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4. Program Regulations

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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 MassHealth regulations, including but not limited to MassHealth regulations set forth in 130 CMR 437.000 and 450.000: *Administrative and Billing Regulations*.

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.

Accountable Care Organization (ACO) — an entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and MCO-administered ACOs.

Adult Day Health (ADH) — a community-based and non-residential service that provides nursing care, supervision, and health related support services in a structured group setting to MassHealth members who have physical, cognitive, or behavioral health impairments. The ADH service has a general goal of meeting the ADL, and/or skilled nursing therapeutic needs of MassHealth members delivered by a MassHealth agency approved ADH provider that meets the conditions of 130 CMR 404.000: *Adult Day Health Services*.

Adult Foster Care (AFC) — a service ordered by a primary care provider delivered to a member in a qualified setting as described in 130 CMR 408.435: *Adult Foster Care Qualified Setting Requirements* by a multidisciplinary team (MDT) and qualified AFC caregiver, that includes assistance with ADLs, IADLs, other personal care as needed, nursing oversight, and AFC care management, as described in 130 CMR 408.415(C): *Care Management*.

Attending Physician — a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the Commonwealth, a nurse practitioner who meets the training, education, and experience requirements as described in 42 CFR § 410.75(b), or a physician assistant who meets the requirements of 42 CFR § 410.74(c) 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.

Bereavement Counseling — emotional, psychosocial, and spiritual support and services provided before and after the death of the member to assist with issues related to grief, loss, and adjustment.

Capitated Program — an ICO, SCO, ACO, MCO, or PACE organization, or any other entity that, according to a contract with EOHHS, covers hospice and other medical services for members on a capitated basis.

Comprehensive Assessment — a thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient.

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Day Habilitation (DH) — a service, for individuals with an intellectual disability (ID) or a developmental disability (DD), that is based on a day habilitation service plan that sets forth measurable goals and objectives, and prescribes an integrated program of activities and therapies necessary to reach the stated goals and objectives.

Dual-Eligible Member — individuals who are entitled to Medicare Part A and/or Part B and are eligible for a MassHealth coverage type as listed in 130 CMR 450.105: *Coverage Types* that includes MassHealth hospice services.

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 election period, a subsequent 90-day election period, and an unlimited number of subsequent 60-day election 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 direction of the hospice.

Group Adult Foster Care (GAFC) — services ordered by a physician delivered to a member in a qualified GAFC setting by a multidisciplinary team and qualified GAFC caregiver, that includes assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), nursing oversight and care management of GAFC services.

Home and Community-based Services (HCBS) Waiver — a federally approved program operated under Section 1915(c) of the Social Security Act that authorizes the U.S. Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements so that a state may furnish home and community based services to certain Medicaid beneficiaries who need a level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID).

Hospice Care — a comprehensive set of services, as described in 130 CMR 437.423, identified and coordinated by an interdisciplinary team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill member or family members as delineated in a specific member plan of care.

Hospice Election Form — a form that complies with election statement requirements established in 130 CMR 437.412 and 42 CFR 418.24(b) and allows the member to elect their MassHealth hospice benefit.

Hospice Inpatient Facility — a palliative-care facility that cares solely for hospice members requiring short-term, general inpatient, or respite care and is owned and operated directly by a licensed hospice pursuant to 105 CMR 141.000: *Licensure of Hospice Programs*.

Hospice Interdisciplinary Team — the interdisciplinary team of professionals who attend to the physical, medical, psychosocial, emotional, and spiritual needs of both the hospice member and the hospice member's family. Requirements for the composition and duties of the interdisciplinary team are provided at 130 CMR 437.421(C).

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Hospice Provider — 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.

Integrated Care Organization (ICO) — an organization with a comprehensive network of medical, behavioral health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with EOHHS and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrolled members with the full continuum of Medicare- and MassHealth-covered services.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) — a facility, or distinct part of a facility, that provides intermediate care facility services as defined under 42 CFR § 440.150, and that meets federal conditions of participation, and is licensed by the State primarily for the diagnosis, treatment, or rehabilitation for individuals with intellectual disabilities; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or rehabilitative services to help individuals function at their greatest ability.

