DMHF Rules Matrix 4-18-24

Rule Summary	Bulletin Publication	Effective
R414-14A Hospice Care (Five-Year Review); The Department will continue this rule because it defines the scope of hospice care services available to Medicaid members.	**4-15-24**	**3-25-24**

The public may access proposed rules published in the State Bulletin at https://rules.utah.gov/publications/utah-state-bull/

State of Utah
Administrative Rule Analysis
Revised May 2023

FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION		
Title No. - Rule No.		
Rule Number:	**R414-14A**	**Filing ID: Office Use Only**
Effective Date:	**Office Use Only**	

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
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Please address questions regarding information on this notice to the persons listed above.

General Information

2. Rule catchline:

R414-14A. Hospice Care.

3. A concise explanation of the particular statutory provisions under which the rule is enacted and how these provisions authorize or require this rule:

Section 26B-3-108 requires the department to implement Medicaid through administrative rules, and Section 26B-1-213 grants the department the authority to adopt, amend, or rescind these rules. Additionally, 42 CFR 418 sets forth provisions of hospice care services for Medicaid members.

4. A summary of written comments received during and since the last five-year review of this rule from interested persons supporting or opposing this rule:

The department did not receive any written comments regarding this rule since its last five-year review.

5. A reasoned justification for continuation of this rule, including reasons why the agency disagrees with comments in opposition to this rule, if any:

The department will continue this rule because it is required by statute and defines the scope of hospice care services available to Medicaid members. As the department received no public comments, it did not respond to any comments.

Agency Authorization Information

To the agency: Information requested on this form is required by Section 63G-3-305. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin*.

Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	03/25/2024

Reminder: Text changes cannot be made with this type of rule filing. To change any text, please file an amendment or a nonsubstantive change.

R414. Health and Human Services, Integrated Healthcare.
R414-14A. Hospice Care.
R414-14A-1. Introduction and Authority.

This rule defines the scope of hospice care services available to Medicaid members. Authorization of this rule is in accordance with Sections 26B-1-213 and 26B-3-108, 42 CFR 418, Subsection 1861(dd) and Subsection1905(o) of the Social Security Act, 42 U.S.C. 1396d, and Pub L. No. 111 148 of the Affordable Care Act.

R414-14A-2. Definitions.

In addition to the definitions in Rule R414-1, the following definitions apply to this rule.

(1) "Adult" means a member who is 21 years of age or older.

(2) "Attending physician" means:

(a) an individual identified by the member when the member elects to receive hospice care as having the most significant role in determining and delivering the member's medical care; and

(b) a healthcare practitioner who is:

(i) a physician who is a doctor of medicine or osteopathy; or

(ii) a nurse practitioner or physician assistant who meets proper training, education, and experience requirements within their scope of licensing.

(3) "Cap period" means the 12-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in 42 CFR 418.309.

(4) "Consecutive months" means any number of months in a row wherein a hospice agency provides hospice care under the Medicaid benefit, including any portion of a month.

(5) "Continuous home care day" means a day in which a member, who has elected to receive hospice care at home, receives a minimum of eight aggregate hours of care from the hospice provider during a 24-hour day, which begins and ends at midnight. The eight aggregate hours of care must be predominantly nursing care provided by either a registered nurse or licensed practical nurse.

(6) "General inpatient care day" means a day when a member with elected hospice care receives general inpatient care for pain control or acute or chronic symptom management that is not manageable in the member's place of residence or another outpatient setting.

(7) "Hospice agency" means an agency licensed under Rule R432-750 and is primarily engaged in providing hospice care to terminally ill individuals.

(8) "Inpatient respite care day" means a day when a member with elected hospice care receives short-term inpatient care necessary to relieve family members or other persons caring for the member at their place of residence.

(9) "Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care addresses physical, intellectual, emotional, social, and spiritual needs while facilitating patient autonomy, access to information, and choice.

(10) "Pediatric" means a member who is under 21 years of age.

(11) "Pediatric hospice agency" means an enrolled hospice agency that has trained employees in providing hospice care to patients who are younger than 21 years of age.

(12) "Representative" means an individual who is authorized under state law to make health care decisions on behalf of a member, including initiating, continuing, refusing, or terminating medical treatments for a member who cannot make these decisions.

(13) "Terminally ill" means a medical prognosis to live no more than six months if the illness runs its ordinary course.

