

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

ATTORNEY GENERAL

January 12, 1988

BOB HAMPER
Rules Division

JULIE A. LEPPINK
Special Assistant
Attorney General

6-9422

In the Matter of the Adopted Rule Relating to
Medical Assistance Hospice Care Services

The above-referenced rule has been approved as to its legality by the Attorney General on January 6, 1989.

Enclosed is the agency's copy of the approved rule. This office has already filed two copies with the Secretary of State who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accoradance with Minn. Stat. §14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. §14.34.

If you have any questions in this regard, please contact me.

JAL:rer
Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Administrative Rules

William Brown
Chief Administrative Law Judge
Office of Administrative Hearings

File No. 1559 Docket 05-0009-0866

DATE RECEIVED 12/28/88 ADOPTED W/O HEARING Y

REVIEW DATE 1/6/89 EMERGENCY RULE _____

DUE DATE 1/13/89 REVISOR APPROVED _____

APPROVED 1/6/89 REVISOR DISAPPROVED _____

DISAPPROVED _____ FILED W/SEC. OF STATE _____

WITHDRAWN _____ RETURNED TO AGENCY _____

✓ Rule as adopted (4 copies)

✓ Notice to Solicit Outside Information/Opinion (if applicable)

9/21/87 Date published in State Register
none Comments

~~Petition for Adoption of a Rule (if applicable)~~

~~Board's Authorizing Resolution~~

~~Date adopted~~

✓ Proposed Rule

yes Revisor's Certificate

✓ Notice of Intent to Adopt Rule

~~256B.02 sub 8~~ (cl 20). Statutory Authority
no Small Business Statement
yes Expenditure of public money statement
yes Signature

✓ Statement of Need and Reasonableness (if applicable)

no Small Business Statement
no Fees - § 16A.128

✓ Affidavit of Mailing Notice of Intent to Adopt Rule

11/16/88 Date (30)/25 days before adoption
yes Notice attached
~~Copy of rule or summary attached~~

✓ Publication in State Register

11/21/88 Date (30)/25 days before adoption

180-day deadline from:

12/21/88 end of comment period (§ 14.26) (rules without hearing)
~~effective date of statutory authority (§ 14.29) (emergency rules)~~

~~Resolution Adopting~~

~~Date adopted~~

✓ Findings of Fact, Conclusions & Order Adopting

12/27/88 Date

✓ Written requests, submissions or comments (1)

✓ Declaration of attorney

Pat Sonnenberg Name of SAAG representing agency

✓ ~~Notice of Submission to Atty. Gen. (if applicable)~~ Certificate

~~Aff. of Mailing Notice to Atty. Gen. (if applicable)~~

Department of Human Services

Adopted Permanent Rules Relating to Medical Assistance Hospice Care Services

Rules as Adopted

9505.0297 HOSPICE CARE SERVICES.

Subpart 1. **Applicability.** Parts 9505.0297 and 9505.0446 must be read in conjunction with United States Code, title 42, section 1396a, and Code of Federal Regulations, title 42, part 418.

Subp. 2. **Definitions.** For purposes of this part and part 9505.0446, the following terms have the meanings given them.

A. "Business days" means every day except Saturday, Sunday, and legal holidays in Minnesota.

B. "Cap amount" means the limit on overall hospice reimbursement provided by part 9505.0446, subpart 4, and Code of Federal Regulations, title 42, sections 418.308 and 418.309, as amended through October 1, 1987.

C. "Employee" means an employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice unit. Employee also includes a volunteer under the supervision of the hospice.

D. "Home" means the recipient's place of residence.

E. "Hospice" has the meaning given to hospice program in Minnesota Statutes, section 144A.48, subdivision 1, clause (4).

F. "Hospice care" means the services provided by a hospice to a terminally ill recipient under this part.

G. "Inpatient care" means the services provided by an inpatient facility to a recipient who has been admitted to a hospital, long-term care facility, or facility of a hospice that provides care 24 hours a day.

H. "Inpatient facility" means a hospital, long-term

care facility, or facility of a hospice that provides care 24 hours a day.

I. "Interdisciplinary group" has the meaning given to interdisciplinary team in Minnesota Statutes, section 144A.48, subdivision 1, clause (5).

J. "Palliative care" has the meaning given in Minnesota Statutes, section 144A.48, subdivision 1, clause (6).

K. "Representative" means a person who, because of the terminally ill recipient's mental or physical incapacity, may execute or revoke an election of hospice care on behalf of the recipient under Minnesota law.

L. "Respite care" means short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient.

M. "Social worker" means a person who has at least a bachelor's degree in social work from a program accredited or approved by the Council of Social Work Education and who complies with Minnesota Statutes, sections 148B.21 to 148B.28.