Licensed Professional — a person licensed to provide patient-care services by the state in which the services are delivered.

Managed Care Organization (MCO) — any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), and is organized primarily for the purpose of providing health care services.

Marketing — any communication from a hospice provider, or its agent, to a member, or his or her family or caregivers, that can reasonably be interpreted as intended to influence the member's choice of hospice provider, whether by inducing that member

- (1) to retain that hospice provider to provide hospice services to the member,
- (2) not to retain hospice services from another hospice provider, or
- (3) to cease receiving hospice services from another hospice provider.

Nursing Facility — a facility that meets all criteria and certification requirements of 130 CMR 456.404: *Requirements for Provider Participation; In-state* or 456.405: *Requirements for Provider Participation; Out-of-state*.

Palliative Care — member- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, and spiritual needs and facilitating member autonomy, access to information, and choice.

Personal Care Attendant (PCA) Program — a MassHealth program under which personal care management services, fiscal intermediary services, and PCA services are available to MassHealth members.

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Personal Care Attendant (PCA) Services — physical assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) provided to a member by a PCA in accordance with 130 CMR 422.000: *Personal Care Attendant Services*.

Physician Designee — a doctor of medicine or osteopathy, designated by the hospice, who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

Program of All-inclusive Care for the Elderly (PACE) — a program of all-inclusive care for the elderly that is operated by an approved PACE Organization and that provides comprehensive healthcare services to PACE participants in accordance with a PACE Program Agreement and as described at 42 CFR Part 460.

Provider Portal — the online site through which hospice providers submit information to MassHealth or to a MassHealth designated vendor.

Representative — an individual who has the authority under state law to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill member who is mentally or physically incapacitated.

Senior Care Organization (SCO) — a managed care organization that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrolled members with the full continuum of MassHealth-covered services, and for dual eligible members, the full continuum of MassHealth and Medicare-covered services.

Terminal Illness — a condition in which the member has a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.

Unfair or Deceptive Acts or Practices — any unfair or deceptive acts or practices, as that term is defined in M.G.L. c. 93A, § 2, and the regulations promulgated thereunder by the Massachusetts Attorney General.

437.403: Eligible Members

- (A) (1) MassHealth Members. The MassHealth agency covers hospice services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. MassHealth regulations at 130 CMR 450.105: *Coverage Types* 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: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

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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: *Out-of-state Services*.

437.406: Early and Periodic Screening, Diagnostic 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: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction* without regard to service limitations described in 130 CMR 437.000, and with prior authorization.

437.407: Hospice Election Periods

- (A) A member who meets all eligibility criteria set forth in 130 CMR 437.000, 130 CMR 450.000: *Administrative and Billing Regulations*, and all other applicable federal and MassHealth regulations may elect to receive hospice care during one or more of the following election periods:
- (1) an initial 90-day period;
 - (2) a subsequent 90-day period; or
 - (3) an unlimited number of subsequent 60-day periods.
- (B) The election periods are available in the order listed and may be elected separately at different times.
- (C) A member may continue to receive hospice services through the initial 90-day election period and the subsequent election periods without interruption if the member remains in the care of the hospice provider and does not revoke the election under 130 CMR 437.412(C).

(130 CMR 437.408 through 437.410 Reserved)

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437.411: Certification of Terminal Illness

(A) Timing of certification. The hospice provider must obtain written certification of terminal illness for each of the periods listed in 130 CMR 437.407, even if a single election continues in effect for an unlimited number of periods, as provided in 130 CMR 437.412.

- (1) If the hospice provider cannot obtain the written certification within two calendar days after a period begins, it must obtain an oral certification within two calendar days after a period begins and the written certification before the hospice provider submits a claim for payment to the MassHealth agency.
- (2) Certifications may be completed no more than 15 calendar days prior to the effective date of election.
- (3) Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent election period.

(B) Face-to-face Encounter. When the hospice provider anticipates the member will reach their third benefit period, the hospice physician or hospice nurse practitioner must have a face-to-face encounter with the member. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to the third benefit period recertification, and every benefit period recertification thereafter to gather clinical findings to determine the member’s continued eligibility for hospice care. This requirement applies to members receiving hospice services within the same hospice organization. The hospice physician or hospice nurse practitioner must attest in writing that he or she had a face-to-face encounter with the member.

