Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 50—Hospice Services Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
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13 CSR 70-50.010 Hospice Services Program

PURPOSE: This rule establishes the regulatory basis for administration of a medical assistance program of hospice care as mandated by House Bill 1139, 84th General Assembly. More specific details of the conditions for provider participation, criteria and methodology of provider reimbursement, recipient eligibility, and amount, duration and scope of services covered are included in the provider program manual. The Missouri Title XIX Hospice Services Program is similar to the Title XVIII Medicare Hospice Services program as defined and prescribed in Title 42, ***Code of Federal Regulations*** *part 418.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Administration. The Hospice Program shall be administered by the Department of Social Services, Division of Medical Services. The medical services covered and not covered, the program limitations and the maximum allowable fee for all covered services shall be determined by the Department of Social Services, Division of Medical Services.

(2) Persons Eligible. Any person who is eligible for medical assistance benefits from the Department of Social Services is certified by a physician to be terminally ill with a medical prognosis of life expectancy of six (6) months or less if the illness runs its normal course and who elects hospice benefits is eligible. The individual must agree to seek only palliative care for the duration of the hospice enrollment.

(3) Enrollment of Recipient. The components involved in hospice enrollment are—physician certification; election procedures, including election statement, revocation and change; the assignment of an attending physician; and the development of the plan of care.

(A) Physician Certification. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. Prior to billing for the first period of hospice coverage (ninety (90) days), the hospice must obtain, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if that attending physician is other than a hospice staff member). The certification must include the statement that the individual's medical prognosis is a life expectancy of six (6) months or less if the illness runs its normal course and the signature(s) of the physician(s). If the hospice does not obtain written physician certification within two (2) days of the initiation of hospice care, a verbal physician certification must be obtained within the two (2) days. Payment will not be made for days prior to the written certification if the verbal certification requirement is not met.

2. For any subsequent period of hospice coverage, the hospice must obtain, no later than two (2) calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is a life expectancy of six (6) months or less if the illness runs its normal course and the signature of the physician. The hospice must maintain the certification statements.

(B) Election Procedures. To elect hospice services, an individual must file a Hospice Election Statement with a Medicaid participating hospice provider. An election may also be filed by a representative acting pursuant to state law. With respect to an individual granted the power of attorney for the recipient, state law determines the extent to which the individual may act on the patient's behalf.

1. Election period. An election to receive hospice care will be considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election.

2. Waiver of Medicaid fee-for-service payments related to the terminal illness. In order to elect hospice services, the individual must waive all rights to Medicaid payments for services that would be covered under the Medicare program for the duration of the election of hospice care for the following services:

A. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and

B. Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or that are equivalent to hospice care except for services—

(I) Provided (either directly or under arrangement) by the designated hospice;

(II) Provided by another hospice under arrangements made by the designated hospice; or

(III) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

3. Election, revocation and change of hospice.

A. Election periods. An individual may elect to receive hospice care during one (1) or more of the following election periods:

(I) An initial ninety (90)-day period;

(II) A subsequent ninety (90)-day period; and

(III) Unlimited subsequent sixty (60)-day periods.

B. Election statement. The election statement must include the following items of information:

(I) Identification of the particular hospice that will provide care to the individual;

(II) The individual's or representative's acknowledgment that s/he has been given a full understanding of hospice care;

(III) The individual's or representative's acknowledgment that s/he understands that certain Medicaid services are waived by the election;

(IV) The effective date of the election;

(V) The name of the attending physician;

(VI) The signature of the individual or representative; and

(VII) The signature of the witness when the recipient's representative signs the form.

C. Revocation. An individual or representative may revoke the election of hospice care at any time. To revoke the election of

hospice care, the individual, or representative, must file a revocation of hospice benefit statement with the hospice. This statement must include a signed statement that the individual revokes the election for Medicaid coverage of hospice care for the remainder of that election period. The date that the revocation is to be effective is the date of the signature or may be a later date subsequent to the date of signature. The individual forfeits coverage for any remaining days in that election period. The individual or representative, may not designate an effective date earlier than the date that the revocation statement is signed. Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual resumes Medicaid coverage of the benefits waived when hospice care was elected. An individual may elect at any time to receive hospice coverage for any other hospice election periods for which s/he is eligible.

D. Change of hospice. An individual may change, once in each election period, the designation of the particular hospice from which s/he elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice providers, the individual must file with the hospice from which s/he has received care and with the newly designated hospice a signed statement that includes the following information: the name of the hospice from which the individual has received care, the name of the hospice from which s/he plans to receive care and the date the change is to be effective.

(C) Attending Physician. The attending physician is a doctor of medicine or osteopathy and is identified by the individual, at the time s/he elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. The attending physician is the recipient's physician of choice who participates in the establishment of the plan of care and works with the hospice team in caring for the patient. The physician continues to give the medical orders and may have privileges in the hospice inpatient care. Medicaid will make payments directly to a hospice recipient's attending physician if the physician is not employed by the hospice provider.

(D) Plan of Care. After an individual has been certified as terminally ill and has elected hospice services, a plan of care must be established before services can be rendered. All services rendered to the recipient must be consistent with the plan of care. In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet with or call at least one (1) other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care. At least one (1) of the persons involved in developing the initial plan of care must be a nurse or a physician and the physician must sign the plan of care. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. The other two (2) members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two (2) calendar days following the day of assessment. Signatures of all parties are required.

(4) Provider Participation. To be eligible for participation in the Missouri Medicaid Hospice Program, a provider must meet the following criteria:

(A) Be certified as a Medicare hospice provider;

(B) Be licensed by the Missouri State Department of Health as a hospice provider; and

(C) Be enrolled as a Medicaid hospice provider.

