Division of Medical Assistance Programs
Policy and Planning Section

Hospice Services Administrative Rulebook

Chapter 410, Division 142

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410-142-0020 Definitions

(1) Accredited/Accreditation: A designation by an accrediting organization that a hospice program has met standards that have been developed to indicate a quality program.

(2) Ancillary staff: Staff that provides additional services to support or supplement hospice care.

(3) Assessment: Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

(4) Attending physician: A physician who is a doctor of medicine or osteopathy and is identified by the client, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care.

(5) Bereavement counseling: Counseling services provided to the client's family before and after the client's death. Bereavement counseling is required to be offered per the Conditions of Participation and is a non-reimbursable hospice service.

(6) Bundled Rate: the Nursing Facility (NF) rate as defined in 411-070-0085.

(7) Client-family unit includes a client who has a life threatening disease with a limited prognosis and all others sharing housing, common ancestry or a common personal commitment with the client.

(8) Conditions of Participation (CoPs): The applicable federal regulations that hospice programs are required to comply with in order to participate in the federal Medicare and Medicaid programs.

(9) Coordinated: When used in conjunction with the phrase "hospice program," means the integration of the interdisciplinary services provided by client-family care staff, other providers and volunteers directed toward meeting the hospice needs of the client.

(10) Coordination of Care (COC): The federal regulations for coordination of client care between the hospice and the nursing facility that hospice programs are required to comply with in order to serve hospice clients in a nursing facility and participate in the federal Medicare and Medicaid programs.

(11) Coordinator: A registered nurse designated to coordinate and implement the care plan for each hospice client.

(12) Counseling: A relationship in which a person endeavors to help another understand and cope with problems as a part of the hospice plan of care.

(13) Curative: Medical intervention used to ameliorate the disease.

(14) Dying: The progressive failure of the body systems to retain normal functioning, thereby limiting the remaining life span.

(15) Family: The relatives and/or other significantly important persons who provide psychological, emotional, and spiritual support of the client. The "family" need not be blood relatives to be an integral part of the hospice care plan.

(16) Hospice: A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill clients, and is certified by the federal Centers for Medicare and Medicaid Services as a program of hospice services meeting current standards for Medicare and Medicaid reimbursement and Medicare Conditions of Participation; and currently licensed by the Oregon Health Authority (Authority), Public Health Division.

(17) Hospice continuity of care: Services that are organized, coordinated and provided in a way that is responsive at all times to client/family needs, and which are structured to assure that the hospice is accountable for its care and services in all settings according to the hospice plan of care.

(18) Hospice routine home care: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to client/family in the place of residence. The hospice will deliver at least 80 percent of the care in the place of residence.

(19) Hospice philosophy: Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, clients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

(20) Hospice Program: A coordinated program of home and inpatient care, available 24 hours a day, that uses an interdisciplinary team of personnel trained to provide palliative and supportive services to a client-family unit experiencing a life threatening disease with a limited prognosis. A hospice program is an institution for purposes of ORS

(21) Hospice Program registry: A registry of all licensed hospice programs maintained by the Authority, Public Health Division.

(22) Hospice services: Items and services provided to a client/family unit by a hospice program or by other clients or community agencies under a consulting or contractual arrangement with a hospice program. Hospice services include home care, inpatient care for acute pain and symptom management or respite, and bereavement services provided to meet the physical, psychosocial, emotional, spiritual and other special needs of the client/family unit during the final stages of illness, dying and the bereavement period.

(23) Illness: The condition of being sick, diseased or with injury.

(24) Interdisciplinary team: A group of individuals working together in a coordinated manner to provide hospice care. An interdisciplinary team includes, but is not limited to, the client-family unit, the client's attending physician or clinician and one or more of the following hospice program personnel: Physician, nurse practitioner, nurse, hospice aide (nurse's aide), occupational therapist, physical therapist, trained lay volunteer, clergy or spiritual counselor, and credentialed mental health professional such as psychiatrist, psychologist, psychiatric nurse or social worker.

(25) Medical director: The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's client care program.

(26) Medicare certification: Licensed and certified by the Authority, Public Health Division as a program of services eligible for reimbursement.

(27) Nursing facility: A facility licensed and certified by the Department of Human Services (Department) as a nursing facility and defined in OAR 411-070-0005.

(28) Nursing facility services: The bundled rate of services which incorporates all services, including room and board, for which the nursing facility is paid per OAR 411-070.