N. "Terminally ill" means that the recipient has a medical prognosis that life expectancy is six months or less.

Subp. 3. **Provider eligibility.** A provider of hospice services is eligible for medical assistance payments if the provider is:

A. licensed or registered as a hospice under Minnesota Statutes, section 144A.48 or 144A.49; and

B. certified as a provider of hospice services under Medicare, in accordance with title XVIII of the Social Security Act, and Code of Federal Regulations, title 42, part 418.

Subp. 4. **Recipient eligibility.** To be eligible for medical assistance coverage of hospice care, a recipient must be certified as being terminally ill in the manner required by subpart 5.

Subp. 5. **Certification of terminal illness.** Within two calendar days after hospice care is initiated, the hospice must obtain written statements certifying that the recipient is terminally ill, signed by:

A. the medical director of the hospice or the physician member of the hospice's interdisciplinary group; and

B. the recipient's attending physician, if the recipient has one.

Within two calendar days after the recipient's first 90 days of hospice care and within two calendar days after the beginning of each subsequent 90-day period, the hospice must obtain a written statement certifying that the recipient is terminally ill, signed by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.

Subp. 6. **Election of hospice care.** A recipient who is eligible for hospice care under subpart 4 and elects to receive hospice care, must submit an election statement to the hospice. The statement must include:

A. designation of the hospice that will provide care;

B. the recipient's acknowledgement that the recipient fully understands that the hospice provides palliative care rather than curative care with respect to the recipient's terminal illness;

C. the recipient's acknowledgement that the services under subpart 9 are waived by the election;

D. the effective date of the election, which must be no earlier than the date that the election is signed; and

E. the recipient's signature.

Subp. 7. **Election by representative.** A representative of the recipient may make the election and sign and submit the election statement to the hospice for the recipient according to subpart 6.

Subp. 8. **Notification of the election.** The hospice must mail or deliver a copy of the election statement required by subpart 6 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date the hospice receives the signed election statement.

Subp. 9. **Waiver of other benefits.** A recipient who elects hospice care under subpart 6 or for whom a representative elects

hospice care under subpart 7 waives the right to medical assistance payments during the recipient's hospice stay for the following services:

A. Hospice care provided by a hospice other than the hospice designated by the recipient or the recipient's representative, unless the care is provided under arrangements made by the designated hospice.

B. Health services related to treatment of the terminal illness for which hospice care was elected or a condition related to the terminal illness, or services that are equivalent to hospice care, except for services:

(1) provided by the designated hospice;

(2) provided by another hospice under arrangements made by the designated hospice; and

(3) provided by the recipient's attending physician if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services.

C. Personal care services, under part 9505.0335.

Subp. 10. **Duration of hospice services.** A recipient may receive hospice care until the recipient revokes the election under subpart 11 or no longer is eligible for hospice care under subpart 4.

Subp. 11. **Revoking the election.** A recipient or the recipient's representative may revoke the election of medical assistance coverage of hospice care at any time. To revoke the election, the recipient or representative must submit a statement to the hospice that includes:

A. a signed statement that the recipient or representative revokes the recipient's election of medical assistance coverage of hospice care; and

B. the date that the revocation is to be effective, which must be no earlier than the date on which the revocation is signed.

Subp. 12. **Notification of revocation.** The hospice must mail or deliver a copy of the revocation statement submitted

under subpart 11 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date that the hospice receives the signed statement revoking the election.

Subp. 13. **Effect of revocation.** A recipient, upon revoking the election of medical assistance coverage of hospice care under subpart 11:

A. is no longer covered under medical assistance for hospice care;

B. resumes medical assistance coverage of the benefits waived under subpart 9; and

C. may elect to receive medical assistance coverage of hospice care at a later time, if eligible under this part at that time.

Subp. 14. **Change of hospice.** A recipient or the recipient's representative may change the designation of the hospice from which the recipient will receive hospice care. The change of the designated hospice is not a revocation of the election of medical assistance coverage of hospice care. To change the designation of the hospice, the recipient or the recipient's representative must submit both to the hospice where care has been received and to the newly designated hospice a signed statement that includes the following information:

A. the name of the hospice where the recipient has received care and the name of the hospice from which the recipient plans to receive care; and

B. the date the change is to be effective.

Subp. 15. **Requirements for medical assistance payment.** To be eligible for medical assistance coverage, hospice care must be:

A. reasonable and necessary for the palliation or management of the terminal illness and conditions related to the terminal illness;

B. in compliance with Minnesota Statutes, sections 144A.43 to 144A.49, and with the rules adopted under Minnesota Statutes, section 144A.48; and

C. consistent with the recipient's plan of care, established by the hospice.

Subp. 16. **Covered services.** As required by the recipient's plan of care, the services listed in items A to D must be provided directly by hospice employees, except that the hospice may contract for these services under the circumstances provided for in Code of Federal Regulations, title 42, section 418.80. As required by the recipient's plan of care, the services listed in items E to I must be provided directly or be made available by the hospice.