- (1) The attestation documenting the Face-to-Face Encounter, which must be a separate and distinct part of the member’s recertification for hospice services, or an addendum to the recertification associated with the third election period, must be clearly titled as the “Face-to-Face Encounter”, and include the following information:
 - (a) accompanying signature, and date signed by the authorized individual who performed the visit;
 - (b) date of the visit;
 - (c) clinical findings to determine continued hospice eligibility; and
 - (d) when the hospice NP performs the face-to-face encounter, the attestation must also state that the clinical findings were provided to the certifying physician for use in determining continued eligibility for hospice care.
- (2) Dual-eligible Members. For dual-eligible members, MassHealth will consider a face-to-face encounter conducted in accordance with all requirements of 42 CFR 418.22 to meet the Face-to-Face encounter requirements described in 130 CMR 437.411(C).

(C) Contents of the Certification Statement. The certification of the member’s terminal illness must be in writing and completed by either the medical director of the hospice or the physician member of the hospice interdisciplinary team, in collaboration with the member’s attending physician, if the member has an attending physician. The certification must also meet the following requirements.

- (1) The certification must specify that the member’s life expectancy is six months or less, if the terminal illness runs its normal course;
- (2) The certification must include clinical information and other documentation that supports the medical prognosis of six months or less, and this documentation must be filed in the member’s medical; record;

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(3) The certification must include a brief narrative written by the physician completing the certification or recertification. The narrative must explain the clinical findings that support a life expectancy of six months or less 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 associated with the member's third benefit period with the same hospice provider must also include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less. The narrative must reflect the member's individual clinical circumstances and may not contain checkboxes or standard language used for all members. The narrative must also be a part of the certification or recertification forms, or as an addendum to the certification and recertification forms;

(a) If the narrative is part of the certification or recertification form, the narrative must be located immediately before the physician's signature; or

(b) If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

(4) For recertifications associated with the member's third benefit period and any subsequent election period, the recertification must also include documentation of the face-to-face encounter as described in 130 CMR 437.411(B)

(5) The certification must be signed and dated by the physician completing the certification

(6) The certification must include the benefit period dates to which the certification or recertification applies.

(D) Obtaining Certification. For the first 90-day election period of hospice services to be covered by MassHealth, the hospice provider must obtain written certification statements 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.

(E) 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.

437.412: Electing Hospice Services

(A) Eligibility for Hospice Services.

(1) MassHealth members, including dual-eligible members, 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: *Coverage Types* covers hospice services; and

(b) they fulfill the following requirements:

1. are certified as terminally ill in accordance with 130 CMR 437.411;

2. agree to waive certain MassHealth benefits in accordance with 130 CMR 437.412(B); and

3. elect to receive hospice services in accordance with 130 CMR 437.412(C).

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(2) MassHealth members younger than 21 years old 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) or accountable care organization (ACO) who elect hospice services, the hospice provider must be contracted with the member's ACO/MCO plan, as applicable, and the hospice provider must comply with the ACO/MCO's requirements for the delivery of hospice services.

(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 coverage for the following services for the duration of the election of hospice services:

- (1) hospice services provided by a hospice provider other than the one designated by the member on the hospice election 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 or ICF/IID when nursing facility or ICF/IID is otherwise a covered benefit for a member's coverage type (*see* 130 CMR 437.424(B) and 130 CMR 450.105: *Coverage Types*); and
- (3) any MassHealth services that are equivalent to or duplicative of hospice services, except for
 - (a) MassHealth state plan personal care services, including MassHealth Personal Care Attendant (PCA) Program services (130 CMR422.000) and MassHealth Adult Foster Care/Group Adult Foster care Program services (130 CMR 408.000), as well as MassHealth Home and Community-based Services (HCBS) waiver services that provide assistance with personal care, when used to the extent that the hospice provider would routinely use the services of a member's family in implementing the plan of care. As provided under 130 CMR 437.423(B), PCA, AFC/GAFC, and HCBS waiver services that provide personal care must be coordinated with the provision of hospice services, as well as 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 Election and Change in Hospice Election. 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 hospice providers in accordance with 42 CFR 418.24 and 130 CMR 437.412, the hospice provider must notify the MassHealth agency of the member's hospice election or change in hospice election.