(29) Pain and Symptom Management: For the hospice program, the focus of intervention is to maximize the quality of the remaining life through the provision of palliative services that control pain and symptoms. Hospice programs recognize that when a client/family is faced with terminal illness, stress and concerns may arise in many aspects of their lives. Symptom management includes assessing and responding to the physical, emotional, social and spiritual needs of the client/family.

(30) Palliative services: Comfort services of intervention that focus primarily on reduction or abatement of the physical, psychosocial and spiritual symptoms of terminal illness. Palliative therapy:

(a) Active: Is treatment to prolong survival, arrest the growth or progression of disease. The person is willing to accept moderate side-effects and psychologically is fighting the disease. This person is not likely to be a client for hospice;

(b) Symptomatic: Is treatment for comfort, symptom control of the disease and improves the quality of life. The person is willing to accept minor side-effects and psychologically wants to live with the disease in comfort. This person would have requested and been admitted to a hospice.

(31) Period of crisis: A period in which the client requires continuous care to achieve palliation or management of acute medical symptoms.

(32) Physician designee: Means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

(33) Primary caregiver: The person designated by the client or representative. This person may be family, a client who has personal significance to the client but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. The primary caregiver assumes responsibility for care of the client as needed. If the client has no designated primary caregiver the hospice may, according to client program policy, make an effort to designate a primary caregiver.

(34) Prognosis: The amount of time set for the prediction of a probable outcome of a disease.

(35) Representative: An individual who has been authorized under state law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill client who is mentally or physically incapacitated.

(36) Terminal illness: An illness or injury which is forecast to result in the death of the client, for which treatment directed toward cure is no longer believed appropriate or effective.

(37) Terminally Ill means that the client has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(38) Volunteer: An individual who agrees to provide services to a hospice program without monetary compensation.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0040 Eligibility for the Hospice Services

(1) Hospice services are covered for clients who have:

(a) Been certified as terminally ill in accordance with OAR 410-1420060, and;

(b) Oregon Health Plan (OHP) Plus or OHP Standard benefit package coverage.

(2) Providers must bill Medicare for hospice services for clients with Medicare Part A coverage. Medicare's payment is considered payment in full.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0060 Certification of Terminal Illness

(1) In order to receive reimbursement from the Division of Medical Assistance Programs (Division), the hospice must obtain and retain a physician's written certification of a client's terminal illness in accordance with the following procedures. The Division will not pay for services provided prior to certification.

(2) The attending physician is a doctor of medicine or osteopathy or a nurse practitioner and is identified by the client at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the client's medical care. A nurse practitioner serving as the attending physician may not certify or recertify the terminal illness.

(3) Certifications may be completed up to two weeks before hospice care is elected.

(4) The certification of a client who elects hospice is based on the physician's or medical director's clinical judgment regarding the normal course of the client's illness and must include:

(a) The statement that the client's medical prognosis indicates a life expectancy of six months or less if the terminal illness runs its normal course; and

(b) Clinical information and other documentation which support the medical prognosis must accompany the certification and be filed in the medical record with the certification.

(5) A written certification signed by the physician(s) must be on file in the hospice client's record prior to submission of a claim to the Division for all benefit periods.

(6) For the initial period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the client's

attending physician (if the client has an attending physician). If the written certification is not dated, a notarized statement or some other acceptable documentation may be obtained to verify the actual certification date.

(7) For any subsequent periods, the hospice must obtain, no later than two calendar days after the first date of each period, a written certification from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days.

(8) The requirements specified in this rule also apply to clients who had been previously discharged during a benefit period and are again being certified for hospice care.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0080 Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form has been obtained for every individual, either from the individual or representative as defined in OAR 410-142-0020. The form must specify the type of care and services that may be provided as hospice care during the course of the illness.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0100 Election of Hospice Care

(1) An individual who meets the eligibility requirements of OAR 410142-0040 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative may file the election statement.

(2) The election statement must include the following:

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

(b) The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;

(c) Except for children (see 410-124-0110), acknowledgment that certain otherwise covered services are waived by the election. Election of a hospice benefit means that the Division of Medical Assistance Programs (Division) will only reimburse the hospice for those services included in the hospice benefit;

(d) The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement;

(e) The signature of the individual or representative.

