These new rules are being proposed to replace rules in [40 TAC Chapter 30, concerning Medicaid Hospice Program](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=30). The changes of this rule project include an update as a result of federal rate changes in 42 CFR Part 418, Subpart G, Payment for Hospice Care, and align the hospice aggregate cap period with the federal fiscal year of October 1 through September 30. Additionally, we propose to align the hospice election periods to that in 42 CFR Part 418, Subpart B, Duration of hospice care coverage – Election periods, and new rules are added regarding recoupment, informal review, and appeals along with clarifying and adding definitions. Obsolete program rules have been removed.TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 266 MEDICAID HOSPICE PROGRAM

SUBCHAPTER A INTRODUCTION

§266.101. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. Individual subchapters may have definitions that are specific to the subchapter.

(1) Attending physician--A physician who:

(A) is a doctor of medicine or osteopathy; and

(B) is identified by an individual as having the most significant role in the determination and delivery of the individual's medical care.

(2) Cap year--The 12-month period ending September 30 used in the application of the caps on hospice reimbursement specified in §266.209 of this chapter (relating to Medicaid Hospice Payments and Limitations).

(3) CFR--Code of Federal Regulations.

(4) CHC--Continuous home care. A category of care provided during a period of crisis consisting primarily of skilled nursing care.

(5) CMS--Centers for Medicare and Medicaid Services. The federal agency that provides funding and oversight for the Medicare and Medicaid programs.

(6) Crisis--A sudden or severe intensification of symptoms that appropriate medical intervention and nursing services could reasonably be expected to ameliorate. Expected fluctuations in an individual’s condition related to the end of life process are not a crisis.

(7) Curative--Designed to restore a person to health.

(8) Employee--An employee, as defined in the Social Security Act §210(j) (42 U.S.C. §410), of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. The term “employee” also refers to a volunteer under the jurisdiction of the hospice.

(9) HHSC--Texas Health and Human Services Commission.

(10) ICF/IID--Intermediate care facility for individuals with an intellectual disability or related conditions.

(11) IDT--Interdisciplinary team. An interdisciplinary team must include persons who are qualified and competent to practice in the following professional roles:

(A) physician who is an employee or under contract with the hospice who may also be the hospice medical director or the hospice medical director’s designee;

(B) RN;

(C) social worker; and

(D) pastoral or other counselor.

(12) Licensed vocational nurse--A nurse who is currently licensed by the Texas Board of Nursing to practice vocational nursing.

(13) Period of crisis--A period of time during which an individual requires continuous care that is primarily skilled nursing care to achieve palliation or management of acute medical symptoms.

(14) Physician--A doctor of medicine or doctor of osteopathy currently licensed by the Texas Medical Board to practice medicine or osteopathy at the time and place the service is provided.

(15) 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 individual who is mentally or physically incapacitated.

(16) RN--Registered nurse. An individual currently licensed by the Texas Board of Nursing to practice professional nursing.

(17) SIA--Service intensity add-on. Payments for direct patient care provided by a social worker or an RN during the last seven days of life when provided during routine home care.

(18) Skilled nursing care--Tasks that are determined by the assessing RN to require the skill of a licensed nurse when considering the inherent complexity of the task, the condition of the individual, and the accepted standards of medical and nursing practice.

(19) Social worker--A person who is currently licensed as a social worker under Texas Occupations Code Chapter 505.

(20) TAC--Texas Administrative Code.

(21) Terminally ill--The individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(22) TMHP--Texas Medicaid & Healthcare Partnership. The Texas Medicaid program claims administrator.

(23) UR--Utilization review. Medical record review of paid hospice claims to determine if provider compliance meets the requirements for payment of services.

§266.103. Submitting Written Information to HHSC.

A hospice must submit written information to HHSC in accordance with the instructions on the HHSC website.

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 266 MEDICAID HOSPICE PROGRAM

SUBCHAPTER B UTILIZATION REVIEW

§266.201. Duration of Hospice Care Coverage: Election Periods.

(a) An individual who is eligible may elect to receive hospice care during one or more of the following election periods:

(1) an initial 90-day period;

(2) a subsequent 90-day period; or

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

(b) The election periods are available in the order listed and may be elected consecutively or separately at different times.

(c) An individual receiving Medicaid hospice services on the date this rule becomes effective may continue receiving those services until the current election period expires. Any subsequent election period is a 60-day period under subsection (a)(3) of this section.

§266.203. Certification of Terminal Illness.

(a) Written certification.

(1) For the initial election period, a hospice must obtain a signed and dated Physician Certification of Terminal Illness Form that meets the requirements of this section before the hospice submits an initial request for payment, but no more than 15 days before the election period begins.

(2) For an election period after the initial election period, a hospice must obtain a signed and dated Physician Certification of Terminal Illness Form that meets the requirements of this section before the previous period expires, but no more than 15 days before the next election period begins.

