Hospice Services – MassHealth ACO and NaviCare SCO (Medicaid-only) Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☐ Medicare Advantage
☒ MassHealth ACO
☐ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☐ Summit Eldercare PACE
☐ Fallon Health Weinberg PACE
☐ Community Care

Policy

This policy applies to hospice services for MassHealth ACO and NaviCare SCO (Medicaid-only) members only.

The Plan covers hospice services provided to eligible MassHealth ACO and NaviCare SCO (Medicaid-Only) in accordance with MassHealth Program Regulations at **130 CMR 437.000: Hospice Services** (effective 01/01/2023).

Electing hospice services (130 CMR 437.412: Electing Hospice Services)

(A) Eligibility for Hospice Services

(1) MassHealth ACO and NaviCare SCO (Medicaid-only) members are eligible for hospice services if they meet all of the following requirements:

(a) are certified as terminally ill in accordance with 130 CMR 437.411;

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

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

(2) MassHealth ACO members younger than 21 years old who have elected the hospice benefit 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 MassHealth ACO and NaviCare SCO (Medicaid-only) members, the hospice provider must be contracted with Fallon Health, and the hospice provider must comply with the Fallon Health's requirements for the delivery of hospice services.

(B) Waiver of Other Benefits - With the exception of members younger than 21 years old, upon electing to receive hospice services, the member waives all rights to 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 Plan;

(2) any 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 when nursing facility is otherwise a covered benefit for the member; and

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

(a) MassHealth Personal Care Attendant (PCA) Program services (130 CMR 422.000) and MassHealth Adult Foster Care/Group Adult Foster Care (AFC/GAGC) 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 member who meets the eligibility criteria for hospice services seeks to elect hospice services, revoke hospice services, or change hospice providers, the hospice provider must notify the Plan of the member's hospice election or change in hospice election.

(1) Hospice Election Statement - When a member meets the eligibility criteria for hospice services 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.

Hospice Election Statement Addendum - As part of this hospice election statement requirement, hospice providers must also provide notification of the right for members and representatives to receive an election statement addendum. Such an addendum must include any conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice provider. The hospice provider must provide this addendum when requested (See **MassHealth Hospice Bulletin 25** (January 2023).

(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 Plan. Upon revocation of the election of hospice services for a particular election period, the member:

(a) is no longer covered for any hospice services;

(b) resumes 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 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 Plan 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) Notifying the Plan of Hospice Election and Change in Hospice Election - A hospice provider must notify the Plan of a member's hospice election or change in hospice election by faxing the hospice election statement to the Plan's Prior Authorization Department, fax number 508-368-9700, within 14 calendar days after the effective date of election.

(6) Exceptions - If a Hospice provider is unable to timely notify the Plan of a hospice election and/or change in hospice election, the hospice provider must fully document and furnish any requested documentation to the Plan 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) the member's MassHealth eligibility is approved and retroactively applied after the member signs the hospice election form;

(c) other situations determined by the Plan to be beyond the control of the hospice.

MassHealth updated the MassHealth Hospice Election Form, which replaces all previous versions of the MassHealth Hospice Election Form in October 2020. The MassHealth Hospice Election Form can be accessed at: **MassHealth Provider Forms by Provider Type H-M**. Select "Hospice" from the menu (See **MassHealth Hospice Bulletin 15** (October 2020)**.**

Hospice providers must ensure that all MassHealth members or their representatives, as appropriate, sign and date a hospice election statement when they elect the MassHealth hospice benefit. See 130 CMR 437.412(C). See **Electronic signature policy for hospice providers** under **Referral/notification/prior authorization requirements** below for guidance on the use of electronic signatures on forms requiring signatures.

Providers may use a provider-created election and revocation statement to acquire the signature of a member or member's representative. The provider-created election and revocation statement must meet all federal and MassHealth requirements set forth in 42 CFR 418.24(b) and 130 CMR 437.412(C). The election statement must be specific to MassHealth and the member's waiver of their rights to certain MassHealth services for the duration of their hospice election (See **MassHealth Hospice Bulletin 24** (February 2022)**.**

Hospice providers may wish to use Section D of the MassHealth Hospice Election Form to ensure that all election statement requirements are included. Alternatively, they may incorporate all elements of Section D of the MassHealth Hospice Election Form into their own provider-created election statement (See **MassHealth Hospice Bulletin 24** (February 2022)**.**

Hospice providers must retain the completed election and revocation statement in the member's medical record and follow all requirements in 130 CMR 437.425: Record Keeping (See **MassHealth Hospice Bulletin 24** (February 2022)**.**

(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 Plan.

