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DATE: January 17, 2024

TO: Interested Parties

FROM: Michelle Probert, Director, MaineCare Services

Handwritten signature of Michelle Probert in black ink.

SUBJECT: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual Chapter II, Section 43, Hospice Services, and 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual Chapter III, Section 43, Allowances for Hospice Services.

This letter gives adoption notice of MaineCare Benefits Manual (the “MBM”) Chapter II, Section 43, Hospice Services and Chapter III, Section 43, Allowances for Hospice Services.

Chapter II Rule Changes:

1. Adds a requirement for Electronic Visit Verification (“EVV”) for Hospice Services delivered in-home. Federal Medicaid law mandates that EVV be utilized for personal care services and home health care services that require an in-home visit by a provider (42 U.S.C. Sec. 1396b(1)). The federal EVV requirement does not explicitly include Hospice services, however, to remain consistent with MaineCare efforts to prevent fraud, waste, and abuse for home-based services, EVV requirements are implemented for all Hospice Services delivered in-home. The adopted rule also clarifies that Physician Services are delivered and billed separately as described in MBM Ch. II, Section 90, and are exempt from EVV requirements. On February 6, 2023, CMS approved the Maine SPA which requires EVV for in-home hospice services. CMS, Maine state Plan, TN No 22-0044, Attachment 3.1-A, #18 (Hospice Care), Page 7, Effective Date: 1/1/23 (“The state will require Electronic Visit Verification System (EVV) requirements for in-home services effective January 1, 2023.”). Hence, EVV is mandated for these MaineCare Hospice Services by the Federal Government.

Facilities providing Hospice Services will not be subject to EVV, this requirement only applies to services offered within the member’s home. EVV implementation for all in-home Hospice Services, including those reimbursed at a per diem rate, will support the Department’s goal of improving oversight of Hospice Services and, in turn, reduce the occurrence of fraud, waste, and abuse in home settings. Providers may utilize the Department’s EVV system at no cost or may procure and utilize their own EVV system, so long as the Department’s EVV system can accept and integrate data from the provider-owned EVV system and the provider-owned system is otherwise compatible with the Department’s system and billing guidelines.

In response to comments, the Department changed the effective date of the EVV requirement from January 1 to July 1, 2024, in order to give providers more time.

2. Amends the definition of “Attending Physician” to include Nurse Practitioners and Physician Assistants. This is consistent with Section 51006 of the Bipartisan Budget Act (BBA) of 2018 (P. L. 115-123), as codified in 42 U.S.C. § 1395x(dd)(3)(B). The BBA considers Physician Assistants to be qualified to provide Hospice Services as an Attending Physician. Nurse Practitioners were qualified Attending Physicians in Section 1861(dd)(3)(B) of the Social Security Act (SSA) prior to the passing of the BBA. The adopted rule mirrors SSA statute, stating an Attending Physician must be a medical Doctor of Medicine or Osteopathy, Nurse Practitioner, or Physician Assistant licensed in the state of Maine.
3. Adds a definition for the term “Benefit Period” which appears multiple times throughout this rule to provide clarity.
4. Section 43.07-5 (Payment for Inpatient Care): Changes the date by which Hospice providers must submit inpatient data to the Department, upon Department request, from January 1st to October 1st, following the period ending September 30th of the previous year, in keeping with the federal fiscal year. This change grants providers additional time to compile and submit reports to the Department.
5. Adds Opioid Health Home Services to the list of services that may be continued after the election of hospice. The Department recognizes treatment for Substance Use Disorder may be required through the end of a member’s life. As such, MaineCare will reimburse for services under Chapter II, Section 93 Opioid Health Home Services and under Chapter II, Hospice Services provided concurrently.
6. Makes minor technical edits to improve the clarity of the rule.
7. Sec. 43.09: Adds a new section – Allowances for Hospice Services – which is largely moved from the Ch. III rule, which is being repealed. The Department will henceforth list the specific reimbursement rates on the MaineCare Fee Provider Schedule which is posted on the Department’s website, as authorized by 22 M.R.S. Sec. 3173-J(7). The Department, after OAG review, added language explaining the current methodology of annual adjustments to the reimbursement for the services. CMS has approved this methodology in the Maine Medicaid state Plan, and this is the methodology that has been utilized by the Department historically. In accordance with 22 M.R.S. Section 3173-J, the Department will not have to go through rulemaking if there is no change to this methodology and the rates are posted in accordance with this law.

Chapter III Rule Changes:

The Department repeals Ch. III.