R414-14A-3. Member Eligibility Requirements.

(1) Hospice benefits are available to categorically and medically needy Medicaid-eligible individuals.

(2) A member, or representative if the member is incapacitated, must file an election statement with a hospice agency when choosing to use the hospice benefit.

(3) A member who has been assessed and provided with a written certification of terminal illness from a physician may obtain hospice services in accordance with 42 CFR 418.22.

(4) A member dually enrolled in Medicare and Medicaid must elect the hospice benefit for both Medicare and Medicaid in accordance with 42 CFR 418.21 and 418.24. The member must receive hospice coverage under Medicare primarily. Election for the Medicaid hospice benefit provides the member coverage for Medicare coinsurance and room and board expenses while admitted to a Medicare-certified nursing facility, intermediate care facility for people with an intellectual disability ICF/ID, or freestanding hospice facility.

(5) A primary diagnosis of debility or failure to thrive in adults does not meet eligibility criteria for the coverage of hospice services.

R414-14A-4. Program Access Requirements.

(1) The hospice agency must operate and furnish services in compliance with applicable federal, state, and local laws and regulations related to the health and safety of patients.

(2) The hospice agency must be licensed with the state, Medicare-certified in accordance with 42 CFR 418, and an enrolled Medicaid provider before initiating hospice services. At the time of a change of ownership, the previous owner's provider agreement terminates as of the effective date of the change of ownership.

(3) Medicaid accepts waivers granted to hospice agencies by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicare certification process.

(4) If a member who resides in a nursing facility, ICF/ID, or a freestanding hospice inpatient facility elects to receive hospice benefits, the hospice agency and the facility must have a written agreement in which a comprehensive service plan specifies the total care of the member.

(a) The agreement must outline that the hospice agency is responsible for the professional management of the member's hospice care.

(b) The facility agrees to provide room and board and services unrelated to the care of the terminal condition of the member.

(5) The agreement must include the following:

(a) identification of the services to be provided by the hospice agency and the facility as well as the method of care coordination to ensure services are consistent with the hospice approach to care and are organized to achieve the outcomes defined by the hospice plan of care;

(b) a stipulation that services may be provided only with the express authorization of the hospice agency;

(c) how the contracted services are coordinated, supervised, and evaluated by the hospice agency;

(d) the delineation of the roles of the hospice agency and the facility in the admission process that includes an assessment process, an interdisciplinary team care conference, and a service planning process;

(e) requirements for documenting that services are furnished following the agreement;

(f) the qualifications of the personnel providing the services; and

(g) the billing and reimbursement process by which the facility will bill the hospice agency for room and board to receive reimbursement from the hospice agency.

R414-14A-5. Service Coverage.

(1) Hospice service coverage includes medically necessary services as outlined in Subsection R414-1-2(18).

(2) Continuous home care is limited to alleviate or manage acute medical symptoms.

(a) Extended stay residents of nursing facilities are not eligible for continuous home care days.

(b) Continuous home care is covered only as required to maintain the terminally ill member at the member's place of residence.

(c) The hospice agency shall maintain documentation to support the requirement that the service was medically necessary and complied with an established plan of care.

(3) Medicaid covers hospice room and board in a nursing facility, ICF/ID, or a freestanding hospice inpatient facility and includes:

(a) medication administration;

(b) personal care;

(c) social activities;

(d) routine and therapeutic dietary services, including direct feeding assistance;

(e) maintaining the cleanliness of the member's room;

(f) assistance with activities of daily living (ADLs);

(g) durable medical equipment;

(h) medical supplies; and

(i) prescribed therapies.

(4) Other services unrelated to care associated with the terminal illness are covered under the Utah Medicaid State Plan nursing facility benefit.

(5) If a member who resides in a nursing facility revokes one's hospice benefits, the hospice agency shall notify the facility of the revocation. The following notification requirements apply:

(a) the notice must be in writing; and

(b) the hospice agency must provide the notification to the facility on or before the revocation date.

(6) A member may receive general inpatient care provided in a hospice inpatient unit, a hospital, or a nursing facility. General inpatient care days may not be used due to the breakdown of the primary caregiving living arrangements or the collapse of other sources of support for the member.

(7) Any change in hospice agencies must adhere to the requirements of 42 CFR 418.30. The member or the member's legal representative shall file the change with both the hospice agency from which care has been received and with the newly designated hospice agency on or before the effective date.

