpatient	*Per Diem*	$1,124.34	$1,102.43

Rural: Dukes, Franklin, and Nantucket			Compliant Rate	Non-Compliant Rate
T2042	Routine Home Care (1-60 days)	*Per Diem*	$208.92	$204.86
T2042 UD	Routine Home Care (61+ days)	*Per Diem*	$165.12	$161.90
G0299 (RN services) G0155 (Social Worker services)	Service Intensity Add-on	Per Hour/Max four hours	$62.40	$61.19
T2043	Continuous Home Care	Per Hour	$62.41	$61.19
T2044	Inpatient Respite	*Per Diem*	$500.95	$491.18
T2045	General Inpatient	*Per Diem*	$1,090.48	$1,069.23

Use modifier TN for T2042 and T2043 when billing for members outside the county in which the provider is located.

343.05: Severability

The provisions of 101 CMR 343.00 are hereby declared to be severable. If any such provisions or the application of such provisions to any eligible provider or circumstances shall be held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 343.00 or the application of such provisions to eligible providers or circumstances other than those held invalid.

REGULATORY AUTHORITY

101 CMR 343.00: M.G.L. c. 118E.