(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.

Hospice election periods (130 CMR 437.407: Hospice Election Periods)

(A) A member who meets eligibility criteria for hospice services may elect to receive hospice care during one or more of the following election periods:

(a) an initial 90–day period;

(b) a subsequent 90–day period; or

(c) 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 hospice election.

Certification of terminal illness (130 CMR 437.411: Certification of Terminal Illness)

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

(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 submitting a claim for payment to the Plan.

(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 – Effective January 1, 2023, 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 face-to-face 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) For NaviCare HMO SNP (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).

MassHealth considers a face-to-face encounter that occurs on the first day of the member's benefit period to be considered timely (See **MassHealth Hospice Bulletin 26** (March 2023).

Beginning January 1, 2023, hospice providers were given 30 days to comply with the face-to-face encounter for members who are already in their third benefit period, or any subsequent benefit period, after January 1, 2023 (See **MassHealth Hospice Bulletin 26** (March 2023).

In accordance with **MassHealth Hospice Bulletin 29** (July 2023), effective for dates of service on or after May 12, 2023, consistent with the federal Consolidated Appropriations Act of 2023, the face-to-face visit required for members entering their third hospice benefit period may be provided via telehealth through December 31, 2024. Under the Consolidated Appropriations Act, the face-to-face visit may only be conducted via two-way audio-video telecommunications technology that allows for real-time interaction.

(C) Content 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;

(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-toface 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 faceto-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 the Plan, 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.

Administration and staffing requirements (130 CMR 437.421: Administrative and Staffing Requirements)

Hospice providers must meet administration and staffing requirements described in 130 CMR 437.421.

(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 hospice medical director must be a doctor of medicine or osteopathy. The hospice Medical Director assumes 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, 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 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 - The hospice provider and the nursing facility 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 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 must also include:

(a) The manner in which the nursing facility 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 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.

Note: In accordance with **MassHealth Hospice Bulletin 29** (July 2023), providers will have through the end of calendar year 2023 to resume requirements for volunteer services in accordance with 130 CMR 437.421 (E). Providers must resume use of volunteers at a level of at least 5% of the member care hours provided by all paid hospice employees and contract staff by January 1, 2024.

Initial and comprehensive assessment of the member (130 CMR 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.

(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.

Plan of care (130 CMR 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.

Covered services (130 CMR 437.424: Covered Services)

The hospice provider must provide services for the palliation and management of the terminal illness and related conditions. Terminally ill means the member has a medical prognosis that his or her life expectancy is six months or less. 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 and provision of certain routine nursing care is appropriately coordinated with the nursing facility 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.

(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 the Plan separately only for those services not related to the member's terminal illness.

(H) Short-term Inpatient Care -

(1) 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: Condition of participation: Short-term inpatient care.

(2) 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 payment may otherwise be made.

Provider responsibilities (130 CMR 437.425)

Hospice providers must meet Recordkeeping Requirements described in 437.425(A) including Administrative Records, Clinical Records and Incident and Accident Reports.

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.

Hospice services in conjunction with adult day health services

By electing the hospice benefit, the member agrees to receive all MassHealth covered services related to their terminal illness from their hospice provider. They also agree to waive all rights to MassHealth services in accordance with 130 CMR 437.412(B). This includes any services related to the treatment of the terminal illness for which the hospice services were elected. The services include those that are equivalent to or duplicative of hospice services (except those described in 130 CMR 437.412(B)(3)).

Members who elect hospice may choose to receive Adult Day Health (ADH) services if the ADH services are not related to the member's terminal illness, or related conditions, are not equivalent to or duplicative of hospice services, and are provided in accordance with all requirements set forth in 130 CMR 404.000. The hospice provider must coordinate services with the ADH provider and must provide documentation to the ADH provider that the ADH services are not related to the member's terminal illness. Hospice services provided to members must comply with all requirements set forth in 130 CMR 437.000.

In accordance with **MassHealth Hospice Bulletin 20** (May 2021), the hospice provider must initiate the coordination of hospice services with ADH services to ensure that ADH services are not related to the member's terminal illness and not equivalent to or duplicative of hospice

services. The hospice provider must document in the member's plan of care, as described in 130 CMR 437.423, the member's receipt of ADH services and the start date of ADH services. The hospice provider must also maintain in the member's record the documentation given to the ADH provider that the ADH services are not related to the member's terminal illness or related conditions and are not duplicative of hospice services, in accordance with 130 CMR 437.000.