A. Nursing services provided by or under the supervision of a registered nurse.

B. Medical social services provided by a social worker under the direction of a physician.

C. Services performed by a physician, dentist, optometrist, or chiropractor.

D. Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided both to train the recipient's family or other caregiver to provide care, and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

E. Inpatient care, including procedures necessary for pain control or acute or chronic symptom management provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care. Inpatient care must conform to the written plan of care. A hospice that provides inpatient care must meet the standards in Code of Federal Regulations, title 42, sections 418.100(a) and (f), as amended through October 1, 1987.

F. Inpatient care, as a means of providing respite for the recipient's family or other persons caring for the recipient at home, provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care, or in a medical assistance

certified intermediate care facility, subject to subpart 18.

G. Medical equipment and supplies, including drugs. Only drugs approved by the commissioner under part 9505.0340, subpart 3, item A, and used primarily to relieve pain and control symptoms of the recipient's terminal illness are covered. Medical equipment includes durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical equipment must be provided by the hospice for use in the recipient's home while the recipient is under hospice care. Medical supplies include those specified in the written plan of care.

H. Home health aide services and homemaker services. Home health aides may provide personal care services as described in part 9505.0335, subparts 8 and 9. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the recipient's bed linens or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

I. Physical therapy, occupational therapy, and speech-language pathology services provided to control symptoms or to enable the recipient to maintain activities of daily living and basic functional skills.

Subp. 17. **Services provided during a crisis.** A hospice may provide nursing services, including homemaker or home health aide services, to a recipient on a continuous basis for as much as 24 hours a day during a crisis as necessary to maintain a recipient at home. More than half of the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. A crisis is a period in which the recipient requires continuous care for palliation or management of acute medical symptoms.

Subp. 18. **Respite care.** A hospice may provide respite care to a recipient only on an occasional basis and may not be

paid for more than five consecutive days of respite care at a time. A hospice shall not provide respite care to a recipient who resides in a long-term care facility.

Subp. 19. **Bereavement counseling.** Bereavement counseling services must be made available by the hospice to the recipient's family until one year after the recipient's death. For purposes of this subpart, family includes persons related to the recipient or those considered by the recipient to be family because of their close association.

Subp. 20. **Medical assistance payment for hospice care.** Medical assistance shall be paid to a hospice for covered services according to part 9505.0446.

9505.0446 HOSPICE CARE PAYMENT RATES AND PROCEDURES.

Subpart 1. **Rate categories.** Providers of hospice care as described in part 9505.0297 are paid at one of four fixed daily rates that apply to each of the four categories of services in subpart 3. The fixed daily rates apply to all services, except for certain physician services as described in subpart 5, and room and board in a long-term care facility as described in subparts 6 and 7.

Subp. 2. **Long-term care facility as residence.** For purposes of this part, a recipient who resides in a long-term care facility is considered to live at home.

Subp. 3. **Categories of service.** Except as otherwise provided by subparts 4 to 6, no payments shall be made for specific services provided by the hospice. Fixed daily rates are calculated under subpart 4 for each of the following categories of services:

A. Routine home care day, which is a day on which a recipient who has elected to receive hospice care is at home and is not receiving continuous care as defined in item B.

B. Continuous home care day, which is a day on which a recipient who has elected to receive hospice care has not been admitted to a facility that provides inpatient care, except when a long-term care facility is the recipient's residence under

subpart 2, and the recipient receives hospice care consisting of nursing services, including home health aide or homemaker services, on a continuous basis at home, as provided by part 9505.0297, subpart 17. No fewer than eight hours a day of nursing care must be provided by a registered nurse or licensed practical nurse. Continuous home care may be furnished only during periods of crisis as described in part 9505.0297, subpart 17, and only as necessary to maintain the terminally ill recipient at home.

C. Inpatient respite care day, which is a day on which the recipient who has elected hospice care receives inpatient care in an inpatient facility certified for medical assistance on a short-term basis for respite. This item is subject to the limits provided by part 9505.0297, subpart 18. This item does not apply to a recipient whose residence is a long-term care facility under subpart 2.

D. General inpatient care day, which is a day on which a recipient who has elected hospice care receives general inpatient care in a hospital or skilled nursing facility that provides inpatient care for control of pain or management of acute or chronic symptoms that cannot be managed in other settings. This item does not apply to a recipient who receives inpatient care in a long-term care facility in which the recipient is a resident under subpart 2.

Subp. 4. **Payments and limitations.** Medical assistance will pay a hospice for each day a recipient is under the hospice's care. Payment is in the same amounts, uses the same methodology, and is subject to the same limits and cap amount used by Medicare under Code of Federal Regulations, title 42, sections 418.301 to 418.309, as amended through October 1, 1987, except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS), as provided by United States Code, title 42, section 1396d(o)(1)(B). The rates are determined by the Health Care Financing Administration (HCFA), United States Department of

Health and Human Services, as provided by Code of Federal Regulations, title 42, section 418.306, as amended through October 1, 1987, and as adjusted by HCFA for the Medicare co-pay amounts not allowed under medical assistance. Payments to long-term care facilities under subparts 6 and 7 are not included in the cap amount. Changes in rates are announced in the Federal Register. No payment will be made for bereavement counseling under part 9505.0297, subpart 19.