(3) The hospice must submit the Physician Certification of Terminal Illness Form to the TMHP Long Term Care Online Portal.

(b) Oral certification. If a hospice does not obtain the written certification required by subsection (a)(1) of this section within two days after an initial election period begins, the hospice must obtain an oral certification that meets the requirements of this section no later than two days after the initial election period begins. The hospice must obtain a written certification before it submits a claim for payment. An election period is described in §266.201 of this subchapter (relating to Duration of Hospice Care Coverage: Election Periods).

(c) Content of certification. An oral or written certification must:

(1) specify that an individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course;

(2) include a physician narrative that states individual-specific clinical findings of signs and symptoms, anthropometric measurements, weights, oral intake, and laboratory and diagnostic testing results supporting the conclusion the individual is terminally ill; and

(3) include clinical information that supports the medical prognosis, which may be provided orally for an oral certification and must be provided with accompanying documentation for a written certification.

(d) Additional requirement for election period after the subsequent 90-day election period. To determine an individual’s continued eligibility for hospice care for an election period after the subsequent 90-day election period, a hospice physician or hospice advanced practice RN must perform a face-to-face assessment of the individual.

(1) The hospice must ensure a face-to-face assessment is performed before each subsequent election period begins, but no more than 30 days before the subsequent election period begins.

(2) For an individual who is dually eligible for Medicare and Medicaid, a Medicare face-to-face encounter satisfies the requirement for a face-to-face assessment.

(3) During a state of disaster declared by the Governor under Texas Government Code §418.014 or a disaster declared by the President of the United States, a hospice physician or hospice advanced practice registered nurse may determine an individual’s continued eligibility for hospice care, for a period of care after the initial period, through a telemedicine medical service, as defined in Texas Government Code §531.001(8).

(e) Sources of certification. The hospice must obtain the certification required by subsection (a) or (b) of this section from:

(1) for the initial election period:

(A) the medical director of the hospice or a physician who is a member of the hospice IDT; and

(B) the individual's attending physician, if the individual has an attending physician; and

(2) for an election period after the initial election period, a physician described in paragraph (1)(A) of this subsection.

(f) Documentation.

(1) After the hospice receives a certification:

(A) for an oral certification, the hospice physician or RN must make an entry in the individuals’ hospice record that includes the name of the physician who made the oral certification, the clinical information that supports the prognosis, the date the hospice received the certification, the signature of the staff person who makes the entry, and the date of the entry; and

(B) for a written certification, the hospice staff must file the written certification and supporting documentation in the individual's hospice record.

(2) For an election period after the subsequent 90-day election period, the hospice record must include clearly labeled documentation of the face-to-face assessment.

§266.205. Election of Hospice Care.

(a) Filing an election statement. An individual who meets the eligibility requirements for hospice care may elect hospice by filing the Individual Election/Cancellation/Update Form with a particular hospice. If the individual is physically or mentally incapacitated, the individual's representative may file the form. If the individual is dually eligible for Medicaid and Medicare, the individual must elect the Medicaid and Medicare hospice benefit at the same time.

(b) Content of election statement. The election statement must include the following:

(1) identification of the particular hospice that will provide care to the individual;

(2) the individual's or representative's acknowledgment that the individual or representative has been given a full explanation of the palliative rather than curative nature of hospice care as it relates to the individual's terminal illness;

(3) acknowledgment that certain Medicaid services, as set forth in subsection (d) of this section, are waived by the election;

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

(5) the signature of the individual or representative.

(c) Duration of election. An election to receive hospice care will continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(1) remains in the care of a hospice; and

(2) does not revoke the election under the provisions of §266.204 of this subchapter (relating to Revoking the Election of Hospice Care).

(d) Waiver of other benefits. For the duration of an election of hospice care, an individual 21 years of age or older waives all rights to the following Medicaid services:

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

(2) any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, or a related condition for which the hospice care was elected, or that are equivalent to hospice care except for services:

(A) provided by the designated hospice;

(B) provided by another hospice under arrangements made by the designated hospice; or

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

(e) Re-election of hospice benefits. If an election has been revoked in accordance with §266.204 of this subchapter, the individual, or the individual's representative, if the individual is mentally or physically incapacitated, may at any time file an election in accordance with this section.

(f) Record retention. The hospice must retain copies of all election forms in the hospice record for the individual and in the individual’s nursing facility or ICF/IID record, if applicable. Providers must meet the record retention requirements specified in 40 TAC Chapter 49 (relating to Contracting for Community Services).

(g) The hospice must submit the Individual Election/Cancellation/Update Form on the TMHP Long Term Care Online Portal.

§266.207. Revoking the Election of Hospice Care.

(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period. If the individual is dually eligible for Medicaid and Medicare, the individual must revoke the Medicaid and Medicare hospice election at the same time.