If the ADH provider receives referrals or orders for other services for a member who has elected hospice, the ADH provider must obtain authorization from the member or the member's legal representative to immediately contact the hospice provider. The hospice provider will determine whether the service is related to the member's terminal illness. The hospice provider must document any such communication in the member's record. ADH providers may reference **MassHealth Adult Day Health Bulletin 37** (May 2023) for additional information.

Hospice services in conjunction with day habilitation services

By electing the hospice benefit, the member agrees to receive all MassHealth covered services related to their terminal illness from their hospice provider. They also agree to waive all rights to MassHealth services in accordance with 130 CMR 437.412(B). This includes any services related to the treatment of the terminal illness for which the hospice services were elected. The services include those that are equivalent to or duplicative of hospice services (except those described in 130 CMR 437.412(B)(3)).

Members who elect hospice may choose to receive Day Habilitation (DH) services if the DH services are not related to the member's terminal illness or related conditions, are not equivalent to or duplicative of hospice services, and are provided in accordance with all the requirements in 130 CMR 419.000. The hospice provider must coordinate services with the DH provider and must give the DH provider documentation that the DH services are not related to the member's terminal illness or related conditions. Hospice services provided to members must comply with all the requirements in 130 CMR 437.000.

In accordance with **MassHealth Hospice Bulletin 28** (May 2023), the hospice provider must initiate the coordination of hospice services with DH services to ensure that the DH services are not related to the member's terminal illness or related conditions and are not equivalent to or duplicative of hospice services. The hospice provider must document in the member's plan of care, as described in 130 CMR 437.423, the member's receipt of DH services and the start date of DH services. The hospice provider must also maintain in the member's record the documentation given to the DH provider that the DH services are not related to the member's terminal illness or related conditions and are not duplicative of hospice services, in accordance with 130 CMR 437.000.

If the DH provider receives referrals or orders for other services for a member who has elected hospice, the DH provider must get authorization from the member or their legal representative to immediately contact the hospice provider. The hospice provider will determine whether the service is related to the member's terminal illness. The hospice provider must document any communication from the DH provider in the member's record. DH providers may reference **MassHealth Day Habilitation Bulletin 27** (May 2023) for additional information.

Definitions

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.

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.

Reimbursement

Reimbursement for covered hospice services will be made in accordance with the terms of this payment policy unless otherwise indicated in the provider's contract with the Plan.

Payment for hospice services (130 CMR 437.426: Payment for Hospice Services)

(A) Type of Care - 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 per diem rate is paid for each day the member is at home or residing in a nursing facility, 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.

(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. 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. Continuous home care is not reimbursed in addition to routine home care.

(4) Inpatient Respite care - The inpatient respite care rate is paid for each day the member is in an approved inpatient facility and is receiving respite care from the hospice 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 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 **-** The Plan will pay the hospice provider a room and board per diem amount for a member residing in a nursing facility in accordance with all applicable MassHealth regulations and in addition to either the routine home care rate (130 CMR 437.426(A)(1)) or the continuous home care rate (130 CMR 437.426(A) (2)).

(1) The Plan will not pay a hospice provider the room and board per diem amount, and will not pay for medical-leave-of-absence (MLOA) days, for any day that a member receives inpatient respite care (130 CMR 437.426(A)(3)) or general inpatient care (130 CMR 437.426(A)(4)) from the hospice provider.

(2) If a member receiving hospice services in a nursing facility is hospitalized, the Plan 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 - The Plan will 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 and continue to reside in the nursing facility after hospice discharge

(D) Payment of Hospice Provider on Date of Death - The Plan will pay 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, the Plan 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.

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

Payment for attending physician not employed by or paid under arrangement by the member's hospice provider

The Plan reimburses physician's services provided by the member's Attending Physician if that physician is not employed by or paid under arrangement by the member's hospice provider (437.412(B)(b)).

Attending Physician services provided by physicians who are employed by or paid under arrangement by the member's hospice provider are hospice services and the hospice provider is responsible.

Payment for services not related to the hospice condition

In those cases where a MassHealth ACO or a NaviCare member enrolled in hospice receives covered services for the treatment for a condition not related to the member's terminal iillness, the Plan will reimburse the provider rendering those services.

In those cases where a hospice member is admitted to an acute care facility for a diagnosis that is unrelated to the terminal illness of the member, the acute facility will be reimbursed at that facility's contractual rates, or at the rates paid to a non-participating acute care facility. During the period of admission, hospice is not reimbursed.