Subp. 5. **Payment for physician services.** Physician services are paid according to items A to C.

A. The services specified in subitems (1) and (2) are included in the rates provided by subpart 4:

(1) general supervisory services of the hospice's medical director; and

(2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice's interdisciplinary group.

B. Other than for services described in item A, medical assistance shall pay the hospice for physician services furnished by physicians who are employees of the hospice or who provide services under arrangements with the hospice, at the rate provided by part 9505.0445, item E. Payment for these physician services is included in the amount subject to the cap amount in subpart 4. No payment will be made to the hospice for services donated by physicians who are employees of the hospice or who provide services under arrangements with the hospice.

C. Services of the recipient's attending physician, if the physician is not an employee of the hospice or is not providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the cap amount in subpart 4. These services are reimbursed according to parts 9505.0345 and 9505.0445, item E.

Subp. 6. **Payment for room and board in long-term care facilities.** If a recipient resides in a long-term care facility

under subpart 2 that is certified as a medical assistance provider and the recipient has elected medical assistance coverage of hospice services, the long-term care facility shall not be paid by medical assistance under parts 9549.0010 to 9549.0080, but shall be paid by the hospice at a rate negotiated by the long-term care facility and the hospice.

Subp. 7. **Payment to hospice for residents of long-term care facilities.** The commissioner shall establish the payments to hospices for the room and board of medical assistance recipients who reside in long-term care facilities certified by medical assistance, as provided by items A and B.

A. The daily room and board payment rate shall be either:

(1) 83 percent of the long-term care facility's daily payment rate for the recipient's resident class, as determined under parts 9549.0010 to 9549.0080; or

(2) 83 percent of the long-term care facility's daily payment rate for the recipient's certification level, if the long-term care facility is not subject to parts 9549.0010 to 9549.0080.

B. The payment to the hospice is the product of the hospice's daily room and board payment rate determined in item A and the number of days for which the recipient resides in the long-term care facility in the month, less the recipient's spend-down amount for that month under part 9505.0065, subpart 11, item F.

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED

JAN 11 1989

Joan Anderson Growe

Secretary of State

9:10 AM

APPROVED AS TO FORM AND LEGALITY

January 6, 19 89

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY Julie A Zeppenk
SPECIAL ASSISTANT ATTORNEY GENERAL

Office of the Revisor of Statutes

Administrative Rules

TITLE: Adopted Permanent Rules Relating to Medical Assistance Hospice Care Services

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9505

The attached rules are approved for filing with the Secretary of State

Kathleen M. Traxler
Assistant Revisor

Department of Human Services

Proposed Permanent Rules Relating to Medical Assistance Hospice Care Services

Rules as Proposed (all new material)

9505.0297 HOSPICE CARE SERVICES.

Subpart 1. **Applicability.** Parts 9505.0297 and 9505.0446 must be read in conjunction with United States Code, title 42, section 1396a, and Code of Federal Regulations, title 42, part 418.

Subp. 2. **Definitions.** For purposes of this part and part 9505.0446, the following terms have the meanings given them.

A. "Business days" means every day except Saturday, Sunday, and legal holidays in Minnesota.

B. "Cap amount" means the limit on overall hospice reimbursement provided by part 9505.0446, subpart 4, and Code of Federal Regulations, title 42, sections 418.308 and 418.309, as amended through October 1, 1987.

C. "Employee" means an employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice unit. Employee also includes a volunteer under the supervision of the hospice.

D. "Home" means the recipient's place of residence.

E. "Hospice" has the meaning given to hospice program in Minnesota Statutes, section 144A.48, subdivision 1, clause (4).

F. "Hospice care" means the services provided by a hospice to a terminally ill recipient under this part.

G. "Inpatient care" means the services provided by an inpatient facility to a recipient who has been admitted to a hospital, long-term care facility, or facility of a hospice that provides care 24 hours a day.

H. "Inpatient facility" means a hospital, long-term

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care facility, or facility of a hospice that provides care 24 hours a day.

I. "Interdisciplinary group" has the meaning given to interdisciplinary team in Minnesota Statutes, section 144A.48, subdivision 1, clause (5).

J. "Palliative care" has the meaning given in Minnesota Statutes, section 144A.48, subdivision 1, clause (6).

K. "Representative" means a person who, because of the terminally ill recipient's mental or physical incapacity, may execute or revoke an election of hospice care on behalf of the recipient under Minnesota law.

L. "Respite care" means short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient.

M. "Social worker" means a person who has at least a bachelor's degree in social work from a program accredited or approved by the Council of Social Work Education and who complies with Minnesota Statutes, sections 148B.21 to 148B.28.