(b) To revoke the election of hospice care, the individual or representative must file the Individual Election/Cancellation/Update Form with the hospice.

(c) The revocation effective date may not be earlier than the date the revocation is made.

(d) An individual, upon revoking the election of hospice care for a particular election period:

(1) is no longer covered under Medicaid for hospice care;

(2) resumes Medicaid coverage of the benefits waived under §266.203(d) of this subchapter (relating to Election of Hospice Care); and

(3) may at any time elect to receive hospice coverage as long as the individual meets eligibility requirements.

(e) The hospice must submit the Individual Election/Cancellation/Update Form to the TMHP Long Term Care Online Portal.

§266.209. Requirements for Payments.

To be eligible for Medicaid hospice payment, the hospice must document that services provided meet the following requirements.

(1) The hospice providing the services must have a Medicaid hospice contract with HHSC on the date it provides services.

(2) The services must be reasonable and necessary for the palliation or management of the terminal illness, as well as conditions related to the terminal illness.

(3) The hospice must deliver the services on or after the date the individual elects hospice care in accordance with §266.203 of this subchapter (relating to Election of Hospice Care), but before the date the individual revokes the election of hospice care in accordance with §266.204 of this subchapter (relating to Revoking the Election of Hospice Care).

(4) The hospice election statement must identify the hospice requesting payment as the individual’s hospice provider.

(5) A physician must certify that the individual receiving hospice services is terminally ill in accordance with §266.202 of this subchapter (relating to Certification of Terminal Illness).

(6) The individual receiving services must be eligible for Medicaid.

(7) The hospice must establish an individualized plan of care prior to initiating services.

(8) The services the hospice provides must be consistent with the plan of care.

(9) If the individual receiving services lives in a nursing facility or ICF/IID, the hospice must have a contract with that nursing facility or ICF/IID.

(10) If the individual receiving services is dually eligible for Medicare and Medicaid, the hospice service must not be covered by the Medicare hospice benefit.

(11) The hospice must submit both the Individual Election/Cancellation/Update Form and the Physician Certification of Terminal Illness Form to the TMHP Long Term Care Online Portal.

§266.211. Continuous Home Care.

CHC is provided only during a period of crisis to maintain an individual at the individual's place of residence.

(1) A minimum of eight hours of CHC must be provided during a 24-hour day that begins and ends at midnight. The care need not be continuous. For example, four hours could be provided in the morning and another four hours in the evening of that day.

(2) Skilled nursing care must be provided for the identified crisis for more than half of the CHC period and must be provided by either a RN or licensed vocational nurse. The RN or licensed vocational nurse must be an employee of the hospice providing services. For an individual residing in a nursing facility, the skilled nursing care requirement is not met when facility staff provided skilled nursing care for the crisis. For the purpose of CHC, skilled nursing care includes at least one of the following:

(A) administration of intravenous or intramuscular medications;

(B) insertion, sterile irrigation, and replacement of catheters;

(C) initial clinical assessment for specific therapeutic responses; or

(D) application of dressings involving prescription medications.

(3) Homemaker, home health aide services, medical social work, or chaplain services may be provided to supplement the nursing care. The hospice must document why the physician considers social work or chaplain services necessary to ameliorate the crisis and what these services accomplished during CHC. On-call staff may be used to provide CHC, but must be on site, providing care to the individual in the individual’s place of residence to be considered for inclusion in CHC hours.

(4) The hospice must have a signed physician's order for skilled nursing care. The physician’s order must:

(A) be specific to the identified crisis and be dated before the initiation of CHC, but not more than three days before the initiation of CHC;

(B) document the rational for increased nursing needs and care; and

(C) be in the individual’s hospice record and plan of care.

(5) The attending physician, hospice medical director or his designee, and the IDT must establish the plan of care before initiating CHC. The hospice RN must coordinate the plan of care. The plan of care must:

(A) be updated when the individual’s condition changes; and

(B) include the following:

(i) a description of the specific crisis and how the hospice plans to resolve the crisis;

(ii) the needs of the individual;

(iii) identification of the services needed to meet the needs of both the individual and family, including management of discomfort and symptom relief;

(iv) the scope and frequency of the services needed to meet the needs of both the individual and family;

(v) documentation of daily physician care plan oversight; and

(vi) clinical findings and documentation that support the scope and frequency of crisis care needed.

(6) Before initiating CHC, the hospice must advise and discuss with the family or responsible party that temporary alternate placement may be necessary at the end of the five consecutive days. The hospice must document the discussion with the family or responsible party in the individual’s records, including:

(A) the date and time of the discussion;

(B) the names and titles of the participating IDT members;

(C) at least one potential alternate placement; and

(D) any other outcomes of the discussion.

