

Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

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Rules Coordinator	Address	Telephone

RULE CAPTION

Implement Federal and state requirements in nursing facility with payment rate changes rule language clarification

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

6/17/2013	10:30	500 Summer St NE, Salem, OR 97301, Room 137C	Cheryl Peters
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: OAR 410-142-0020 and OAR 410-142-0290

REPEAL:

Stat. Auth. : ORS 413.042, 414.065, Federal statute, Title XIX (Sec. 1902.[42U.S.C. 139a (a) and Sec. 1905(o)(3))

Other Auth.: None

Stats. Implemented: ORS 414.065

RULE SUMMARY

This program will be implemented May 1, 2013. The Division needs to amend the rules listed to incorporate federal compliance requirements for payment when a client resides in a nursing facility (NF) and elects hospice care; make rate changes, clarify language, and update definitions based on provider, stakeholder, and Oregon Hospice Association participation and input in the Rules Advisory Committee (RAC) held on March 28, 2013.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

6/19/2013 by 5:00 p.m.

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

		4/11/13
Signature	Printed name	Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)	410
Agency and Division	Administrative Rules Chapter Number

Implement Federal and state requirements in nursing facility with payment rate changes rule language clarification

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The amendment of 410-142-0020 Definitions and 410-142-0290 Hospice Services in a Nursing Facility

Statutory Authority: ORS 413.042, 414.065, Federal statute, Title XIX (Sec. 1902.[42U.S.C. 139a (a) and Sec. 1905(o)(3))

Other Authority: None

Stats. Implemented: ORS 414.065

Need for the Rule(s): This program will be implemented on May 1, 2013. The Division needs to amend the rules listed above to incorporate federal compliance requirements for payment when a client resides in a nursing facility (NF) and elects hospice care; clarify language; make payment and rates changes, and update definitions based on provider, stakeholder, and Oregon Hospice Association participation and input in the Rules Advisory Committee (RAC) meeting on March 28, 2013.

Documents Relied Upon, and where they are available: Federal Statute, Title XIX (Sec. 1902.[42U.S.C. 139a (a) and Sec. 1905(o)(3)]; RAC minutes; and OAR 411-070.

Fiscal and Economic Impact: See below

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Amending these rules has some additional impact upon the state agencies involved. The Division and the Aging and People with Disabilities (APD, previously Seniors and Persons with Disabilities, SPD) are impacted with an increase of payment for the NF bundled rate previously proposed at 95% back to 100% which is the current rate paid. Other impacts include an increase in administrative costs and payment for a new change request in the current electronic payment system; administratively to update the program with stakeholder input, and develop and execute new training and education for staff and providers on the updated billing process. It is not anticipated that local government will be impacted. These amendments will improve nursing facility and hospice providers' willingness to provide hospice care in a nursing facility for Medicaid clients with these improved rates and payments. It is anticipated these amendments may also improve the ability for nursing facilities and hospice providers to contract together to provide these services and coordinate care for these clients and may improve communication and care for the Medicaid clients, and potentially reduce state costs by reducing inappropriate billing and payment for duplicative services. The cost is unknown at this time.

2. Cost of compliance effect on small business (ORS 183.336): Compliance effect will be improved with these rate and payment amendments, however the federal requirement for this process in general may be significant with these businesses given the increased administration for both the NF and the hospice agency in particular. There is also the potential for delayed payment to the NF.

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: The Division does not currently track how many hospice and NF providers are small or large businesses. According to APD, there are 18 nursing facilities with less than 50 beds. According to the Oregon Hospice Association (OHA), there are a significant number of hospices that are considered small businesses within the approximately 70+ hospice agencies within Oregon.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: Hospices and NFs will be required to improve communication and work together with their billing processes and NF payment through the hospice agency to and from the state. This will introduce the responsibility of the hospice to oversee and process the NF payment in a timely fashion. Increased administration is anticipated for both the hospice and the nursing facility, however the cost is not known. The OHA expresses concern for the increased complexity of the hospice billing, coordination of care issues, and increased administration required without additional compensation. These amendments improve the rates and payments which will decrease contention between NF and hospice providers. These amendments improve the ability for NF and hospices to coordinate the care they provide to Medicaid clients who reside in a

NF and elect hospice care, providing the potential to reduce duplication of equipment, supplies, and labor. However, due to the federal requirement in general, there will be increases in administration for all parties: the state, the NF, and the hospice.

c. Equipment, supplies, labor and increased administration required for compliance: This rule requires NF and hospices to coordinate the care they provide to Medicaid clients who reside in a NF and elect hospice care, providing the potential to reduce duplication of equipment, supplies, and labor. However, there will be an increase in administration for all parties: the state, the NF, and the hospice.

How were small businesses involved in the development of this rule? The Division has involved stakeholders and small businesses (the Oregon Hospice Association, hospice and NF providers, the Oregon Health Care Association, APD, and the state hospice licensing office) in multiple rules and implementation meetings over the past year. Also, rule input was requested from the Long Term Care (LTC) Ombudsman and the Oregon Alliance of Seniors and Health Services. The Rules Advisory Committee (RAC) meeting announcement was sent to the Division's and APD's stakeholder lists. Participants at the March 28, 2013 RAC included representatives from the OHA, OAH, managed care providers, and state agency representatives. The Division maintains regular communication with APD and stakeholders including through meetings, email and phone conversations.

Administrative Rule Advisory Committee consulted?: Yes, the RAC met on March 28, 2013, and the Division continues to consult with members for further clarification as needed.

If not, why?:

Proposed effective date: 7-1-2013

4/11/13

Signature

Printed name

Date

Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310. ARC 925-2007

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.

(76) 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.

(87) 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.

(98) 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.

(109) 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.

(1140) Coordinator: A registered nurse designated to coordinate and implement the care plan for each hospice client.

(124) 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.

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

| (143) Dying: The progressive failure of the body systems to retain normal functioning, thereby limiting the remaining life span.

| (154) 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.

| (165) 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.

| (176) 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.

| (187) 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.

| (198) 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.

| (2049) 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

| (210) Hospice Program registry: A registry of all licensed hospice programs maintained by the Authority, Public Health Division.

| (224) 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.

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

(243) 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.

(254) 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.

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

(276) Nursing facility: A facility licensed and certified by the Department of Human Services (Department) as a nursing facility, Seniors and People with Disabilities (SPD) and defined in OAR 411-070-0005.

(287) 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.

(298) 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.

(3029) 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 [and 414.065](#)

Stats. Implemented: ORS 414.065

[5-1-2013](#)

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 an~~ additional amount ~~equal to at least not to exceed~~ 95% of ~~the per diem rate what~~ the state would have paid ~~payto~~ 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;

(~~cb~~) The Division shall pay the hospice provider for the hospice care provided and not to exceed ~~95% of~~ 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;

(~~de~~) 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

(~~ed~~) 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) Managed Care clients who reside in a NF and elect hospice care shall remain in the CCO and PHP managed care 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 managed care capitation and the hospice must bill the Division directly for payment of hospice and NF services.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.065

5-1-2013