N. "Terminally ill" means that the recipient has a medical prognosis that life expectancy is six months or less.

Subp. 3. **Provider eligibility.** A provider of hospice services is eligible for medical assistance payments if the provider is:

A. licensed or registered as a hospice under Minnesota Statutes, section 144A.48 or 144A.49; and

B. certified as a provider of hospice services under Medicare, in accordance with title XVIII of the Social Security Act, and Code of Federal Regulations, title 42, part 418.

Subp. 4. **Recipient eligibility.** To be eligible for medical assistance coverage of hospice care, a recipient must be certified as being terminally ill in the manner required by subpart 5.

Subp. 5. **Certification of terminal illness.** Within two calendar days after hospice care is initiated, the hospice must obtain written statements certifying that the recipient is terminally ill, signed by:

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A. the medical director of the hospice or the physician member of the hospice's interdisciplinary group; and

B. the recipient's attending physician, if the recipient has one.

Within two calendar days after the recipient's first 90 days of hospice care and within two calendar days after the beginning of each subsequent 90-day period, the hospice must obtain a written statement certifying that the recipient is terminally ill, signed by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.

Subp. 6. **Election of hospice care.** A recipient who is eligible for hospice care under subpart 4 and elects to receive hospice care, must submit an election statement to the hospice. The statement must include:

A. designation of the hospice that will provide care;

B. the recipient's acknowledgement that the recipient fully understands that the hospice provides palliative care rather than curative care with respect to the recipient's terminal illness;

C. the recipient's acknowledgement that the services under subpart 9 are waived by the election;

D. the effective date of the election, which must be no earlier than the date that the election is signed; and

E. the recipient's signature.

Subp. 7. **Election by representative.** A representative of the recipient may make the election and sign and submit the election statement to the hospice for the recipient according to subpart 6.

Subp. 8. **Notification of the election.** The hospice must mail or deliver a copy of the election statement required by subpart 6 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date the hospice receives the signed election statement.

Subp. 9. **Waiver of other benefits.** A recipient who elects hospice care under subpart 6 or for whom a representative elects

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hospice care under subpart 7 waives the right to medical assistance payments during the recipient's hospice stay for the following services:

A. Hospice care provided by a hospice other than the hospice designated by the recipient or the recipient's representative, unless the care is provided under arrangements made by the designated hospice.

B. Health services related to treatment of the terminal illness for which hospice care was elected or a condition related to the terminal illness, or services that are equivalent to hospice care, except for services:

(1) provided by the designated hospice;

(2) provided by another hospice under arrangements made by the designated hospice; and

(3) provided by the recipient's attending physician if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services.

C. Personal care services, under part 9505.0335.

Subp. 10. **Duration of hospice services.** A recipient may receive hospice care until the recipient revokes the election under subpart 11 or no longer is eligible for hospice care under subpart 4.

Subp. 11. **Revoking the election.** A recipient or the recipient's representative may revoke the election of medical assistance coverage of hospice care at any time. To revoke the election, the recipient or representative must submit a statement to the hospice that includes:

A. a signed statement that the recipient or representative revokes the recipient's election of medical assistance coverage of hospice care; and

B. the date that the revocation is to be effective, which must be no earlier than the date on which the revocation is signed.

Subp. 12. **Notification of revocation.** The hospice must mail or deliver a copy of the revocation statement submitted

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by Revisor _____

under subpart 11 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date that the hospice receives the signed statement revoking the election.

Subp. 13. **Effect of revocation.** A recipient, upon revoking the election of medical assistance coverage of hospice care under subpart 11:

A. is no longer covered under medical assistance for hospice care;

B. resumes medical assistance coverage of the benefits waived under subpart 9; and

C. may elect to receive medical assistance coverage of hospice care at a later time, if eligible under this part at that time.

Subp. 14. **Change of hospice.** A recipient or the recipient's representative may change the designation of the hospice from which the recipient will receive hospice care. The change of the designated hospice is not a revocation of the election of medical assistance coverage of hospice care. To change the designation of the hospice, the recipient or the recipient's representative must submit both to the hospice where care has been received and to the newly designated hospice a signed statement that includes the following information:

A. the name of the hospice where the recipient has received care and the name of the hospice from which the recipient plans to receive care; and

B. the date the change is to be effective.

Subp. 15. **Requirements for medical assistance payment.** To be eligible for medical assistance coverage, hospice care must be:

A. reasonable and necessary for the palliation or management of the terminal illness and conditions related to the terminal illness;

B. in compliance with Minnesota Statutes, sections 144A.43 to 144A.49, and with the rules adopted under Minnesota Statutes, section 144A.48; and

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by Revisor _____

C. consistent with the recipient's plan of care, established by the hospice.

Subp. 16. **Covered services.** As required by the recipient's plan of care, the services listed in items A to D must be provided directly by hospice employees, except that the hospice may contract for these services under the circumstances provided for in Code of Federal Regulations, title 42, section 418.80. As required by the recipient's plan of care, the services listed in items E to I must be provided directly or be made available by the hospice.