§266.213. Extension of Continuous Home Care

(a) If the hospice believes that the period of crisis will extend beyond five consecutive days, the IDT must discuss the temporary alternate placement available to meet the needs of the individual during the period of crisis, such as a hospital or nursing facility. This discussion must occur and be documented before the 5th day of the crisis. If, after this discussion, the hospice believes that an extension of CHC is necessary instead of alternate placement, the hospice must fax a Request for CHC Extension Form to HHSC.

(1) The extension request must be faxed to HHSC by the fourth day of the CHC period.

(2) The faxed request must include:

(A) a description of the specific crisis and how the hospice plans to resolve the crisis;

(B) documentation of all CHC provided during the period of crisis for which the hospice is seeking the extension;

(C) physician's orders;

(D) documentation of daily physician plan of care oversight;

(E) documentation that skilled nursing care was provided as more than half of the care given in a 24-hour period for each of the three days of CHC;

(F) documentation of the IDT’s discussion regarding alternate placement prior to the initiation of CHC; and

(G) documentation of the reasons the CHC period must be extended, including the reasons the originally documented alternate placement is no longer appropriate or desired.

(b) HHSC denies the CHC extension request if the documentation is incomplete.

(c) HHSC reviews documentation faxed on or before the fourth consecutive day of the period of crisis within 16 work hours of receiving the documentation if it is sent in accordance with the instructions in subsection (a)(1) of this section.

(d) HHSC will not consider requests faxed after the fourth consecutive day of the period of crisis.

(e) HHSC will not consider multiple requests for extensions for the same period of crisis.

(f) HHSC notifies a hospice in writing, via fax, of its decision no later than the end of the fifth consecutive day of the period of crisis.

(g) If HHSC denies the request for an extension of CHC, HHSC sends a notice of denial to the individual whose CHC the hospice was seeking to extend. The notice of denial informs the individual of the individual’s right to request a Medicaid fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

(h) If HHSC denies the request for an extension of CHC, HHSC pays the hospice at the routine home care rate or inpatient care rate, if applicable, for subsequent days of care.

(i) The approval of a CHC extension request is not an approval of the initial CHC period, nor an approval for the care provided during the extension period. HHSC will conduct a review of all paid CHC claims to determine compliance with eligibility requirements for the hospice payment.

§266.215. Respite care.

(a) Respite care is short-term inpatient care provided to an individual only when necessary to relieve the family members or other persons caring for the individual at home.

(b) Respite care can be provided by:

(1) a hospice that meets the condition of participation for providing inpatient care directly; or

(2) a hospital or nursing facility that also meets the Medicare standards regarding 24-hour nursing service and patient areas.

(c) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

(d) Respite care may not be provided when the hospice patient is a nursing home resident.

§266.217. Medicaid Hospice Payments and Limitations.

(a) Medicaid hospice per diem and hourly rates. For each day that an individual is under the care of a hospice, the hospice is paid an amount applicable to the type and intensity of the services furnished to the individual. HHSC pays a daily rate for routine home care, in-patient respite care, and general inpatient care. For CHC and the SIA, the amount of payment is based on the number of hours of care furnished to the individual on that day.

(1) Routine home care. The hospice is paid the routine home care rate for each day the individual is at home, under the care of the hospice, and not receiving CHC. The appropriate routine home care rate is determined as follows.

(A) For routine home care delivered during the first 60 days an individual is receiving hospice care, the routine home care rate is the higher base payment rate.

(B) For routine home care delivered after the first 60 days an individual is receiving hospice care, the routine home care rate is the reduced base payment rate.

(C) If an individual receiving hospice services is discharged and readmitted to hospice not more than 60 days after the discharge, HHSC will count all days the individual received hospice services since the original hospice admission in determining the proper base payment rate.

(D) If an individual receiving hospice services is discharged and readmitted to hospice more than 60 days after the discharge, HHSC disregards the previous hospice admission in determining the proper base payment rate.

(2) Service Intensity Add-on. The hospice is paid an SIA in addition to the routine home care rate for visits provided by an RN or social worker during the last seven days of a hospice election ending with an individual discharged due to death. The SIA is the CHC hourly rate, multiplied by the number of hours of care provided by the RN or social worker, up to 4 hours during a 24-hour day that begins and ends at midnight. To claim the SIA, a hospice must submit:

(A) documentation of the in-person, skilled services provided by the RN, the social worker, or both;

(B) the times the services were provided; and

(C) the Individual Election/Cancellation/Update Form indicating the hospice election was canceled due to death.

(3) Continuous Home Care. The hospice is paid the CHC rate when direct patient care is provided. The CHC rate is divided by 24 hours to arrive at an hourly rate. A minimum of 8 hours of direct patient care must be provided per day. For every hour or part of an hour direct patient care is furnished, the hourly rate is paid to the hospice up to 24 hours a day. HHSC pays for a maximum of five consecutive days of CHC, unless HHSC receives and grants a request for an extension of CHC. If the hospice ceases to provide direct patient care, CHC has ended.