(1) Hospice Election Statement. When a member meets the requirements of 130 CMR 437.412(A) and chooses to elect hospice, the hospice provider must have the member or member's representative sign a hospice election statement that meets all requirements of 42 CFR 418.24(b) and (c). The hospice election statement must be specific to MassHealth and the member must be aware that in signing the election statement they are waiving their rights to MassHealth coverage for certain services for the duration of their hospice election. *See* 130 CMR 437.412(B).

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(2) Hospice Revocation. The member or the member’s representative may revoke the election of hospice services at any time during the hospice election period. The hospice provider must document the revocation in the member’s medical record and notify the MassHealth agency according to 130 CMR 437.412(C). Upon revocation of the election of hospice services for a particular election period, the member:

- (a) is no longer covered under MassHealth for hospice services;
- (b) resumes MassHealth coverage for the services waived upon election of hospice services; and
- (c) may at any time elect to receive hospice services for any remaining hospice election periods for which the member is eligible.

(3) Change in MassHealth Hospice Providers. A member may change hospice providers once in each hospice election period. To change from one hospice provider to another, the new hospice provider must notify the MassHealth agency according to 130 CMR 437.412(C) indicating a change in hospice providers. A member does not revoke election of hospice services by changing their MassHealth hospice provider.

(4) Hospice Disenrollment. The hospice provider must document hospice disenrollment in the member’s medical record and include the reason for disenrollment and the effective date of disenrollment.

(5) MassHealth Application Pending. Once an individual’s eligibility is approved for a MassHealth coverage type that includes hospice care, MassHealth coverage for hospice services for an individual who meets the requirements of 130 CMR 437.412(A) may be effective only on or after the date the individual signs a hospice election statement that meets the requirements of 130 CMR 437.412(C)(1), regardless of any previous hospice election by the individual for an insurer other than MassHealth, and no earlier than the date the individual’s MassHealth eligibility is approved.

(6) Dual-Eligible Members. Hospice providers must ensure that dual-eligible members elect and revoke their MassHealth hospice benefit simultaneously with their Medicare hospice benefit.

(7) Notifying the MassHealth Agency of Hospice Election and Change in Hospice Election. A hospice provider must notify the MassHealth agency of a member’s hospice election or change in hospice election through the provider portal, or as otherwise instructed by the MassHealth agency within 14 calendar days after the effective date of election.

(8) Exceptions. If a Hospice provider is unable to timely notify the MassHealth agency of a Hospice Election and/or Change in Hospice Election, the hospice provider must fully document and furnish any requested documentation to the MassHealth agency for a determination of exception as soon as possible and no later than 90 days from the date of election. The permissible exceptions are as follows:

- (a) fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice provider’s ability to operate;
- (b) an event that produces a data filing problem due to a MassHealth contractor systems issue that is beyond the control of the hospice provider;
- (c) a newly enrolled MassHealth hospice provider that is notified of enrollment after the MassHealth enrollment date, or is awaiting its MassHealth provider ID from MassHealth;
- (d) the member’s MassHealth eligibility is approved and retroactively applied after the member signs the hospice election form;
- (e) other situations determined by the MassHealth agency to be beyond the control of the hospice.

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(D) Effective Date for Hospice Services.

(1) The effective date for hospice election, hospice revocation, or changing hospice providers is the effective date entered by the hospice provider on the hospice election 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 election statement.

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437.421: Administration and Staffing Requirements

(A) Governing Body. The hospice provider 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) Hospice Interdisciplinary Team. The hospice provider must designate a hospice interdisciplinary team composed of hospice personnel, including a registered nurse, whose role is to provide coordination of care, including in-home supports, continuous assessment of member and family needs, and implementation of the interdisciplinary plan of care.