(5) Benefits and Limitations. All services must be performed by appropriately qualified personnel. Nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. A hospice must ensure that substantially all the core services are routinely provided directly by hospice employees. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet all requirements. The following services are hospice-covered services when specified in the individual's plan of care:

(A) Nursing care provided by or under the supervision of a registered nurse (RN);

(B) Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and who is working under the direction of a physician;

(C) Physician's services performed either directly or under contract with the hospice by a doctor of medicine or osteopathy to meet the general medical needs of the individual to the extent that these needs are not met by the attending physician;

(D) Counseling services must be available to both the patient and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care and for the purpose of helping the individual and those caring for him/her to adjust to the individual's approaching death;

(E) There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one (1) year following the death of the patient);

(F) Dietary counseling, when required, must be provided by a qualified individual;

(G) Spiritual counseling must include notice to the patient as to the availability of clergy;

(H) Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice;

(I) Short-term inpatient care required for procedures necessary for pain control or acute or chronic symptom management provided in a participating hospice inpatient unit, or a participating hospital, or nursing facility (NF) that additionally meets the special hospice standards regarding staffing and patient areas;

(J) Short-term inpatient respite care furnished as a means of providing respite for the individual's family or other persons caring for the individual at home. The participating hospice inpatient unit, or a participant hospital, or NF must meet the special hospice standards regarding staffing and patient areas.

(K) Medical appliances and supplies including all drugs and biologicals used primarily for the relief of pain and symptom control related to the individual's terminal illness.

1. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness.

2. Equipment is provided by the hospice for use in the patient's home while s/he is under hospice care.

3. Medical supplies include those that are part of the written plan of care;

(L) Home Health Aide Services Furnished by Certified Aides. Home health aides may

provide personal care services and perform household services to maintain a safe and sanitary environment in areas of the home used by the patient. Examples of these services are: changing the bed linen or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of an RN. Home health aide services must be available and adequate in frequency to meet the needs of the patient, as defined in the plan of care;

(M) Homemaker services furnished to provide assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan;

(N) Physical therapy, occupational therapy and speech/language pathology services for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills. When provided, the services must be offered in a manner consistent with accepted standards of practice; and.

(O) Any other item or service which is specified in a patient's Plan of Care and for which Medicaid may pay.

(6) The following services are not covered through the hospice program:

(A) Any services provided by inappropriately qualified personnel;

(B) Any service or treatment not listed in the individual's plan of care;

(C) Any service or treatment that is not directly related to pain control or palliation of the recipient's terminal illness;

(D) Nurse's aide services not under the supervision of an RN;

(E) Inpatient services beyond the boundaries of the inpatient cap; and

(F) Respite care over five (5) days per calendar month.

(7) Reimbursement. Hospice services, as defined in this rule and provided by qualified providers, shall be reimbursed for dates of service beginning on or after May 15, 1989. The reimbursement rate for hospice services includes all covered services related to the treatment of the terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities would include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care and inpatient respite care.

(A) A per-diem rate for each day on which hospice services are provided will be established based on the Title XVIII Medicare rate for the specific hospice based on the level of care provided—

1. Routine home care;

2. Continuous home care. A minimum of eight (8) hours of continuous care must be provided during a twenty-four (24)-hour period;

3. General inpatient care; and

4. Inpatient respite care. Reimbursement is limited to five (5) days per calendar month and to the mandatory inpatient day limit.

(B) Nursing Home Room and Board. Medicaid-eligible individuals residing in Medicaid-certified NFs who meet the hospice eligibility criteria may elect Medicaid hospice care services. In addition to the routine home care or continuous home care per-diem rates, an amount may be paid to the hospice to cover the nursing home room and board costs. The hospice will reimburse the nursing home. Room and board include the performance of personal care services that a caregiver would provide if the individual were at home. These services include assistance in the activities of daily living: washing and grooming, toileting, dressing, meal service, socializing (companionship, hobbies, and the like), administration of medication, maintaining the cleanliness of the resident's bed and room and supervising and assisting in the use of durable medical equipment and prescribed therapies (for example, range of motion exercises, speech and language exercises).

1. There must be a written agreement between the hospice and the nursing home under which the hospice takes full responsibility for the professional management of the individual's hospice care and the nursing home agrees to provide room and board to the individual. The hospice and the nursing home will retain a copy of the agreement.

2. For purposes of the Medicaid hospice benefit, a NF can be considered the individual's residence.

3. Payment for NF room and board will be determined in accordance with rates established under section 1902(a)(13) of the Social Security Act.

(C) Physician Services. Medicaid will reimburse the hospice provider for certain physician services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis. Medicaid will reimburse the hospice for attending physician services when the physician is employed by the hospice. These physician services will be reimbursed in accordance with Medicaid reimbursement policy for physician services based on the lower of the actual charge or the Medicaid maximum allowable amount for the specific service.

(D) Limitation on Payments for Inpatient Care. Payments to hospice providers for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12)-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospice's cap period (11/1–10/31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. Any excess reimbursement will be refunded by the hospice.

(8) Cost Sharing. Hospice services shall be exempt from these Medicaid cost-sharing requirements as may be otherwise applicable to a comparable service when provided other than as a hospice service.

(9) General Regulations. This rule shall not encompass all of the general regulations of the Medicaid program. These regulations, however, shall be in effect for hospice services.

AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo 2000. Emergency rule filed May 17, 1989, effective May 27, 1989, expired Sept. 13, 1989. Original rule filed May 17, 1989, effective Aug. 11, 1989. Amended: Filed June 18, 1991, effective Dec. 9, 1991. Amended: Filed Sept. 2, 1993, effective April 9, 1994. Amended: Filed Aug. 24, 2001, effective March 30, 2002.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*