Rules and related rulemaking documents may be reviewed at and printed from MaineCare Services website at <http://www.maine.gov/dhhs/oms/rules/index.shtml> or, for a fee, interested parties may request a paper copy of rules by calling 207-624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE:

10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Chapter II, Section 43, Hospice Services, and 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Chapter III, Section 43, Allowances for Hospice Services (repeal)

ADOPTED RULE NUMBER:

CONCISE SUMMARY:

The Department adopts this amended Chapter II, Section 43 rule and repeals Chapter III, Section 43.

1. Adds a requirement for Electronic Visit Verification (“EVV”) for Hospice Services delivered in-home. Federal Medicaid law mandates that EVV be utilized for personal care services and home health care services that require an in-home visit by a provider (42 U.S.C. Sec. 1396b(1)). The federal EVV requirement does not explicitly include Hospice services, however, to remain consistent with MaineCare efforts to prevent fraud, waste, and abuse for home-based services, EVV requirements are implemented for all Hospice Services delivered in-home. The adopted rule also clarifies that Physician Services are delivered and billed separately as described in MBM Ch. II, Section 90, and are exempt from EVV requirements. On February 6, 2023, CMS approved the Maine SPA which requires EVV for in-home hospice services. CMS, Maine state Plan, TN No 22-0044, Attachment 3.1-A, #18 (Hospice Care), Page 7, Effective Date: 1/1/23 (“The state will require Electronic Visit Verification System (EVV) requirements for in-home services effective January 1, 2023.”). Hence, EVV is mandated for these MaineCare Hospice Services by the Federal Government.

Facilities providing Hospice Services will not be subject to EVV, this requirement only applies to services offered within the member’s home. EVV implementation for all in-home Hospice Services, including those reimbursed at a per diem rate, will support the Department’s goal of improving oversight of Hospice Services and, in turn, reduce the occurrence of fraud, waste, and abuse in home settings. Providers may utilize the Department’s EVV system at no cost or may procure and utilize their own EVV system, so long as the Department’s EVV system can accept and integrate data from the provider-owned EVV system and the provider-owned system is otherwise compatible with the Department’s system and billing guidelines.

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See <http://www.maine.gov/dhhs/oms/rules/index.shtml> for rules and related rulemaking documents.

EFFECTIVE DATE: January 17, 2024

STATUTORY AUTHORITY: 22 M.R.S. §§ 42, 3173 and 3173-J

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SECTION 43

HOSPICE SERVICES

ESTABLISHED: 1/15/01
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43.01 **DEFINITIONS**

- 43.01-1 **Attending Physician** must be a medical doctor of medicine or osteopathy, nurse practitioner, or physician assistant licensed to practice in the State of Maine (or the state in which the services are provided). The Attending Physician provides services within the scope of practice of his or her profession as defined by Maine (or applicable law), identified by the member at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the member's medical care.
- 43.01-2 **Benefit Period** is the time period of consecutive days during which medical benefits for covered services, within certain maximum limits, are available to the Member.
- 43.01-3 **Department** means the Maine Department of Health and Human Services.
- 43.01-4 **Hospice** is any public, private or non-profit organization, or a subdivision of such an organization, that is primarily engaged in providing pain relief, symptom management, and support services to terminally ill members and their families. For a hospice to receive MaineCare reimbursement, it must be Medicare-certified and licensed under applicable state or provincial law.
- 43.01-5 **Hospice Services** are a range of interdisciplinary services provided twenty four (24) hours a day, seven days a week to a person who is terminally ill and to that person's family. These services are to be delivered in the least restrictive setting possible by volunteers and professionals who are trained to help the member with physical, social, psychological, spiritual and emotional needs related to the terminal illness with the least amount of technology possible. Services are focused on pain relief and symptom management and are not curative in nature.
- 43.01-6 **Interdisciplinary Team** is the team that manages the hospice services provided to the terminally ill member and the member's family. The team includes at least the following individuals: a doctor of medicine or osteopathy, a physician assistant, a registered nurse, a medical social worker and a counselor as outlined in Section 43.06-3. All individuals must be employees of the hospice, except the physician who may be a contractor of the hospice.
- 43.01-7 **Medical Director** must be a hospice employee or contractor who is a doctor of medicine or osteopathy licensed in the state in which services are provided, who has overall responsibility for the medical component of patient care at the hospice.
- 43.01-8 **Representative** is an individual authorized under state or provincial law to end medical care or to elect or revoke the election of hospice care on behalf of a terminally ill member who is mentally or physically incapacitated. For purposes of making health care decisions, a member's representative may also be a "guardian," "agent" or "surrogate," as these terms are defined in 18-C MRS § 5-802.