The hospice provider is responsible for all hospice services as described in the hospice Plan of Care.The Plan of Care 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. In terms of billing, the hospice provider is the only entity that can determine whether the services provided are related to a member's terminal illness and/or are contained in a member's plan of care and therefore represent expenses that should be paid for by the hospice, not the Plan. Regulations at 130 CMR 437.423 make it clear that the hospice provider must coordinate all care for members in hospice and must document all the services the members receive in their plans of care.

Payment for curative treatment and services not related to the hospice condition for masshealth aco members younger than 21 years

In those cases where a MassHealth ACO member younger than 21 years of age receives treatment for the terminal illness or treatment for a condition not related to the member's terminal illness, the Plan will reimburse the provider rendering those services.

In those cases where a hospice member is admitted to an acute care facility for a diagnosis that is unrelated to the terminal illness of the member, the acute facility will be reimbursed at that facility's contractual rates, or at the rates paid to a non-participating acute care facility. During the period of admission, hospice is not reimbursed.

The hospice provider is responsible for all hospice services as described in the hospice Plan of Care.The Plan of Care 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. In terms of billing, the hospice provider is the only entity that can determine whether the services

provided are related to a member's terminal illness and/or are contained in a member's plan of care and therefore represent expenses that should be paid for by the hospice, not the Plan. Regulations at 130 CMR 437.423 make it clear that the hospice provider must coordinate all care for members in hospice and must document all the services the members receive in their plans of care.

Referral/notification/prior authorization requirements

Prior authorization is required for hospice services for MassHealth ACO and NaviCare SCO (Medicaid-only) members.

A MassHealth ACO or NaviCare SCO member who meets eligibility criteria for hospice services may elect to receive hospice services during one or more of the following hospice election periods:

(a) an initial 90-day period;

(b) a subsequent 90-day period; or

(c) an unlimited number of subsequent 60-day periods.

Hospice election periods are available in the order listed.

To obtain authorization for the initial 90-day period, the hospice provider must submit the Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, within 14 calendar days after the effective date of election. The hospice provider must indicate the type of hospice services (e.g., routine home care) being requested on the authorization request.

1. A copy of the written Certification of Terminal Illness must be submitted to the Plan with the authorization request for the initial 90-day period. The Certification must be signed and dated by the physician completing the certification (see 130 CMR 437.411: Certification of Terminal Illness for additional information on requirements related to the Certification of Terminal Illness).
2. A copy of the signed Hospice Election Form must be submitted to the Plan with the authorization request for the initial 90-day period. Hospice services cannot be authorized without a copy of the signed Hospice Election Form. The signed Hospice Election Form ensures all parties that the member is aware that they are waiving their rights to coverage for certain services for the duration of their hospice election.

To obtain prior authorization for the subsequent 90-day and any subsequent 60-day election periods, the hospice provider must send the Universal Health Plan/Home Health Authorization Form to the Plan's Prior Authorization Department, fax number 508-368-9700, within 14 calendar days after the effective date of the election period. The hospice provider must indicate the services being requested on the authorization form.

Reminder: The hospice provider must obtain written Certification of Terminal Illness for each hospice election period, even if an election continues in effect for an unlimited number of periods. Additionally, when the hospice provider anticipates the member will reach their third benefit period, and every benefit period recertification thereafter, the hospice physician or hospice nurse practitioner must have a face-to-face encounter with the member to gather clinical findings to determine the member's continued eligibility for hospice care. Fallon Health will not require submission of the written Certification of Terminal Illness for subsequent election periods, however, the Certification of Terminal Illness must be on file in the member's clinical record before the submission of a claim. Fallon Health reserves the right to request a copy of the written certification of terminal illness for any hospice election period. See 130 CMR 437.411: Certification of Terminal Illness for additional information on requirements related to the certification of terminal illness.

All changes in type of hospice care must be authorized. For example, a change from routine home care to continuous home care requires prior authorization. Changes must be submitted on a Universal Health Plan/Home Health Authorization Form to the Plan's Prior Authorization

Department, fax number 508-368-9700, within 14 calendar days after the effective date of the change in hospice level of care.

If the member changes hospice providers at any time, the new hospice provider must submit a new Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, within 14 calendar days after the effective date of the change in hospice providers. A new signed Hospice Election Form must be submitted with the authorization request.

When Fallon Health authorizes hospice services, we will update the member's record in our claims processing system indicating that the member has elected hospice. This ensures that all claims submitted on the member's behalf are subject to system edits intended to prevent the Plan from paying for any services that should be paid for by the hospice provider.