(1) Composition of Team. The hospice interdisciplinary team 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 Team. The hospice interdisciplinary team must provide the care and services offered by the hospice. The hospice must designate a registered nurse that is a member of the interdisciplinary team to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The team in its entirety must also supervise care and services by

- (a) establishing a written, individualized plan of care for members and families that includes all services necessary for the palliation and management of the terminal illness and related conditions;
- (b) providing for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions;
- (c) ensuring that the plan of care is coordinated with any services the member may be authorized to receive from the MassHealth Personal Care Attendant Program or the MassHealth Adult Foster Care Program and any in-home support services available to the member from a home- and community-based service network;
- (d) reviewing and revising the individualized plan of care as frequently as the member's condition requires, but no less frequently than every 15 calendar days; and
- (e) establishing the policies governing the day-to-day provision of hospice services to members, families, and caregivers.

(D) Contracted Services. A hospice provider may arrange for the provision of certain services on a contract basis, including highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impractical and prohibitively expensive. These services may not include routine nursing services, medical social services, and counseling services specified in 130 CMR 437.000, except in circumstances in 42 CFR 418.64. If the other covered services listed in 130 CMR 437.423 (physician services; physical, occupational,

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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 provider must meet the following requirements.

- (1) Written Agreement. The hospice provider 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 provider;
 - (c) states how the contracted services will be coordinated, supervised, and evaluated by the hospice provider;
 - (d) delineates the role of the hospice provider and the contractor in the admission process, member/family assessment, and the interdisciplinary team-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.
- (2) Professional Management Responsibility. The hospice provider must ensure that contracted services are authorized by the hospice provider, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with each member's plan of care.
- (3) Financial Responsibility. The hospice provider 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 provider must ensure that inpatient care is furnished in a MassHealth-participating facility that meets the requirements specified in 42 CFR 418.108 or is a hospice inpatient facility as defined in 130 CMR 437.402. The hospice provider must have a written agreement with the facility that specifies
 - (a) that the hospice provider 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 provider and agrees to abide by the patient-care protocols established by the hospice provider 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 provider;
 - (d) that the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provision of ; and
 - (e) that the hospice provider retains responsibility for ensuring that the training of personnel who will be providing the member's care in the inpatient facility has been provided.
- (5) Room and Board in a Nursing Facility or ICF/IID. The hospice provider and the nursing facility or ICF/IID must enter into a written agreement under which the hospice provider takes full responsibility for the professional management of the member's hospice services and the nursing facility or ICF/IID 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. In addition to all other applicable requirements established under 130 CMR 437.421(D), the written agreement between the hospice provider and the nursing facility or IFC/IID must also include:

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- (a) The manner in which the nursing facility or ICF/IID and the hospice provider are to communicate with each other and document such communications to ensure that the needs of members are addressed and met 24 hours a day; and
- (b) A provision that the nursing facility or ICF/IID immediately notifies the hospice of any significant change in the member's physical, mental, social, or emotional status, clinical needs or health insurance coverage.

(E) Volunteer Services. The hospice provider must use volunteers in administrative or direct patient-care roles. The hospice provider must appropriately train volunteers and document its ongoing efforts to recruit and retain volunteer staff. The hospice provider must complete the same personnel screenings for volunteer staff that are required for paid employees of the hospice provider.

- (1) Level of Activity. A hospice provider 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 patient-care hours of all paid hospice employees and contract staff. The hospice provider must document the 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 provider 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.

437.422: Initial and Comprehensive Assessment of the Member

(A) The hospice provider must conduct and document in writing a member-specific comprehensive assessment that identifies the member's need for hospice care and services, and the member's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

(B) Timeframe for Completion of the Initial and Comprehensive Assessments. The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with 130 CMR 437.412. The hospice interdisciplinary team, in consultation with the individual's attending physician (as applicable), must complete the comprehensive assessment no later than five calendar days after the election of hospice care in accordance with 130 CMR 437.412.

(C) Content of the comprehensive assessment. The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the member's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:

- (1) the nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
- (2) complications and risk factors that affect care planning.
- (3) functional status, including the member's ability to understand and participate in his or her own care.
- (4) imminence of death.
- (5) severity of symptoms.

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(6) drug profile. A review of all of the member's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:

- (a) effectiveness of drug therapy.
- (b) drug side effects.
- (c) actual or potential drug interactions.
- (d) duplicate drug therapy.
- (e) drug therapy currently associated with laboratory monitoring.