A. Nursing services provided by or under the supervision of a registered nurse.

B. Medical social services provided by a social worker under the direction of a physician.

C. Services performed by a physician, dentist, optometrist, or chiropractor.

D. Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided both to train the recipient's family or other caregiver to provide care, and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

E. Inpatient care, including procedures necessary for pain control or acute or chronic symptom management provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care. Inpatient care must conform to the written plan of care. A hospice that provides inpatient care must meet the standards in Code of Federal Regulations, title 42, sections 418.100(a) and (f), as amended through October 1, 1987.

F. Inpatient care, as a means of providing respite for the recipient's family or other persons caring for the recipient at home, provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care, or in a medical assistance

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certified intermediate care facility, subject to subpart 18.

G. Medical equipment and supplies, including drugs. Only drugs approved by the commissioner under part 9505.0340, subpart 3, item A, and used primarily to relieve pain and control symptoms of the recipient's terminal illness are covered. Medical equipment includes durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical equipment must be provided by the hospice for use in the recipient's home while the recipient is under hospice care. Medical supplies include those specified in the written plan of care.

H. Home health aide services and homemaker services. Home health aides may provide personal care services as described in part 9505.0335, subparts 8 and 9. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the recipient's bed linens or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

I. Physical therapy, occupational therapy, and speech-language pathology services provided to control symptoms or to enable the recipient to maintain activities of daily living and basic functional skills.

Subp. 17. **Services provided during a crisis.** A hospice may provide nursing services, including homemaker or home health aide services, to a recipient on a continuous basis for as much as 24 hours a day during a crisis as necessary to maintain a recipient at home. More than half of the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. A crisis is a period in which the recipient requires continuous care for palliation or management of acute medical symptoms.

Subp. 18. **Respite care.** A hospice may provide respite care to a recipient only on an occasional basis and may not be

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paid for more than five consecutive days of respite care at a time. A hospice shall not provide respite care to a recipient who resides in a long-term care facility.

Subp. 19. **Bereavement counseling.** Bereavement counseling services must be made available by the hospice to the recipient's family until one year after the recipient's death. For purposes of this subpart, family includes persons related to the recipient or those considered by the recipient to be family because of their close association.

Subp. 20. **Medical assistance payment for hospice care.** Medical assistance shall be paid to a hospice for covered services according to part 9505.0446.

9505.0446 HOSPICE CARE PAYMENT RATES AND PROCEDURES.

Subpart 1. **Rate categories.** Providers of hospice care as described in part 9505.0297 are paid at one of four fixed daily rates that apply to each of the four categories of services in subpart 3. The fixed daily rates apply to all services, except for certain physician services as described in subpart 5, and room and board in a long-term care facility as described in subparts 6 and 7.

Subp. 2. **Long-term care facility as residence.** For purposes of this part, a recipient who resides in a long-term care facility is considered to live at home.

Subp. 3. **Categories of service.** Except as otherwise provided by subparts 4 to 6, no payments shall be made for specific services provided by the hospice. Fixed daily rates are calculated under subpart 4 for each of the following categories of services:

A. Routine home care day, which is a day on which a recipient who has elected to receive hospice care is at home and is not receiving continuous care as defined in item B.

B. Continuous home care day, which is a day on which a recipient who has elected to receive hospice care has not been admitted to a facility that provides inpatient care, except when a long-term care facility is the recipient's residence under

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subpart 2, and the recipient receives hospice care consisting of nursing services, including home health aide or homemaker services, on a continuous basis at home, as provided by part 9505.0297, subpart 17. No fewer than eight hours a day of nursing care must be provided by a registered nurse or licensed practical nurse. Continuous home care may be furnished only during periods of crisis as described in part 9505.0297, subpart 17, and only as necessary to maintain the terminally ill recipient at home.

C. Inpatient respite care day, which is a day on which the recipient who has elected hospice care receives inpatient care in an inpatient facility certified for medical assistance on a short-term basis for respite. This item is subject to the limits provided by part 9505.0297, subpart 18. This item does not apply to a recipient whose residence is a long-term care facility under subpart 2.

D. General inpatient care day, which is a day on which a recipient who has elected hospice care receives general inpatient care in a hospital or skilled nursing facility that provides inpatient care for control of pain or management of acute or chronic symptoms that cannot be managed in other settings. This item does not apply to a recipient who receives inpatient care in a long-term care facility in which the recipient is a resident under subpart 2.