(4) Inpatient respite care. The hospice is paid at the inpatient respite care rate for each day on which the individual is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is at the routine home care rate.

(A) An individual who receives hospice respite care in a nursing facility and returns home after the respite care does not have to be in a Medicaid bed in the nursing facility.

(B) Respite care days are subject to the limitation on total hospice inpatient care days, as outlined in subsection (c) of this section.

(C) If the individual dies while receiving inpatient respite care, HHSC pays the inpatient respite care rate for the day of death.

(5) General Inpatient Care. Payment is made at the general inpatient rate for each day on which the individual is in an approved inpatient facility and is receiving general inpatient care.

(A) The general inpatient care rate is paid for the day of admission and all subsequent inpatient days except the day of discharge.

(B) For the day of discharge, HHSC pays the routine home care rate.

(C) If the individual dies while in an inpatient facility, HHSC pays the general inpatient care rate for the day of death.

(D) General inpatient care days are subject to the limitation on total hospice inpatient care days, as outlined in subsection (c) of this section.

(b) Medicaid payments for physician services. The hospice:

(1) is paid for hospice physician services in accordance with the HHSC reimbursement rates for physician services;

(2) is paid for physician services on the day of discharge if the physician provides direct patient services on that day;

(3) is not paid for hospice physician services when the services are provided by physicians who are not on staff with the hospice or who are independent contractors under contract with the hospice; or

(4) must include physician services in the hospice plan of care and clinical records.

(c) Medicaid payment limitations for inpatient care. During the cap year, the aggregate number of inpatient hospice care days must not exceed 20 percent of the total number of hospice care days for the same cap year. This limitation is applied once each year, at the end of the cap year for each Medicaid hospice provider. A day counts as an inpatient hospice care day only if it is a day on which the individual who has elected hospice care receives inpatient respite care or general inpatient care. The limitation is calculated as follows.

(1) The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment is necessary.

(3) If the total number of days of inpatient care exceeds the maximum allowable number, the limitation is determined by:

(A) calculating a ratio of the maximum allowable days to the number of actual days of inpatient care and multiplying this ratio by the total reimbursement for inpatient care that was made;

(B) multiplying excess inpatient care days by the routine home care rate;

(C) adding together the amounts calculated in subparagraphs (A) and (B) of this paragraph; and

(D) comparing the amount calculated under subparagraph (C) of this paragraph with interim payments made to the hospice for inpatient care during the cap year.

(d) Medicaid aggregate payment limitations. During the cap year, the aggregate payments to a hospice are subject to an annual aggregate cap. This limitation is applied once each year, at the end of the cap year for each Medicaid hospice provider. A hospice's aggregate cap is calculated by multiplying the adjusted cap amount, as determined under paragraph (1) of this subsection, by the number of Medicaid beneficiaries, as determined under paragraph (2) of this subsection.

(1) Cap Amount*.* The cap amount was set at $6,500 in 1983 and is updated using one of two methodologies described in subparagraphs (A) and (B) of this paragraph.

(A) For accounting years that end on or after October 1, 2025, the cap amount is adjusted for inflation by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year.

(B) For accounting years that end before October 1, 2025, the cap amount is the cap amount for the preceding accounting year updated by the percentage update to payment rates for hospice care for services furnished during the fiscal year beginning on October 1st preceding the beginning of the accounting year as determined pursuant to the Social Security Act §1814(i)(1)(C) (42 U.S.C. §1395f), including the application of any productivity or other adjustments to the hospice percentage update.

(2) Number of Medicaid Beneficiaries. For purposes of this paragraph, HHSC adopts by reference the streamlined methodology and the patient-by-patient proportional methodology in 42 CFR §418.309(b) and (c), adopted to be effective October 1, 2018, to determine the number of Medicaid beneficiaries for purposes of the aggregate cap.

(A) A hospice that is both Medicare- and Medicaid-certified determines the number of Medicaid beneficiaries using the same methodology it uses to determine the number of Medicare beneficiaries under 42 CFR §418.309(b) or (c).

(B) A Medicaid-certified hospice that is not Medicare-certified determines the number of Medicaid beneficiaries using the patient-by-patient proportional methodology described in 42 CFR §418.309(c).

(e) Recoupment of Excess Payments. HHSC recoups payments in excess of the limitations for inpatient care and the aggregate payment limitations from subsequent Medicaid hospice provider claims.

(f) Pediatric Concurrent Care.

(1) An individual under 21 years of age who elects to receive Medicaid hospice care may receive Medicaid services related to the treatment of the terminal illness, or a related condition, for which the hospice care was elected concurrently with the hospice care.

(2) The hospice is responsible for palliative care related to the terminal illness or a related condition. The hospice is not responsible for acute care services related to the treatment of the terminal illness or a related condition or for services unrelated to the terminal illness or a related condition.