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43.01 **DEFINITIONS** (cont.)

43.01-9 **Terminal Illness** is a medical condition resulting in a prognosis that a member has a life expectancy of six (6) months or less if the illness runs its normal course.

43.02 **MEMBER ELIGIBILITY FOR CARE**

A member is eligible for covered hospice services if he or she meets both the General MaineCare financial eligibility requirements and the Hospice Services Eligibility Requirements, with the exception of the following: those members deemed eligible for coverage under Medicare hospice benefits shall not be eligible for services which would be duplicative under this Section.

43.02-1 **General MaineCare Eligibility Requirements**

Individuals must meet the financial eligibility criteria set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

43.02-2 **Hospice Services Eligibility Requirements**

- A. A member must be certified by a physician as having a terminal illness as set forth in Section 43.03-1, Certification of Terminal Illness; and
- B. The member or his or her Representative must elect hospice benefits in lieu of other MaineCare covered services as specified in Section 43.03-2 by completing an election statement as set forth in that section. Members under age 21 making said election do not waive any MaineCare covered services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

43.03 **MEMBER ELIGIBILITY PROCEDURE**

43.03-1 **Certification of Terminal Illness**

- A. No later than two (2) calendar days after the initiation of hospice care the hospice must obtain verbal certification of terminal illness from the Medical Director or the physician on the hospice's Interdisciplinary Team and the member's Attending Physician, if the member has an Attending Physician. The hospice must obtain written certification prepared by both the Medical Director or the physician on the hospice's Interdisciplinary Team and the member's Attending Physician (if he/she has one) and submit a copy of the certification to: Office of MaineCare Services, Classification Review, 11 State House Station, Augusta, ME 04333-0011, before submitting any claim for payment.

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43.03 **MEMBER ELIGIBILITY PROCEDURE** (cont.)

- B. With respect to any subsequent election of hospice benefits, the hospice must obtain written certification of the member's terminal illness from the Medical Director or the physician on the hospice's Interdisciplinary Team before submitting the claim for payment.

- C. The certification must include:
 - 1. The statement that the member's life expectancy is six (6) months or less if the terminal illness runs its normal course; and
 - 2. The signature(s) of the physician(s).

The hospice must keep the certification statement(s) in the member's record.

43.03-2 **Election/Revocation of Hospice Benefits**

A member or his/her Representative must choose hospice care by filing an election statement. An election will remain effective as long as the member remains in the care of the hospice and does not revoke the election, regardless of the number of benefit periods elapsed. A new election statement must be filed if the member seeks to obtain hospice care after such benefits have been revoked. A member may designate the effective date for hospice benefits as the first or any subsequent day of hospice care, but the effective date may not be earlier than the date of election.

A. Contents of Election Statement

The election statement must include:

- 1. Identification of the hospice that will provide care to the member;
- 2. The member's or Representative's acknowledgment that he or she fully understands the palliative rather than curative nature of the hospice care related to the terminal illness;
- 3. The member's or Representative's acknowledgment that he or she understands that the MaineCare services listed in Section 43.03-2(B) and Section 43.05-4 are waived (or subject to limitations) by the election and that the member may be held financially liable for obtaining said services;
- 4. The effective date of the election; and

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43.03 **MEMBER ELIGIBILITY PROCEDURE** (cont.)

5. The signature of the member or Representative.

The hospice must keep the election statement(s) in the member's record.

The hospice must ensure that the member and/or Representative is adequately educated with regard to services waived by the hospice election and financial responsibility of the member for obtaining services that may duplicate services covered under this Section. This education should inform members under the age of 21 or their representatives that medically necessary services are not waived when electing hospice services provided that these services are not duplicative of hospice services.

B. Waiver of Other MaineCare Benefits

For the duration of the election of hospice care a member waives all rights to MaineCare benefits for the following services only:

1. Hospice care provided by a hospice other than the one designated by the member (unless provided under arrangements made by the designated hospice, or when transferring to another hospice program, see Section 43.03-3);
2. Any MaineCare services related to the treatment of the terminal condition for which hospice care was elected, or services that are determined to be related to the treatment of the member's condition (with respect to which a diagnosis of terminal illness has been made); and
3. Any MaineCare services equivalent to hospice care, except for services:
 - a. provided either directly or arranged by the designated hospice;
 - b. provided by the member's Attending Physician if he or she is not employed by the designated hospice or does not receive payment from the hospice for those services; or
 - c. provided as room and board by a nursing facility if the member is a resident.