Hospice room and board
Separate prior authorization is required for hospice room and board. To obtain authorization for hospice room and board for the initial 90-day period, the hospice provider must send the Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, within 14 calendar days after the effective date of election. To obtain prior authorization for the subsequent 90-day and any 60-day election periods, the hospice provider must send the Universal Health Plan/Home Health Authorization Form to the Plan's Prior Authorization Department, fax number 508-368-9700, within 14 calendar days after the effective date of the election period. Reminder: the Plan will pay the hospice provider for covered hospice room and board.

Hospice election statement
The hospice provider must complete and submit a hospice election statement to the Plan any time a MassHealth ACO or NaviCare SCO (Medicaid-only) member:

- Elects hospice;
- Changes hospice providers;
- Revokes their hospice election; or
- Disenrolls or is disenrolled from hospice.

When a member revokes their hospice election or disenrolls or is disenrolled from hospice, the signed Hospice Election Form must be faxed to the Plan's Prior Authorization Department, fax number 508-368-9700, within 14 calendar days after the effective date.

Electronic signature policy for hospice providers
In accordance with **MassHealth Hospice Bulletin 30** (September 2023), the Plan will accept electronic signatures on all hospice forms (such as election statements and revocation statements). These forms include MassHealth-created hospice forms as well as provider-created hospice forms. Electronic signatures are permissible for individuals including but not limited to the member, the member's authorized signatory, the hospice interdisciplinary team, the member's physician, and other prescribing providers.

Electronic signatures must meet all requirements listed in MassHealth Hospice Bulletin 30. In addition, electronic signatures must meet all other federal and state requirements.

Billing/coding guidelines

Hospice providers use the UB-04 (CMS-1450) or electronic equivalent per industry standard when billing for hospice services.

Hospice providers must use the appropriate HCPCS code and revenue code (0651-0659) when billing for hospice services.

Please note: Although Original Medicare requires the Q codes (Q5001-Q5010) on hospice claims, these codes are NOT required on hospice claims submitted to the Plan.

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

Use modifier UD when billing for members on and after 61 days of hospice care.

Hospice providers can bill hospice room and board on the member's day of discharge from hospice if the member remains in the nursing facility after discharge from hospice. Hospice providers must use patient Status Code 30 (Still Patient).

Hospice providers cannot bill a hospice room and board for any day that it bills at the hospice inpatient respite care rate or general inpatient care rate for hospice services it provided to a member (130 CMR 437.426(B)(1)).

The service intentensity add-on (SIA) rate is an addition to the 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; and (c) Direct patient care is furnished by a registered nurse (RN) or social worker that RHC day. The time of a social worker's phone calls is not eligible for a SIA rate payment.

Hospice providers are to report diagnosis coding on the hospice claim, as required by ICD-10-CM Coding Guidelines. The principal diagnosis reported on the claim is the diagnosis most contributory to the terminal prognosis. The Plan follows CMS guidelines with respect to diagnoses that are not appropriate for reporting as principal diagnoses on hospice claims. See Attachment A. Hospice Invalid Principal Diagnosis Codes in CMS Transmittal R3032CP (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3032CP.pdf).

All of the member's coexisting or additional diagnoses that are related to the terminal illness and related conditions should be reported as secondary diagnoses on hospice claims.

Revenue Code	HCPCS Code - Modifier	Description
0651	G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes (Service intensity add-on for a minimum of 15 minutes and up to 4 hours per day.) (Use when billing for hospice services in member's last 7 days of life.)
0651	G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes (Service intensity add-on for a minimum of 15 minutes and up to 4 hours per day.) (Use when billing for hospice services in member's last 7 days of life.)
0651	T2042	Hospice routine home care; per diem (Use when billing for members in their first 60 days of hospice care.) (A 60-day gap in service is required to reset the service rate.)
0651	T2042 UD	Hospice routine home care; per diem (Use when billing for members on and after 61 days of hospice care.)
0652	T2043	Hospice continuous home care; per hour (within the county in which the provider is located)
0655	T2044	Hospice inpatient respite care; per diem
0656	T2045	Hospice general inpatient care; per diem
0658	T2046	Hospice long-term care, room and board only; per diem
0651	T2042 TN	Hospice routine home care; per diem (outside the county in which the provider is located)
0651	T2042 UD TN	Hospice routine home care; per diem (outside the county in which the provider is located) (Use when billing for members on and after 61 days of hospice care.)

0652	T2043 TN	Hospice continuous home care; per hour (outside the county in which the provider is located)

Place of service

This policy applies to hospice services rendered in all settings.

Policy history

Origination date: 03/01/2024
Previous revision date(s): January 2024 – Introduced as new payment policy.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.