§266.219. Utilization Review and Control Activities Performed by HHSC.

(a) Hospice staff must cooperate with HHSC staff during utilization review of hospice services and the review of hospice clinical records.

(b) The hospice must respond within 30 calendar days after HHSC makes a request for information.

(c) HHSC staff review most claims for payment after they are paid and recoup any overpayments.

(d) HHSC staff review claims for the SIA before paying the SIA.

§266.221. Hospice Documentation Requirements.

(a) Types of Documentation Required. A hospice must maintain the following information on each individual receiving Medicaid hospice services.

(1) Signed hospice election and discharge forms.

(2) Signed Physician’s Certification of Terminal Illness.

(3) Physician narratives.

(4) Documentation of each face-to-face assessment.

(5) Patient history and physical exams before and during the provision of hospice services, including previous and new diagnoses, emergency room visits, and ability to perform activities of daily living.

(6) Physician consultation reports, orders, and progress notes.

(7) Hospital admission and discharge reports.

(8) Plans of care covering all periods during which the hospice provides services to the individual.

(9) Nursing assessments and nursing notes.

(10) IDT meeting notes.

(11) Medication administration records, including doses, frequency, and routes.

(12) Signs and symptoms, anthropometric measurements, weights, oral intake, and laboratory and diagnostic testing results supporting the conclusion that the individual’s condition is terminal.

(13) Other documentation supporting the plan of care, service delivery, and outcome of services.

(14) Summary of circumstances surrounding the death, including date, time, family in attendance, and hospice staff in attendance.

(b) Requirements for Physician’s Orders. A hospice must have a signed physician’s order that:

(1) covers the time period for which hospice services were provided; and

(2) documents the terminal illness and related medical need for skilled nursing care, as provided.

(c) Requirements for the Plan of Care. A hospice must maintain a plan of care for each individual receiving Medicaid hospice services. The plan of care must meet the following criteria.

(1) The plan of care must relate to the identified terminal illness.

(2) The plan of care must be updated every 15 days, or when the individual’s condition changes if sooner than 15 days and include any change in the individual’s status.

(3) The plan of care must include the following:

(A) a description of the individual’s service needs and how the hospice plans to meet those needs;

(B) the baseline condition of the individual at the beginning of the election period including symptoms documented with location, severity, and frequency;

(C) identification of the specific interventions and services necessary for management of the symptoms including the intensity, frequency, duration, and scope of services;

(D) physician orders for the specific interventions and services necessary; and

(E) the measurable outcomes anticipated from implementing the plan of care and reasonable timeframes expected for achieving those measurable outcomes.

(d) Requirements for Physician Services on the Day of Discharge. To request payment for physician services on the day of discharge, the hospice must submit to HHSC proof that:

(1) the physician is a hospice employee; and

(2) the physician provided direct services to the patient on the day of discharge.

(e) Requirements for all documentation. All documentation must be:

(1) clearly labeled to indicate what type of documentation it is;

(2) legible to a reader other than the author; and

(3) signed and dated.

§266.223. Recoupment

(a) HHSC recoups from a hospice under 40 TAC §49.533 (relating to Recoupment) amounts paid to the hospice for a service if the hospice has not complied with the requirements described in this chapter.

(b) Recoupment amounts for hospice eligibility and level of service utilization reviews.

(1) HHSC recoups 100 percent of the hospice claim amount for the dates of service reviewed when the hospice fails to provide HHSC the following:

(A) the Individual Election/Cancellation/Update Form completed in accordance with §266.203 of this subchapter (relating to Election of Hospice Care);

(B) the Physician Certification of Terminal Illness Form completed in accordance with §266.202 of this subchapter (relating to Certification of Terminal Illness);

(C) a physician narrative that meets the minimum criteria in §266.202(c)(2) of this subchapter; or

(D) if the individual receiving hospice services is in an election period after the initial election, documentation of the face-to-face assessment required by §266.202(d).

(2) HHSC recoups 50 percent of the hospice claim amount for the dates of service reviewed when the hospice fails to provide nursing assessments and notes.

(3) HHSC recoups 30 percent of the hospice claim amount for the dates of service reviewed when the hospice fails to provide HHSC supporting clinical documentation related to the terminal illness and the progression of the terminal illness, including signs and symptoms, anthropometric measurements, weights, oral intake, and laboratory and diagnostic testing.

(4) HHSC recoups 25 percent of the hospice claim amount for the dates of service reviewed when the hospice fails to provide HHSC with documentation of an initial plan of care and updated plans of care as required by §266.206 of this subchapter (relating to Continuous Home Care) and §266.211 of this subchapter (relating to Hospice Documentation Requirements).

(c) Recoupment amounts for CHC reviews.