See Section 43.05 for additional provisions related to covered and non-covered services.

43.03 **MEMBER ELIGIBILITY PROCEDURE** (cont.)

C. Revoking the Election of Hospice Care

A member or representative may revoke the election of hospice care at any time by filing a revocation statement with the hospice which includes a signed statement that: a) the member revokes the election for MaineCare coverage of hospice care for the remainder of that benefit period and b) the effective date of the revocation. The effective date may not be earlier than the revocation. Any days that are remaining in that benefit period are forfeited as of the effective date of the revocation. The member may re-elect hospice care at any time. He/she does not have to wait until the previous benefit period would have been completed if the revocation had not occurred.

Upon revoking hospice care, the member resumes coverage of MaineCare benefits waived upon election of hospice care. A person may elect/ revoke hospice care as many times as he or she chooses as long as he or she continues to meet the eligibility standards in Section 43.02. The hospice must forward a copy of the completed revocation statement and the Notice of Consumer Transfer/Death BMS/CS 34 to: Classification Review Unit, Office of MaineCare Services, 11 State House Station, Augusta, ME 04333-0011. The hospice must keep the revocation statement(s) in the member's record. Even if a member has revoked hospice care one or more times, the member is only eligible for a lifetime total of two ninety (90)-day benefits periods (followed by an unlimited number of subsequent sixty (60)-day periods).

43.03-3 **Changing From One Hospice to Another**

- A. A member may change hospice providers once in each benefit period. The change of hospice is not considered a revocation of the election of hospice services.
- B. To change hospice providers, a member shall file a signed statement with the hospice where the member was initially enrolled and with the new hospice. If appropriate, the hospice shall assist the member with preparation of the statement. The statement shall include:
 - 1. The hospice from which the member received hospice services;
 - 2. The hospice from which the member will receive services; and
 - 3. The date the change is effective.
- C. In order to change providers, notification must be sent to the Department on the Notice of Consumer Transfer/Death BMS/CS 34 by the hospice to which the member is transferring.

43.04 DURATION OF CARE

The hospice benefit has two (2) ninety (90)-day benefit periods, followed by an unlimited number of subsequent sixty (60)-day benefit periods. At the beginning of each benefit period the hospice must obtain a new Certification of Terminal Illness.

43.05 COVERED SERVICES

43.05-1 Covered Services

Covered hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. To be covered, all services must be in accordance with the plan of care and approved by the Interdisciplinary Team. Services unrelated to the terminal illness which affect the plan of care must be reflected in the plan in order to assure coordination and non-duplication of services.

The following are considered covered hospice services. Unless noted otherwise, reimbursement shall be based on a per diem or hourly rate, and in accordance with the provisions described in Section 43.07.

- A. Physician Services (see Section 43.07-3 for further details).
- B. Nursing Services provided by or under the supervision of a registered nurse.
- C. Medical Social Services provided by a medical social worker working under the supervision of a physician.
- D. Counseling Services must be available to the member and family members or others caring for the member at home, including dietary, spiritual and other counseling. Counseling may be given both for the purpose of training caregivers to provide care, and for the purpose of helping the member and those caring for him or her to adjust to the member's approaching death.
- E. Home Health Aide Services furnished by certified home health aides and certified nursing assistants. Home health aides may provide personal care and household services essential to the comfort and cleanliness of the member and maintaining a safe and healthy environment to allow implementation of the plan of care. Aide services must be provided under the general supervision of a registered nurse.

Home health aide services can include the provision of homemaker services. Homemaker services include maintenance of a safe and healthy environment and services that enable the member to carry out the plan of care.

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43.05 **COVERED SERVICES** (cont.)