(8) A member or legal representative may voluntarily revoke the member's election of hospice benefits. The member or the member's representative must sign an acknowledgement that the member will forfeit hospice service coverage for any remaining days in the election period.

(9) Medicaid does not separately cover modalities for palliative purposes as this is the responsibility of the hospice agency. For the duration of an election for hospice care services, an individual waives rights to Medicaid payments for the following services.

(a) Hospice care provided by a hospice agency other than the hospice agency designated by the individual, unless provided under arrangements made by the designated hospice agency.

(b) Services for illnesses or conditions unrelated to the member's terminal illness, as these services are covered ancillary to hospice benefits when provided by an appropriate provider or facility.

(c) Any Medicaid services 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 provided by:

(i) the designated hospice agency;

(ii) another hospice agency under arrangements made by the designated hospice agency; and

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

(10) The following applies for concurrent care for members under 21 years of age.

(a) For the duration of the election of hospice care, pediatric members may only receive hospice care that is:

(i) provided by the designated hospice agency; or

(ii) provided under arrangements made by the designated hospice agency.

(b) Pediatric members who elect to receive hospice care services may also receive concurrent Medicaid State Plan services for the terminal illness and other related conditions.

(c) Medicaid does not separately cover any modalities for palliative purposes as this is the responsibility of the hospice agency.

(i) Hospice agencies that provide services outside of the hospice benefit shall report directly to Medicaid for coverage.

(ii) Hospice agencies are not responsible for reimbursing other providers or facilities for life-prolonging services given to pediatric members.

(d) Hospice agencies that perform pediatric care shall develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide hospice care services. Staff members and volunteers who provide pediatric hospice care services must receive training before providing hospice services and at least annually thereafter.

(11) The training shall include the following pediatric-specific elements:

(a) growth and development;

(b) pediatric pain and symptom management;

(c) loss, grief, and bereavement for pediatric families and the child;

(d) communication with family, community, and interdisciplinary team;

(e) psychosocial and spiritual care of children; and

(f) coordination of care with the child's community.

(g) Medicaid incorporates by reference standards for pediatric hospice care services set forth by the National Hospice and Palliative Care Organization, 2022.

(12) The hospice agency is responsible for notifying Medicaid when a member is enrolled in hospice care, when a member is discharged from hospice care, when a member moves into a long-term care facility, ICF/ID, or freestanding inpatient hospice facility, or when there has been a change in hospice agencies.

(13) If Medicare determines that a member is no longer eligible for Medicare coverage of hospice care services, then the member no longer qualifies for Medicaid coverage of hospice services. Subsequently, hospice agencies shall immediately notify Medicaid of the members change in eligibility upon learning of Medicare's determination. Medicaid coverage for hospice care services ends the day after Medicare notifies the hospice agency that the member is no longer eligible for hospice care.

(14) Hospice agencies may not initiate the discharge of a member from hospice unless the member meets the circumstances outlined in 42 CFR 418.26.

(15) Inpatient respite care follows special coverage requirements, which are outlined in 42 CFR 418.204 (b)(2).

(a) Medicaid does not cover inpatient respite care for members who reside in nursing facilities, ICF/IDs, or freestanding hospice inpatient units.

(b) Medicaid may not provide consecutive coverage for inpatient respite care for more than five days at a time.

R414-14A-6. Reimbursement.

(1) Hospice agency and provider reimbursement for hospice services are made in accordance with the methodologies outlined in the Utah Medicaid State Plan.

(2) Reimbursement for services provided during a capped period is limited to the cap amount and Medicaid does not apply the aggregate caps used by Medicare.

(3) Services provided in a veteran's administration hospital or military hospital are not reimbursable.

(4) The hospice provider may request an exception to the inpatient care reimbursement limitation if the hospice provider demonstrates the volume of Medicaid enrollees during the cap period was insufficient to reasonably achieve the required 20% ratio.

(5) Direct care provided by a hospice physician, related to the terminal illness or a related condition, are separately reimbursable.

(6) Service provided by members' attending physicians are separately reimbursable.

(7) Medicaid reimbursement covers the same services and amounts covered by the equivalent Medicare reimbursement rate for comparable service categories.

KEY: Medicaid
Date of Last Change: November 10, 2023
Notice of Continuation: April 8, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-213; 26B-3-108