(1) HHSC recoups 100 percent of the CHC claim amount for the dates of service reviewed when the hospice fails to provide HHSC the following:

(A) documentation establishing that a crisis existed;

(B) a physician’s order for CHC; or

(C) documentation establishing that the individual received care for at least 8 hours within a 24-hour day during the period of crisis.

(2) HHSC recoups 50 percent of the CHC claim for the dates of service reviewed when the hospice fails to provide HHSC documentation establishing that the hospice agency employees provided skilled nursing care for more than 50 percent of the period of crisis.

(3) HHSC recoups 25 percent of the CHC claim amount for the dates of service reviewed when the hospice fails to provide HHSC the following:

(A) the plan of care specific to the identified crisis and dated before the initiation of CHC;

(B) documentation that is legible to a reader other than the author, clear, complete, signed or initialed, and dated in accordance with hospice policy and currently accepted standards of practice; or

(C) documentation that is signed and appropriately authenticated, which means the hospice is able to authenticate each handwritten and electronic signature of a primary author who has reviewed and approved the entry.

(4) HHSC recoups 10 percent of the CHC claim amount for the dates of service reviewed when the hospice fails to provide HHSC documentation of the discussion of temporary alternate placement required by §266.206(6) of this subchapter, including documentation of the IDT meeting and who participated in the IDT meeting.

(d) Other. HHSC will recoup the amount of any overpayment discovered.

§266.225. Informal Review.

(a) Before HHSC issues a notice of proposed recoupment under 40 TAC §49.533(c) (relating to Recoupment), HHSC gives a hospice:

(1) a description of the alleged rule violation warranting the proposed recoupment; and

(2) the option to:

(A) request an informal review to demonstrate that the hospice did not commit the alleged violation; or

(B) accept the proposed recoupment.

(b) A hospice’s request for an informal review must:

(1) be received by HHSC within 10 calendar days after the hospice receives the description of the alleged violation from HHSC; and

(2) contain documentation that refutes the alleged violation.

(c) HHSC conducts the informal review by reviewing the hospice’s written response and supporting evidence.

(d) HHSC provides the hospice with official notice of the outcome of the informal review.

§266.227. Appeals.

(a) HHSC issues a notice or proposed recoupment under 40 TAC §49.533(c) (relating to Recoupment), if HHSC upholds or modifies a proposed recoupment after the informal review.

(b) The notice of proposed recoupment includes:

(1) a description of the alleged rule violations warranting the proposed recoupment;

(2) HHSC’s decision to uphold or modify the proposed recoupment issued after an informal review; and

(3) the option for the hospice to:

(A) accept the proposed recoupment; or

(B) appeal the proposed recoupment as provided in 40 TAC §49.541 (relating to Contractor’s Right to Appeal).

TITLE 26 HEALTH AND HUMAN SERVICES

PART 1 HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 266 MEDICAID HOSPICE PROGRAM

SUBCHAPTER C CONTRACTING REQUIREMENTS

§266.301. Eligibility Requirements.

(a) To be eligible to elect hospice care under Medicaid, an individual must:

(1) be certified as Medicaid eligible by HHSC or the Social Security Administration; and

(2) be certified as being terminally ill in accordance with §266.202 of this chapter (relating to Certification of Terminal Illness)

(b) If dually eligible, an individual must elect the hospice benefit under both the Medicare and Medicaid programs.

§266.303. Change of the Designated Hospice.

(a) An individual or representative may change the particular hospice from which the individual receives hospice care once in each election period. If the recipient is dually eligible for Medicaid and Medicare, the individual must change the Medicaid and Medicare hospice providers at the same time.

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

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

(1) the name of the hospice from which the individual has received care and the name of the hospice from which the individual plans to receive care; and

(2) the date the change is to be effective.

(d) The hospice must submit the Individual Election/Cancellation/Discharge Form on the TMHP Long Term Care Online Portal.

§266.305. General Contracting Requirements.

(a) A hospice participating in the Medicaid Hospice Program must comply with this chapter and applicable federal regulations and state rules, including 42 CFR Part 418; 26 TAC Chapter 558 (relating to Licensing Standards for Home and Community Support Services Agencies); and 40 TAC Chapter 49 (relating to Contracting for Community Services).

(b) A hospice participating in the Medicaid Hospice Program must not have restrictive policies or practices, including:

(1) requiring an individual to execute a will with the hospice named as legatee or devisee;

(2) assigning an individual's life insurance to the hospice;

(3) transferring an individual's property to the hospice;

(4) requiring an individual to pay a lump sum or make any other payment or concession to the hospice beyond the recognized Medicaid rate;

(5) controlling or restricting an individual or legal representative in using the individual's personal needs allowance while in a nursing facility or an ICF/IID;

(6) restricting an individual from transferring or withdrawing from the Medicaid Hospice Program at will, except as provided by state law;

(7) denying appropriate hospice care to an individual on the basis of the individual's race, religion, color, national origin, sex, age, disability, marital status, or source of payment; and

(8) preventing or requiring the execution of written or unwritten directives to reject life-sustaining procedures by an adult individual.