Subp. 4. **Payments and limitations.** Medical assistance will pay a hospice for each day a recipient is under the hospice's care. Payment is in the same amounts, uses the same methodology, and is subject to the same limits and cap amount used by Medicare under Code of Federal Regulations, title 42, sections 418.301 to 418.309, as amended through October 1, 1987, except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS), as provided by United States Code, title 42, section 1396d(o)(1)(B). The rates are determined by the Health Care Financing Administration (HCFA), United States Department of

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Health and Human Services, as provided by Code of Federal Regulations, title 42, section 418.306, as amended through October 1, 1987, and as adjusted by HCFA for the Medicare co-pay amounts not allowed under medical assistance. Payments to long-term care facilities under subparts 6 and 7 are not included in the cap amount. Changes in rates are announced in the Federal Register. No payment will be made for bereavement counseling under part 9505.0297, subpart 19.

Subp. 5. **Payment for physician services.** Physician services are paid according to items A to C.

A. The services specified in subitems (1) and (2) are included in the rates provided by subpart 4:

(1) general supervisory services of the hospice's medical director; and

(2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice's interdisciplinary group.

B. Other than for services described in item A, medical assistance shall pay the hospice for physician services furnished by physicians who are employees of the hospice or who provide services under arrangements with the hospice, at the rate provided by part 9505.0445, item E. Payment for these physician services is included in the amount subject to the cap amount in subpart 4. No payment will be made to the hospice for services donated by physicians who are employees of the hospice or who provide services under arrangements with the hospice.

C. Services of the recipient's attending physician, if the physician is not an employee of the hospice or is not providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the cap amount in subpart 4. These services are reimbursed according to parts 9505.0345 and 9505.0445, item E.

Subp. 6. **Payment for room and board in long-term care facilities.** If a recipient resides in a long-term care facility

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under subpart 2 that is certified as a medical assistance provider and the recipient has elected medical assistance coverage of hospice services, the long-term care facility shall not be paid by medical assistance under parts 9549.0010 to 9549.0080, but shall be paid by the hospice at a rate negotiated by the long-term care facility and the hospice.

Subp. 7. **Payment to hospice for residents of long-term care facilities.** The commissioner shall establish the payments to hospices for the room and board of medical assistance recipients who reside in long-term care facilities certified by medical assistance, as provided by items A and B.

A. The daily room and board payment rate shall be either:

(1) 83 percent of the long-term care facility's daily payment rate for the recipient's resident class, as determined under parts 9549.0010 to 9549.0080; or

(2) 83 percent of the long-term care facility's daily payment rate for the recipient's certification level, if the long-term care facility is not subject to parts 9549.0010 to 9549.0080.

B. The payment to the hospice is the product of the hospice's daily room and board payment rate determined in item A and the number of days for which the recipient resides in the long-term care facility in the month, less the recipient's spend-down amount for that month under part 9505.0065, subpart 11, item F.

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Department of Human Services

In the Matter of the Proposed Adoption of the Rule of the State Department of Human Services Governing Medical Assistance Payment for Hospice Services, Minnesota Rules, parts 9505.0297 and 9505.0446

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING

Notice is hereby given that the State Department of Human Services intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minnesota Statutes, section 256B.02, subdivision 8, clause (20).

All persons have 30 days or until 4:30 p.m. on December 21, 1988, in which to submit comments in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Chris Kiefer
Rules Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
Telephone (612) 297-1461

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

The proposed rule adds hospice to the services that will be paid for by the Medical Assistance program, under Minnesota Rules, parts 9505.0170 to 9505.0475 (Rule 47). The hospice services will be available under the same terms as provided by Medicare, except that the annual limit (cap) on payments to each hospice program imposed by Medicare will not be imposed by Medical Assistance. The rule provides for election and revocation of hospice by a recipient who has a life expectancy of six months or less, or by the recipient's representative; waiver of benefits for services related to the terminal illness; no limit on the duration of services; requirements that the hospice provide all necessary services; requirements for services during a medical crisis, respite care, and bereavement counseling for survivors. The rule also sets forth the categories of service for purposes of payment, limitations on payment, and provides for payment to hospices for the room and board of recipients who reside in long-term care facilities. The rule also has provisions defining terms. The rule will affect hospice programs and recipients of Medical Assistance by providing to them the option of hospice services under the Medical Assistance program. The rule may also affect long-term care facilities, in that they will receive payment from hospices for their residents who elect hospice services, rather than from the Department of Human Services.

A free copy of the rule is available upon request from Chris Kiefer at the address noted above. A copy of the rule may also be viewed at any of the 87 county welfare or human services agencies in the State of Minnesota.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Chris Kiefer at the address noted above upon request.

Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request

notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Chris Kiefer at the address noted above.

November 2, 1988

SANDRA S. GARDEBRING
Commissioner

IN THE MATTER OF THE PROPOSED
ADOPTION OF RULES OF THE
DEPARTMENT OF HUMAN SERVICES
GOVERNING MEDICAL ASSISTANCE
PAYMENT FOR HOSPICE SERVICES,
Minnesota Rules, parts 9505.0297
and 9505.0446

STATEMENT OF NEED
AND REASONABLENESS

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Background and Legal Authority

Authority and Purpose

The proposed rules addressed by this Statement of Need and Reasonableness establish hospice services under the Medical Assistance program, regulated under Minnesota Rules, chapter 9505. The specific rules, Minnesota Rules, parts 9505.0297 and 9505.0446, implement Minnesota Statutes, section 256B.02, subdivision 8, clause (20). This Statement of Need and Reasonableness is prepared to comply with the requirements of the Administrative Procedure Act, specifically Minnesota Statutes, sections 14.131 and 14.23.