- F. Medical Supplies, Drugs and Biologicals are covered only when used primarily for the relief of pain and symptom control related to the member's terminal illness. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to relief or management of the terminal illness. Equipment is provided by the hospice for use in the member's home while under hospice care. Medical supplies include those that are part of the written plan of care.
- G. Short-Term Inpatient Care provided in a participating hospice inpatient unit or a participating hospital or nursing facility which meets the special hospice standards regarding staffing and patient areas. Participating facilities are defined as those with which the hospice has a contract that provides for all requirements contained within the Medicare Hospice conditions of participation. Inpatient services must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for individuals caring for the member at home.
- H. Physical, Occupational and Speech/Language Therapy provided for symptom control or to allow the member to perform daily living activities and basic functional skills.
- I. Special Modalities, including chemotherapy, radiation therapy, and other modalities that may be used for palliative purposes if it is determined that these services are needed for palliation. This determination is based on the member's condition and philosophy of care giving of the hospice. No additional MaineCare reimbursement shall be provided, regardless of the cost of the services.
- J. Ambulance Services, when the medical condition requiring ambulance transport is a result of the member's terminal illness.
- K. Other Items and Services specified in the plan of care for which payment may otherwise be made. This item reflects the hospice's responsibility for providing any and all services in the plan of care necessary for the relief and management of the terminal illness and related conditions.

43.05-2 **Special Coverage Requirements**

Bereavement counseling consists of counseling services provided to the member's family for up to one (1) year after the member's death. It is a required hospice service but is not separately billable.

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43.05 **COVERED SERVICES** (cont.)

43.05-3 **Room and Board Services for Nursing Facility Residents**

The following services shall be included as room and board services and shall be provided by the nursing facility for those MaineCare members who elect to receive hospice while residing in the nursing facility:

- A. Performance of personal care services;
- B. Assistance in activities of daily living
- C. Administration of medication;
- D. Maintaining cleanliness of resident's room; and
- E. Supervising and assisting with the use of durable medical equipment and prescribed therapies.

43.05-4 **Coverage Restrictions During Hospice Election**

A. **Medically Necessary/Non-Duplicative Services**

A Member receiving hospice services may obtain other medically necessary services (as defined by the Department) that are not duplicative of hospice services or unrelated to a member's terminal illness. The provider must appropriately document services rendered in the member record, in accordance with Department specifications. These services are subject to the same coverage provisions, limitations, prior authorization requirements and conditions applied to services available to non-hospice MaineCare members. (All services, related to and unrelated to the terminal illness, must be consistent with the plan of care.) These services are reimbursable by MaineCare outside of the hospice rate.

The services include:

1. Ambulance Services - Chapter II, Section 5, when the medical condition requiring ambulance transport is unrelated to the terminal illness for which the member is receiving services under this Section.
2. Speech and Hearing Services - Chapter II, Section 109
3. Consumer Directed Attendant Services - Chapter II, Section 12, subject to additional restrictions that may be outlined in that Section
4. Chiropractic Services - Chapter II, Section 15
5. Family Planning Agency Services - Chapter II, Section 30
6. Home Health Services - Chapter II, Section 40 subject to additional restrictions that may be outlined in that Section
7. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Chapter II, Section 94.
8. Transportation Services - Chapter II, Section 113
9. Podiatric Services - Chapter II, Section 95
10. Private Duty Nursing and Personal Care Services - Chapter II, Section 96, subject to additional restrictions that may be outlined in that Section

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43.05 **COVERED SERVICES** (cont.)

11. Behavioral Health Services - Chapter II, Section 65
12. Medical Supplies and Durable Medical Equipment - Chapter II, Section 60
13. Medical Imaging Services - Chapter II, Section 101
14. Occupational Therapy Services - Chapter II, Section 68
15. Physical Therapy Services - Chapter II, Section 85

B. Continuation of Services

In order to maintain activities of normal life for as long as possible, certain MaineCare services may be continued after the hospice election for those members who have been receiving these services for a substantial period of time prior to the hospice election.

These services include:

1. Targeted Case Management Services - Chapter II, Section 13
2. Community Support Services - Chapter II, Section 17
3. Developmental & Behavioral Clinic Services - Chapter II, Section 23
4. Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations - Chapter II, Section 28
5. Day Health Services - Chapter II, Section 26
6. Rehabilitative Services - Chapter II, Section 102
7. Behavioral Health Homes Services - Chapter II, Section 92
8. Behavioral Health Services - Chapter II, Section 65
9. Psychiatric Hospital Services - Outpatient services only, Chapter II, Section 46
10. Opioid Health Home Services – Chapter II, Section 93
11. Private Non-Medical Institution Services - Chapter II, Section 97

There may be instances where it is appropriate to allow individual hospice members to receive these services even if they did not receive them prior to electing the hospice benefit. However, the provider must show that services are medically necessary given the member's terminal condition, and are coordinated with the hospice plan of care. These services are reimbursable by MaineCare outside of the hospice rate.

C. Home and Community Benefits

Eligibility for and limits on home and community benefits for members of hospice care are delineated in the relevant section of Chapter II of the *MaineCare Benefits Manual* (MBM).