(c) If a hospice provides services to a resident of a nursing facility or an ICF/IID, the hospice must have a written contract for the provision of services with the nursing facility or ICF/IID.

(d) Medicaid hospice-nursing facility per diem rates. The Medicaid Hospice Program pays the Medicaid hospice provider a hospice-nursing facility rate that is no less than 95 percent of the Medicaid nursing facility rate for each individual in a nursing facility to take into account the room and board furnished by the facility. When the hospice-nursing facility rate is paid to the hospice provider, Medicaid vendor payment to the nursing facility is not paid. Room and board services include performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

(e) Medicaid hospice-ICF/IID per diem rates. The Medicaid Hospice Program pays the Medicaid hospice provider a hospice-ICF/IID rate that is no less than 95 percent of the ICF/IID rate for each individual in an ICF/IID to take into account the room and board furnished by the facility. When the hospice-ICF/IID rate is paid to the hospice provider, Medicaid vendor payment to the ICF/IID is not paid. Room and board services include performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

(f) Medicaid payments on Medicare coinsurance for drugs and biologicals. For Medicare-Medicaid individuals only, the Medicaid Hospice Program pays the Medicaid hospice provider a five percent coinsurance on prescription drugs and biologicals, not to exceed $5.00 per prescription.

(g) Medicaid payments for Medicare respite coinsurance. For Medicare-Medicaid individuals only, the Medicaid Hospice Program pays the hospice provider a five percent coinsurance for each day of respite care for up to five consecutive days of a hospice coinsurance period.

§266.307. Voluntary Termination of Hospice Contract.

(a) At least 10 days before a hospice terminates its contract with HHSC, the hospice must:

(1) for each individual receiving Medicaid hospice services, submit a Individual Election/Cancellation/Update Form to the TMHP Long Term Care Online Portal indicating the individual has changed his designated hospice or revoked his election of hospice care; and

(2) for each individual receiving Medicaid hospice services who is changing his designated hospice, ensure that a copy of the individual's active record is sent to the receiving hospice in order to ensure continuity of care and services to the individual.

(b) Submission of the Individual Election/Cancellation/Update Form to the TMHP Long Term Care Online Portal is governed by §266.302 of this subchapter (relating to Change of the Designated Hospice) and §266.204 of this chapter (relating to Revoking the Election of Hospice Care).

§266.309. Condition of Participation--Physical Therapy, Occupational Therapy, and Speech-language Pathology.

(a) Physical therapy services, occupational therapy services, and speech-language pathology services must be available and, when provided, offered in a manner consistent with accepted standards of practice.

(b) Lab services must be provided under the following conditions.

(1) If the hospice engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the FDA, such testing must be in compliance with all applicable requirements of 42 CFR Part 493.

(2) If the hospice chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and sub-specialties of services in accordance with the applicable requirements of 42 CFR Part 493.

§266.311. Waiver Requirements for Nursing Services or Occupational, Physical, and Speech Therapies.

(a) CMS may approve a waiver for nursing services or occupational, physical, and speech therapies provided by a hospice which is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence that it was operational on or before January 1, 1983, and that it made a good faith effort to hire a sufficient number of nurses or therapists to provide services directly. CMS bases its decision on whether to approve a waiver application on the following:

(1) the current Bureau of the Census designations for determining non-urbanized areas;

(2) evidence that a hospice was operational on or before January 1, 1983, including:

(A) proof that the organization was established to provide hospice services on or before January 1, 1983;

(B) evidence that hospice-type services were furnished to patients on or before January 1, 1983; and

(C) evidence that the hospice care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983; and

(3) evidence that a hospice made a good faith effort to hire nurses or therapists, including:

(A) copies of advertisements in local newspapers that demonstrate recruitment efforts;

(B) job descriptions for nurse employees or therapists;

(C) evidence that salary and benefits are competitive for the area; and

(D) evidence of any other recruiting activities, such as recruiting efforts at health fairs and contacts with nurses or therapists at other providers in the area.

(b) A waiver request for occupational, physical, and speech therapies must be submitted in writing to HHSC.

(c) The department will recommend in writing, approval or disapproval of the requested waiver for occupational, physical, and speech therapies to CMS within 30 days of receiving the request.

(d) CMS receives requests for waivers of nursing services without the involvement of HHSC.

(e) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.

(f) Waivers will remain effective for one year at a time.

(g) CMS may approve a maximum of two one-year extensions for each initial waiver. If a hospice wishes to receive a one-year extension, the hospice must submit a certification to CMS, prior to the expiration of the waiver period, that the employment market for nurses and therapists has not changed significantly since the time the initial waiver was granted.