(3) Re-election of hospice benefits. If an election has been revoked in accordance with OAR 410-142-0160, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

(4) File the election statement in the medical record.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0110 Concurrent Care for Children

(1) Under Section 2302 of the Affordable Care Act, Medicaid or Children's Health Insurance Program (CHIP) eligible children are eligible to receive curative treatment upon the election of the hospice benefit.

(2) The criteria for receiving hospice services does not change for children eligible for Medicaid and CHIP programs. However these children may now receive hospice services without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition.

(3) All other eligibility, coverage, and hospice rules for the Division of Medical Assistance Programs apply.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0120 Duration of Hospice Care

(1) An eligible individual 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;

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

(2) An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(a) Remains in the care of a hospice; and

(b) Does not revoke the election under the provisions of OAR 410142-0160.

(3) For the duration of an election of hospice care, an individual waives all rights to the Division of Medical Assistance Programs' (Division) payments for the following services:

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

(b) Any covered services related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services equivalent to hospice care.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0140 Changing the Designated Hospice

(1) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

(2) The change of the designated hospice is not a revocation of the election for the period in which it is made.

(3) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following:

(a) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care;

(b) The date the change is to be effective.

(4) The statement shall be kept on file in the medical record.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0160 Revoking the Election of Hospice Care

(1) An individual or representative may revoke the individual's election of hospice care at any time during an election period.

(2) Revocation procedure: To revoke the election of hospice care, the individual or representative must file with the Hospice a statement to be placed in the medical record that includes the following information:

(a) A signed statement that the individual or representative revokes the individual's election for coverage of hospice care for the remainder of that election period;

(b) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made.)

(3) An individual, upon revocation of the election of coverage of hospice care for a particular election period:

(a) Is no longer covered for hospice care;

(b) Resumes eligibility for all covered services as before the election to hospice; and

(c) May at any time elect to receive hospice coverage for any other hospice election periods he or she is eligible to receive, in accordance with OAR 410-142-0120.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0180 Plan of Care

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan:

(1) Establishment of plan. The plan is established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(2) Content of plan. The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(3) Review of plan. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0200 Interdisciplinary Group

The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice:

(1) Composition of group. The hospice must have an interdisciplinary group or groups composed of or including at least the following individuals who are employees of the hospice, or, in the case of a doctor, be under contract with the hospice:

(a) A doctor of medicine or osteopathy;

(b) A registered nurse;

(c) A social worker;

(d) A pastoral or other counselor.

(2) Role of interdisciplinary group. Members of the group interact on a regular basis and have a working knowledge of the assessment and care of the patient/family unit by each member of the group. The interdisciplinary group is responsible for:

(a) Participation in the establishment of the plan of care;

(b) Provision or supervision of hospice care and services;

(c) Periodic review and updating of the plan of care for each individual receiving hospice care; and

(d) Establishment of policies governing the day-to-day provision of hospice care and services.

(3) If a hospice has more than one interdisciplinary group, it must document in advance the group it chooses to execute the functions described in section (2) of this rule;

(4) Coordinator. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0220 Requirements for Coverage

To be covered, hospice services must meet the following requirements:

(1) They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.

(2) The individual must elect hospice care in accordance with OAR 410-142-0100 and a plan of care must be established as set forth in OAR 410-142-0180 before services are provided.

(3) The services must be consistent with the plan of care.

(4) A certification that the individual is terminally ill must be completed as set forth in OAR 410-142-0060.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0225 Signature Requirements

(1) The Division of Medical Assistance Programs (Division) requires practitioners to sign for services they order. This signature shall be handwritten or electronic, (or facsimiles of original written or electronic signatures for terminal illness for hospice) and it must be in the client's medical record.

(2) The ordering practitioner is responsible for the authenticity of the signature.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0240 Covered Hospice Services

The following services are covered hospice services when consistent with the plan of care and must be provided in accordance with recognized standards of practice:

(1) Nursing services. The hospice must provide nursing care and services by or under the supervision of a registered nurse:

(a) Nursing services must be directed and staffed to assure that the nursing needs of the patient are met;

(b) Patient care responsibilities of nursing personnel must be specified;

(c) Services must be provided in accordance with recognized standards of practice.