43.06 **POLICIES AND PROCEDURES**

43.06-1 **Member Service Provision Rights**

Receipt of hospice services in no way affects the rights afforded to residents of a nursing facility under Chapter II, Section 67, including those relating to transfer and discharge, status change notification and hearings and appeals.

The election of hospice by a member, however, in no way diminishes the responsibility of the member or nursing facility to obtain required prior authorization, or to comply with eligibility requirements for nursing facility placement.

43.06-2 **Member Status Change**

A. The billing provider must notify the Department of the following changes in consumer status:

1. Admission to or discharge from a nursing facility
2. Transfer from one nursing facility to another
3. Entry into or exit from hospice status
4. Transfer from one hospice to another
5. Member death.

B. As applicable, the following forms must be used:

1. Notice of Consumer Transfer/Death BMS/CS 34
2. Election/Revocation of Hospice
3. Certification of Terminal Illness

C. **Hospice enrollee in a nursing facility (NF)**

This section delineates who is responsible for submitting notification for hospice members who are in a NF.

1. When the change of status involves only the nursing facility, the NF must submit information as outlined in Chapter II, Section 67, of the MBM.
2. When the change of status involves only the hospice (including, but not limited to, election/ revocation) the hospice must submit the appropriate election or revocation form.
3. When the change of status is a transfer from one hospice to another, the hospice to which the member is moving must submit the BMS 34 form.
4. When the change of status involves both the hospice and the nursing facility (e.g. member death) the NF is responsible for submitting the BMS 34 form.

43.06 **POLICIES AND PROCEDURES** (cont.)

D. Members who are in hospice only

When the change of status is a transfer from one hospice to another, the hospice to which the member is moving must submit the BMS 34 form.

43.06-3 **Professional and Other Qualified Staff**

The hospice is responsible for the verification of appropriate licensure, certification or other qualifications of hospice staff, and for monitoring service providers. The hospice must maintain documentation of qualifications of service providers.

Staff must meet orientation and training requirements outlined in hospice licensing regulations.

A. The following professionals, employed directly or by contract with a hospice, by virtue of possession of a current license to practice their discipline in the State of Maine or state or province in which the service is provided, may provide hospice services within the scope of their license:

1. Physician
2. Physician Assistant
3. Registered Nurse
4. Practical Nurse
5. Clinical, Dietary and Pastoral Counselors
6. Physical Therapist
7. Physical Therapist Assistant
8. Occupational Therapist Registered (OTR)
9. Certified Occupational Therapy Assistant (COTA)
10. Medical Social Worker
11. Speech-Language Pathologist
12. Speech-Language Pathology Assistant

B. The following staff, employed directly or by contract with a hospice, may provide hospice services within the scope of their license or certification when they meet the following requirements:

1. Certified Home Health Aide and Certified Nursing Assistant (CNA)

A CNA or home health aide must be listed on the Maine Registry of Certified Nursing Assistants. A CNA or home health aide must be supervised as required by licensing regulations.

43.06 **POLICIES AND PROCEDURES** (cont.)

2. **Other Qualified Staff**

Other qualified staff are staff members, other than those defined above, who have been determined competent by a health care professional and documented by the hospice to have appropriate education, training and experience for the task in the plan of care for which they have been hired.

43.06-4 **Written Plan of Care**

A plan of care must be established before services are provided. The plan of care must be established by the member's Attending Physician, the hospice physician, and the Interdisciplinary Team. Services must be consistent with the plan of care to be reimbursed. The hospice must designate a registered nurse, whose responsibility it is to coordinate the implementation of the plan, and to provide assurance that the member receives necessary care and services on a 24-hour basis. The 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.

43.06-5 **Member Record**

All hospices must maintain a clinical record for each member receiving care and services. The clinical record must include the following information:

- A. The plan of care;
- B. The member's name, MaineCare ID, address, sex, age, and next of kin;
- C. Election/Revocation forms;
- D. Pertinent medical history;
- E. Certification of Terminal Illness; and
- F. Complete documentation of all services and events, including: assessments, progress notes and reviews of the plan of care. Progress notes must be maintained in conformance with Medicare conditions of participation.

43.06-6 **Surveillance and Utilization Review**

The Department shall perform the Surveillance and Utilization Review activities set forth in Chapter I, General Administrative Policies and Procedures, of the MBM.