(7) Bereavement. An initial bereavement assessment of the needs of the member's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the member's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

(8) The need for referrals and further evaluation by appropriate health professionals.

(D) Update of the comprehensive assessment. The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary team (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the member's progress toward desired outcomes, as well as a reassessment of the member's response to care. The assessment update must be accomplished as frequently as the member's condition requires, but no less frequently than every 15 days.

437.423: Plan of Care

(A) Establishment of Plan. The hospice interdisciplinary team in collaboration with the attending physician if any, the member or representative, and primary caregiver must establish and follow an individualized written plan of care in accordance with the member's needs. The hospice must ensure that each member and the primary care giver(s) receive education and training from the hospice provider as appropriate to their responsibilities for the care and services identified in the plan of care.

(B) Scope of Plan. The plan of care must reflect member and family goals and interventions based on problems identified in the initial, comprehensive, and updated comprehensive assessments as described in 130 CMR 437.422. 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 personal care services the member may be authorized to receive from the MassHealth Personal Care Attendant Program and the MassHealth Adult Foster Care /Group Adult Foster Care Program, and/or personal care services provided through a MassHealth HCBS waiver as well as with any in-home support services that the member is receiving or is eligible to receive from a home and community-based services network. Services that provide in-home personal care may be used only to the extent that the hospice provider 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 less frequently than every 15 days, by the attending physician, and the hospice interdisciplinary team (in collaboration with the member's attending physician, if any). These reviews must be documented in the member's clinical record.

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437.424: Covered Services

The hospice provider 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. The hospice must provide nursing care and services by or under the supervision of a nurse. Nursing services must ensure that the nursing needs of the member are met as identified in the member's initial assessment, comprehensive assessment, and any updated comprehensive assessments. The hospice provider is responsible for providing all routine nursing care that can be completed during a standard nursing visit, including the collection of vital signs and treatment of minor injuries or sores, and all such routine nursing care must be completed by the hospice nurse unless the member resides in a nursing facility or ICF/IID and provision of certain routine nursing care is appropriately coordinated with the nursing facility or ICF/IID in accordance with 42 CFR 418.112.

(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 provider, 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: *Physician Services*.

(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 provider. 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. The hospice must:

(a) Provide an assessment of the member's and family's spiritual needs.

(b) Provide spiritual counseling to meet these needs in accordance with the member's and family's acceptance of this service, and in a manner consistent with the member and family beliefs and desires.

(c) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the member's spiritual needs

(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 provider.

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(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 provider must arrange and supply hospice aide and homemaker services that are ordered by the hospice interdisciplinary team, and are provided in accordance with 42 CFR 418.76. Hospice aide and homemaker services may include the provision of personal care and household services. A registered nurse must visit the member's home no less frequently than every 14 days 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. The hospice aide does not have to be present during this visit.

(G) Drugs and Durable Medical Equipment and Medical Supplies. The hospice provider must provide all drugs, durable medical equipment, and medical supplies related to the palliation and management of the members terminal illness and related conditions, as identified in the member's plan of care while the member is under hospice care. The hospice must also comply with 42 CFR 418.106. 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: *Pharmacy Services* 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 418.108.

(2) Limitations. During the 12-month period beginning October 1st of each year and ending September 30th of the following year, the aggregate number of inpatient days (for both general inpatient care and inpatient respite care) may not exceed 20% of the aggregate number of days of hospice services provided to all MassHealth members during that same period.

(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.

437.425: Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 437.000 and 450.000: *Administrative and Billing Regulations*, hospice providers must meet all of the following requirements.

(A) Recordkeeping Requirements

(1) Administrative Records. Hospice providers must maintain administrative records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. All records, including but not limited to the following, must be accessible and made available on site for inspection by the MassHealth agency:

- (a) payroll and staff records, including evidence of completed staff orientation and training;
- (b) financial records;
- (c) staffing levels, including volunteers;
- (d) complaints and grievances;
- (e) contracts for subcontracted services, including a description of how the hospice provider will supervise the subcontracted services;

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- (f) contracts for independent contractor services, including a description of how the hospice provider will supervise the independent contractors and their services; and
- (g) job descriptions that include titles, reporting authority, qualifications, and responsibilities.