(2) Medical social services. Medical social services must be provided by a qualified social worker, under the direction of a physician;

(3) Physician services. In addition to palliative and management of terminal illness and related conditions, physician employees, contractors or volunteers of the hospice, including the physician member(s), of the interdisciplinary group, must also meet the general medical needs of the patient to the extent these needs are not met by the attending physician:

(a) Reimbursement for physician or nurse practitioner supervisory and interdisciplinary group services for those physicians or nurse practitioners employed by the hospice agency is included in the rate paid to the agency;

(b) Reimbursement of attending physician or nurse practitioner services for those physicians not employed by the hospice agency is according to the Division of Medical Assistance Programs (Division) fee schedule. These physicians or nurse practitioners must bill the Division for their services;

(c) Reimbursement of attending physician or nurse practitioner services (not including supervisory and interdisciplinary group services) for those physicians or nurse practitioners employed by the hospice agency is according to the Division fee schedule. These physicians or nurse practitioners must bill the Division for their services;

(d) Reimbursement of the hospice for consulting physician services furnished by hospice employees or by other physicians under arrangements by the hospice is included in the rate paid to the agency.

(4) Counseling services. Counseling services must be available to both the patient and the family. Counseling includes bereavement counseling provided after the patient's death as well as dietary, spiritual and any other counseling services for the patient and family provided while the individual is enrolled in the hospice;

(5) Short-term inpatient care. Inpatient care must be available for pain control, symptom management and respite purposes;

(6) Medical appliances and supplies:

(a) Includes drugs and biologicals as needed for the palliation and management of the terminal illness and related conditions;

(b) Drugs prescribed for conditions other than for the palliation and management of the terminal illness are not covered under the hospice program.

(7) Hospice aide and homemaker services;

(8) Physical therapy, occupational therapy, and speech-language pathology services;

(9) Other services. Other services specified in the plan of care that are covered by the Oregon Health Plan (OHP).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0260 Hospice Level of Care

(1) Each day of hospice care is classified into one of five levels of care. The level of care determines the payment for each day of hospice benefit:

(a) Routine home care. A routine home care day is a day on which a patient who has elected to receive hospice care is in a place of residence and is not receiving continuous home care;

(b) Continuous home care. A continuous home care day is a day on which a patient who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health 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 necessary to maintain the terminally ill individual at home. Nursing care must be provided by a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care must be provided during a 24-hour day, which begins and ends at midnight. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than continuous home care;

(c) In-Home respite care. An in-home respite care day is a day on which short-term in-home care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the patient's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Home health aide/CNA or homemaker services or both may be utilized for providing in-home respite care;

(d) Inpatient respite care. An inpatient respite care day is a day on which short-term inpatient care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an

occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth, and any subsequent days, is to be made at the routine home care rate. Respite care may not be provided when the hospice patient is a nursing home resident;

(e) General inpatient care. A general inpatient care day is a day on which a hospice patient receives care in an inpatient facility for pain control, acute or chronic symptom management, or other procedures which cannot be managed or provided in any other setting.

(2) Inpatient care must be provided by a facility that has an agreement with the hospice:

(a) A hospice capable of providing inpatient care;

(b) A hospital; or

(c) A nursing facility.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0280 Recipient Benefits

An individual who has elected to receive hospice care remains entitled to receive other services not included in the hospice benefit. These services are subject to the same rules as for non-hospice clients. Typical services used that are not covered by the hospice benefit include:

(1) Attending physician care (e.g. office visits, hospital visits, etc.);

(2) Medical transportation;

(3) Any services, drugs or supplies for a condition other than the recipient's terminal illness or a related condition (e.g. broken leg, preexisting diabetes).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0290 - Hospice Services in a Nursing Facility

(1) Pursuant to Title XIX, Section 1902 and 1905, federal statute prohibits the state from paying nursing facility (NF) providers directly for NF services when their Medicaid residents elect hospice care. In these instances, the Centers for Medicare and Medicaid Services (CMS) require the state to pay the hospice provider the additional amount equal to at least 95% of the per diem rate the state would have paid to the NF for NF services for that client in that facility.

(2) When a client resides in a NF and elects hospice care, the hospice provider and the NF must have a written contract which addresses the provision of hospice care and the method upon which the hospice will pay the NF. The hospice and the NF must maintain a copy of the completed and signed contract on file and it must be available upon request.

(3) Reimbursement when a client resides in a NF and elects hospice care:

(a) In accordance with CMS 4308.2, “when hospice care is furnished to an individual residing in a NF, the state will pay hospice an additional amount on routine home care or continuous home care days to take into account the room and board furnished by the NF. In this context, the term „room and board“ includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a residents“ room, and supervision and assisting in the use of durable medical equipment and prescribed therapies,” as well as any other services considered under the bundled rate for which the NF is paid pursuant to OAR 411-070.