Upon request, the provider will furnish to the Department, with no additional charge, the clinical records, or copies thereof, corresponding to and substantiating services billed by that provider.

43.05 **COVERED SERVICES** (cont.)

43.06-7 **Electronic Visit Verification**

Effective July 1, 2024, all Hospice Services provided in-home are subject to the following requirements:

- A. Providers must utilize the Department's Electronic Visit Verification (EVV) system at no cost or procure and utilize their own EVV system, so long as the Department's EVV system can accept and integrate data from the provider-owned EVV system and the provider-owned system is otherwise compatible with the Department's system and billing guidelines.
- B. Visits conducted as part of such services shall be electronically verified with respect to:
 - 1. Type of service performed;
 - 2. Individual receiving the service;
 - 3. Date of the service;
 - 4. Location of the service;
 - 5. Individual providing the service; and
 - 6. Time the service begins and ends.
- C. Hospice Services delivered in facility settings are exempt from EVV requirements.
- D. Physician Services are delivered and billed as described in Section 90, and are exempt from EVV requirements.

43.07 **REIMBURSEMENT**

43.07-1 **Levels of Care**

Each day of care is classified into one of four levels of care:

- 1. Routine Home Care
- 2. Continuous Home Care
- 3. Inpatient Respite Care
- 4. General Inpatient Care

For each day a member receives hospice care, the hospice will be reimbursed an amount applicable to the type and intensity of the services provided to the member for that day. For continuous home care, payment is determined based on the number of hours of continuous care furnished that day. A description of each level of care follows.

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43.07 **REIMBURSEMENT** (cont.)

- A. **Routine Home Care** rate is billed for each day the member is under the care of the hospice and not receiving one of the other categories of hospice care.

In-home respite care may also be billed as Routine Home Care, as long as the respite providers are qualified to perform Routine Home Care services under this Section.

- B. **Continuous Home Care** is to be provided only during a period of crisis. A period of crisis is a period in which a member requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or licensed practical nurse, and a nurse must be providing care for more than half of the period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day beginning at midnight. This care need not be continuous. For example, four (4) hours could be provided in the morning and another four (4) hours that evening. Homemaker and home health aide services may also be provided to supplement the nursing care. Continuous care is covered when it is provided to maintain a member at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

- C. **Inpatient Respite Care** is a day of care in which the member receives care in an approved facility for short-term respite only when necessary to relieve the family members or others caring for the member at home. Respite care may be provided only occasionally and may not be reimbursed at the inpatient respite care rate for more than five (5) consecutive days at a time. Payment for the sixth (6th) and any subsequent day is at the routine home care rate.

Respite care may not be provided when the member is in a nursing home or any other residential facility. For in-home respite care, refer to Section 43.07-1(A), Routine Home Care.

- D. **General Inpatient Care** is a day of care when a member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

43.07-2 **Reimbursement Policy**

Reimbursement for covered services shall be made on the basis of a per diem, quarter hour, or hourly rate and shall be the lowest of:

- A. The amount established by the Department and listed in the MaineCare Provider Fee Schedule; or

43.07 **REIMBURSEMENT** (cont.)

- B. The lowest amount allowed under the Medicare Hospice benefit for covered services with the following exception:

For Routine Home Care only, as is described in Section 43.07-1(A) of this rule, that is rendered on or after April 1, 2002, the lowest rate of MaineCare reimbursement shall be equal to 123% of the Medicare rate.

43.07-3 **Payment for Routine Home Care**

A. Routine Home Care Payment

There are two routine home care payment rates. There is a higher payment for the first sixty (60) days of hospice care and a reduced payment for days thereafter. Hospice providers are required to set their charge rate to appropriately reflect the transition to the lower Routine Home Care rate after sixty (60) days.

If a member revokes his or her election of hospice benefits, or otherwise exits from routine home care hospice status during the first sixty (60) days of routine home care, and later returns to routine home care hospice status, the revocation or exit of routine home care hospice status must last more than sixty (60) days in order for the higher payment to begin again. If the exit status is less than sixty (60) days, then the sixty (60) day count will continue as if the exit status has not occurred.

B. Service Intensity Add-On (SIA) Payment

A service intensity add-on payment will be made for a visit (not telephone or electronic) by a registered nurse (RN) or a clinical social worker when provided during routine home care in the last seven (7) days of a member's life.

The SIA payment is in addition to the routine home care rate. Payment is made only for services of at least fifteen (15) minutes and up to a total of four (4) hours of services provided (for a total of both RN and clinical social worker services) that occurred on the day of service.