(2) **Clinical Records.** All hospice providers must maintain a clinical record that meets the criteria in 42 CFR 418.104 for each member receiving care and services and includes the following information:

- (a) initial plan of care, updated plans of care, initial assessment, comprehensive assessment, and any updated comprehensive assessments;
- (b) the member's name, MassHealth member identification number, address, gender, age, and next of kin;
- (c) completed hospice election statements signed and dated by the member or member's representative
- (d) completed and submitted notices of hospice election as required in 130 CMR 437.412(C);
- (e) pertinent medical history;
- (f) complete documentation of all services and events, including
 1. nursing and hospice aide/homemaker visit notes;
 2. visit documentation for any other services furnished by the hospice provider, either directly or under contract;
 3. documentation from bereavement counseling provided to the member and/or family;
 4. documentation from any other counseling service provided to the member and/or family; and
 5. documentation on any hospitalization or in-patient stay;
- (g) the certification of terminal illness for each certification period the member elects with the hospice provider, as described in 130 CMR 437.411; and
- (h) Signed copies of the notice of member rights in accordance with 130 CMR 437.425(B).

(3) **Incident and Accident Records.** Hospice providers must maintain an easily accessible record of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

- (a) The hospice provider must submit to the MassHealth agency an incident or accident report within five days of having knowledge of the incident and under the following circumstances:
 1. An incident or accident that occurred during a hospice service visit that results in serious injury to the member;
 2. An incident or accident unrelated to the member's life prognosis due to their terminal illness and resulting in the member's unexpected death even if the hospice provider was not involved in the incident or accident;
 3. An incident of abuse or neglect involving a staff member of the hospice provider, including a volunteer, and the member; and
 4. An incident of abuse or neglect committed by another provider supporting the member (if known).
- (b) The incident or accident report must include at least the following information.
 1. general information including but not limited to member name and member identification;
 2. general nature of incident or accident; and

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3. any action that was taken as a result of the incident or accident including all outcomes.

(B) Member Rights. Members have the right to be informed of their rights, and the hospice provider must protect and promote the exercise of these rights in accordance with 42 CFR 418.52 and 130 CMR 437.000.

- (1) The hospice provider must ensure the member has a right to the following:
 - (a) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;
 - (b) Be involved in developing his or her hospice plan of care;
 - (c) Refuse care or treatment;
 - (d) Choose his or her attending physician;
 - (e) Have a confidential clinical record. Access to or release of member information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.
 - (f) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of member property;
 - (g) Receive information about the services covered under the hospice benefit;
 - (h) Receive information about the scope of services that the hospice will provide and specific limitations on those services;
 - (i) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice;
 - (j) To not be subjected to discrimination or reprisal for exercising his or her rights.
 - (k) Receive information verbal or written concerning the hospice provider's policies on advance directives, including a description of applicable state law, that complies with the requirements of 42 CFR Part 489 subpart I.

(2) Member Notice of Rights and Responsibilities. During the initial assessment visit in advance of furnishing care, the hospice provider must provide the member or representative with a written notice of the member's rights and responsibilities that complies with 130 CMR 437.424 (B)(1) in a language and manner that the member understands. The hospice must obtain the member's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities. The member notice must include the process for which a member may file a grievance regarding treatment or care that is furnished, and a clearly identifiable statement indicating that a member will not be subjected to discrimination or reprisal for exercising his or her rights.

437.426: Payment for Hospice Services

(A) Type of Care. MassHealth payment for hospice services is based on the type of care provided rather than the qualifications of the person who provided the service. Payment 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 or residing in a nursing facility or ICF/IID, under the care of the hospice provider, 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) Service-intensity Add-on (SIA). Routine home care days that occur during the last seven days of a hospice election ending with a member discharge due to death are eligible for an SIA payment. The SIA rate may be billed with the routine home care rate, for a minimum of 15 minutes and up to four hours per day for RN or social worker visits to the member during the last seven days of their hospice election ending in discharge due to death.