(b) The hospice shall bill the Division of Medical Assistance Programs (Division) directly for the hospice care provided (under routine home care, Revenue code 651, or continuous home care, Revenue code 652) and for the cost of NF services at their usual and customary rate for NF services delivered in that NF for that client;

(c) The Division shall pay the hospice provider for the hospice care provided and not to exceed 100% of the current NF basic, complex medical, pediatric, or special contract rate according to the rate schedule for NF services delivered in that NF for that client;

(d) The hospice provider must reimburse the nursing facility according to their contract and after the hospice receives payment from the Division for that NF for that client; and

(e) Reimbursement for services provided under this rule is available only if the recipient of the services is Medicaid-eligible, hospice-eligible, and been found to need NF care through the Pre-Admission Screening process under OAR 411-070-0040.

(4) NF Services Overpayment: Any payment received from the Division by a NF for services delivered after a client has elected hospice care shall adjust their claims from the day the client first elected hospice care. Failure to submit an adjustment subjects

the NF to potential sanctions and all means of overpayment recovery authorized under OAR chapter 410, division 120.

(5) Coordination of Care (COC) must be provided according to CMS Conditions of Participation (CoPs), 42CFR418.112 for hospice and nursing facilities.

(6) Coordinated Care Organization (CCO) and Prepaid Health Plan (PHP) clients who reside in a NF and elect hospice care shall remain in the CCO and PHP for all care other than hospice services in the NF. Hospice services for a resident in a NF shall be excluded from CCO and PHP capitation and the hospice must bill the Division directly for payment of hospice and NF services.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0300 Hospice Reimbursement and Limitations

(1) The Division of Medical Assistance Programs (Division) recalculates its hospice rates annually. When billing for hospice services, the provider must bill the usual charge or the rate based upon the geographic location in which the care is furnished, whichever is lower. See hospice rates on the Oregon Health Authority (Authority) Web site at: http://www.dhs.state.or.us/policy/healthplan/guides/hospice/main.html

(2) Rates:

(a) The Division bases its rates on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts;

(b) Under the Medicaid hospice benefit regulations, the Division cannot impose cost sharing for hospice services rendered to Medicaid recipients;

(c) The Division sets rates no lower than the rates used under Part A of Title XVIII of the Social Security Act (Medicare);

(d) The Division uses prospective hospice rates;

(e) The Division makes no retroactive adjustments other than the optional application of the cap on overall payments and the limitation on payments for inpatient care, if applicable.

(3) With the exception of payment for physician services, the Division reimburses providers of hospice services for each day of care at one of five predetermined rates. Rates are based on intensity and type of care, which the Division defines as:

(a) Routine home care. The Division pays the hospice the routine home care rate for each day that the client is under the care of the hospice and that the Division does not reimburse at another rate. The Division pays this rate without regard to the volume or intensity of services provided on any given day;

(b) Continuous home care. The Hospice must provide a minimum of eight hours of continuous home care per day to receive the continuous home care rate:

(A) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate;

(B) The Division pays the hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

(c) Inpatient respite care. The Division pays the hospice at the Inpatient Respite Care rate for each day on which the client is in an approved inpatient facility and is receiving respite care:

(A) The Division pays for inpatient respite care for a maximum of five days at a time, including the date of admission but not counting the date of discharge;

(B) The Division pays for the sixth and any subsequent days at the routine home care rate.

(d) General inpatient care. The Division pays providers at the general inpatient rate when general inpatient care is provided;

(e) In-home respite care. An in-home respite care day is a day on which short-term in-home care is provided to the client only when necessary to relieve the family members or other persons caring for the client at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the client's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Hospice aide/CNA or homemaker services or both may be utilized for providing in-home respite care.

(4) On the day of discharge from an inpatient unit, the Division pays the appropriate home care rate unless the client dies as an inpatient. When the client is discharged deceased, the Division pays the appropriate inpatient rate (general or respite) for the discharge date.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.065

410-142-0380 Death With Dignity

(1) Death with dignity services are defined in the Division of Medical Assistance Programs (Division) Medical-Surgical Services Program and Pharmaceutical Services Program administrative rules.

(2) All death with dignity services must be billed directly to the Division, even if the client is in a prepaid health plan (PHP).

(3) Death with dignity services are not included in the hospice care per diem payment.

Stat. Auth.: ORS 413.042 Stats. Implemented: ORS 414.065