In accordance with Chapter I of the *MaineCare Benefits Manual*, the provider must seek payment from any other available sources before billing MaineCare. MaineCare shall not provide differential payments to hospices that have entered into reimbursement agreements with other payers.

43.07 **REIMBURSEMENT** (cont.)

43.07-4 **Payment for Physician Services**

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the member's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements with the hospice. These activities would generally be performed by the Medical Director and the physician on the Interdisciplinary Team. Team activities would include participation in developing plans of care, supervision of care and services, periodic review and update of plans of care and establishing governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care and inpatient respite care.

Payment will be made to the hospice, when it also meets the provider enrollment requirements for services described in the *MaineCare Benefits Manual* under Section 90, "Physician Services," for other physician services not included in the reimbursement rates for routine home care, continuous home care and inpatient respite care. These include direct member care services, furnished to individual members by hospice employees and under arrangements made by the hospice, unless the member care services were furnished on a volunteer basis. The hospice will be reimbursed in accordance with the usual MaineCare reimbursement policy for Physician Services in Chapter II, Section 90 of the *MaineCare Benefits Manual*. This reimbursement is in addition to the daily rates.

43.07-5 **Payment for Inpatient Care**

Payment for inpatient care is limited. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of reimbursable inpatient days (both for inpatient general care and respite care) shall be capped. The aggregate number of reimbursable inpatient days may not exceed twenty (20) percent of the aggregate days of hospice care provided to all MaineCare members during that twelve (12) month period by the hospice provider. Days of inpatient care provided to members with AIDS (acquired immunodeficiency syndrome) may be excluded from the days counted toward the twenty (20) percent limit.

If the total number of days of inpatient hospice care furnished to MaineCare members is less than or equal to the maximum, no adjustment shall be made. If the total number of days of inpatient care exceeds the maximum allowable number, excess payments must be refunded by the hospice to the Department.

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43.07 **REIMBURSEMENT** (cont.)

If requested, the hospice shall report to the Department the aggregate number of inpatient days (both for inpatient general care and inpatient respite care) and the aggregate number of days of hospice care provided to all MaineCare members during the “cap” period. The report shall be sent by October 1st following the end of the period (September 30 of the previous year) to:

Hospice Benefits
Division of Financial Services-Long Term Care Reimbursement
Office of MaineCare Services
11 State House Station
Augusta, ME 04333-0011

43.07-6 **Payment Based on Location Where Care is Provided**

Hospice providers must submit claims for payment for hospice care furnished in a member’s home or a nursing facility based on the place of service, rather than the location of the hospice.

43.08 **BILLING**

Billing must be accomplished in accordance with the Department's billing requirements as set forth at <https://mainecare.maine.gov>.

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43.09 ALLOWANCES FOR HOSPICE SERVICES

REVENUE CODE	HCPC CODE	DESCRIPTION OF SERVICES	UNITS OF SERVICE
0651	T2042	Routine Home Care	Per Diem
0551	G0299	Service Intensity Add-On (direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting	Per ¼ Hour
0561	G0155	Service Intensity Add-On (services of a clinical social worker in the home health or hospice setting	Per ¼ Hour
0652	T2043	Continuous Home Care	Per Hour
0655	T2044	Inpatient Respite Care	Per Diem
0656	T2045	General Inpatient Care	Per Diem
0657	Appropriate CPT Code	Physician Services non hospice services	N/A

Specific reimbursement rates are listed on the MaineCare Provider Fee Schedule, which is posted on the Department’s web site in accordance with 22 M.R.S. Sec. 3173-J(7).

Rates for Routine Home Care services, both days 1-60 and days over 60, are reimbursed at 123% of the CMS published Medicaid rates, effective October 1 annually, plus an adjustment for regional differences in wages using the hospice wage index.

Continuous Home Care, Inpatient Respite Care, General Inpatient Care and the Service Intensity Add-On services are reimbursed at 100% of the CMS published Medicaid rates, effective October 1 annually, plus an adjustment for regional differences in wages using the hospice wage index.

Hospice providers will be reimbursed a per diem amount to cover room and board services provided by the nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID) for MaineCare members who have elected hospice care and reside in the NF or ICF-IID. This reimbursement rate is equal to 95 percent (95%) of the base rate paid to that particular facility of residence.

Failure by a hospice provider to comply with the Medicare quality reporting requirements during each fiscal year will result in a two percent (2%) reduction to the market basket update applied prospectively to the following hospice rate year.