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(3) Continuous Home Care. The continuous home care rate is paid when a member receives hospice services consisting predominantly of nursing care on a continuous basis at home or in a nursing facility or ICF/IID. Hospice 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.

(4) Inpatient Respite Care. The inpatient respite care rate is paid to the hospice provider for each day the member is in an approved inpatient facility and is receiving respite care from the hospice provider. Payment 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 except in circumstances described in 42 CFR 418.302(e)(5). Payment for any subsequent days will be made at the routine home care rate.

(5) 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 payment 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 or ICF/IID. The MassHealth agency pays the hospice provider a room and board *per diem* amount for a member residing in a nursing facility or an ICF/IID in accordance with all applicable MassHealth 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)).

(1) The MassHealth agency does not pay a hospice provider the room and board *per diem* amount, and does not pay for medical-leave-of-absence days, for any day that a member receives inpatient respite care (130 CMR 437.424(A)(3)) or general inpatient care (130 CMR 437.424(A)(4)) from the hospice provider.

(2) If a member receiving hospice services in a nursing facility or ICF/IID is hospitalized, the MassHealth agency will pay the hospice provider for the medical leave of absence in accordance with 130 CMR 456.000: *Long Term Care Services*, provided that the conditions for medical leave of absence are met in accordance with 130 CMR 456.000: *Long Term Care Services*.

(C) Payment of Hospice Provider on Date of Discharge from Hospice Services. MassHealth does not pay a hospice provider the *per diem* hospice rate or the room and board rate on a member's date of discharge from hospice services, except for when

- (1) the member is discharged due to death
- (2) the member was receiving hospice services in a nursing facility or ICF/IID and continue to reside in the nursing facility or ICF/IID after hospice discharge

(D) Payment of Hospice Provider on Date of Death. MassHealth pays the hospice provider the hospice *per diem* rate and the room and board rate on the member's date of death.

(E) Change of Hospice Providers. When a member changes hospice providers, MassHealth will not pay both hospice providers for the same date of service. The new hospice provider may begin receiving payment for dates of service subsequent to the date of discharge from the previous hospice provider.

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(F) The Hospice Election Form. A hospice provider must complete a hospice election form and notify the MassHealth agency of the member's hospice election in accordance with 130 CMR 437.412. The MassHealth agency will not pay for hospice services provided before the effective date entered on the hospice election form.

(G) Dual-eligible members. The MassHealth agency will not pay for hospice services and/or applicable room and board in an NF or ID/DD during any period in which a dual-eligible member has not simultaneously elected both their MassHealth and Medicare hospice benefit.

(H) MassHealth Members Enrolled in Capitated Programs. A hospice provider may not directly bill MassHealth for hospice services provided to a MassHealth member receiving hospice services through a capitated program.

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

437.427: Quality Management and Utilization Review

(A) A hospice provider must participate in any quality management and program integrity processes as required by the MassHealth agency including making any necessary data available and providing access to visit the hospice provider's place of business upon request by MassHealth or its designee.

(B) A hospice provider must submit requested documentation to the MassHealth agency or its designee for purposes of utilization review and provider review and audit, within the MassHealth agency's or its designee's time specifications. The MassHealth agency or its designee may periodically review a member's certification of terminal illness and other records to determine if services are medically necessary in accordance with 130 CMR 437.000. The hospice provider must provide the MassHealth agency or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) Upon request, a hospice provider must submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the hospice provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 437.000.

437.428: Prohibited Marketing Activities

A hospice provider must not:

(A) with the knowledge that a member is enrolled in a Capitated Program, engage in any practice that would reasonably be expected to have the effect of steering or encouraging the member to disenroll from the Capitated Program in order to retain the hospice provider to provide hospice services on a fee-for-service basis;

(B) offer to a member, or his or her family or caregivers, in-person or through marketing, any inducement to retain the hospice provider to provide hospice services, such as a financial incentive, reward, gift, meal, discount, rebate, giveaway, or special opportunity;

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(C) pay a “finder’s fee” to any third-party in exchange for referring a member to the hospice provider; or

(D) engage in any unfair or deceptive acts or practices in connection with any marketing.

REGULATORY AUTHORITY

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

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