The rules set forth the conditions for recipients and providers participating in the hospice program. These benefits parallel the Medicare hospice benefits in scope, payment methodology and payment rates.

Concept and Philosophy

Hospices are programs that provide health and support services to patients who are terminally ill and to their families. The hospice philosophy centers on the acceptance of the patient's inevitable death. The hospice seeks to help the patient and those close to him or her come to terms with the terminal condition and live the remaining life as fully as possible. Hospice care is an approach to treatment that, recognizing the impending death, focuses on palliative rather than curative care. The medical goal is to control pain and other symptoms. No heroic measures are taken to cure the disease or artificially prolong life. As much as possible, patients are maintained at home with care provided by family, volunteers, and professionals. Counseling is provided to survivors after the patient's death to aid the grieving process. An interdisciplinary approach is used to deliver medical, social, psychological, emotional, and spiritual services. These services are provided by a broad spectrum of professional and other care-givers with the goal of making the individual as physically and emotionally comfortable as possible.

History of Hospice

The modern concept of hospice care began in 1842 when a group of Catholic widows established a hospice in Lyon, France for poor women with incurable and inoperable cancer. In the mid 1800's, the Irish Sisters of Charity established a hospice for the dying in Dublin, Ireland. The most widely known of the modern hospices, St. Christopher's in London, was founded in 1967 to provide care for terminally ill patients. The first hospice program in the United States was established in 1971. The concept of hospice care has expanded widely in this country since 1976. (See Appendix B, Hospice, HEW pamphlet).

Medicare began paying benefits for hospice care in 1983, as required by Section 122 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, P.L. 97-248, codified as section 1861(dd) of the Social Security Act (Act). To receive hospice benefits, Medicare recipients must be terminally ill (i.e., have a life expectancy of six months or less) and voluntarily elect to receive hospice care in lieu of certain other services. Section

1861(dd)(2)(A)(ii)(I) of the Act specifies that a hospice must "routinely provide directly substantially all" of the following core services: nursing care, medical social services, physicians' services and counseling services. The remaining non-core services may be provided either directly by the hospice or under arrangements with others. The hospice must maintain professional management responsibility for all services furnished to a recipient, regardless of the location of or type of facility providing the services. The federal statutory requirements are implemented by the Code of Federal Regulations, title 42, part 418.

Section 9505 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Public Law 99-272), allows states to provide hospice care under their Medicaid plans. COBRA requires that Medicaid hospice services be provided in the same scope, amount, and duration as Medicare and payment rates must be the same as Medicare's.

Rulemaking Process

The Notice of Solicitation of Outside Information or Opinions, published in the State Register on September 21, 1987, announced the department's intent to develop rules for payment for hospice care by the Medical Assistance program.

An advisory committee convened on August 19, 1987 and held six meetings. A list of the committee members is contained in Appendix A. The committee identified relevant issues and problems, provided information about the practices of hospices and related providers, and recommended language for the rule.

RULE PARTS

GENERAL

Section 1902(a)(10) of the Social Security Act, codified in United States Code, title 42, section 1396a(a)(10), provides that a state that opts to include hospice services in its Medicaid plan must not make those services "available in an amount, duration, or scope less than that provided under title XVIII..." Therefore, the Medicare regulations promulgated under Title XVIII of the Social Security Act, provide the basic framework for the Medical Assistance hospice program. The Medicare regulations are published in the Code of Federal Regulations, title 42, part 418.

Section 1902(a)(13)(D) of the Social Security Act, codified in United States Code, title 42, section 1396a(a)(13)(D), provides that the state must provide "for payment for hospice care [under Medicaid] in the same amounts, and using the same methodology, as used under part A of title XVIII..." The statute clearly requires that hospice services must be reimbursed by Medical Assistance in the same amounts and in the same manner as they are under Medicare. The Medicare reimbursement regulations are published in the Code of Federal Regulations, title 42, part 418, subpart E. The Health Care Financing Administration (HCFA), a part of the U.S. Department of Health and Human Services, administers Medicare and Medicaid and periodically publishes in the Federal Register the rates and cap

applicable hospice services. The State Medicaid Manual (SMM), parts 3 and 4 (HCFA Publications 45-3 and 45-4), defines the Medical Assistance eligibility and service requirements, reflecting the federal legislation and Medicare regulations.

Throughout this Statement of Need and Reasonableness, the Code of Federal Regulations, title 42, will be cited as 42 CFR, and HCFA's State Medicaid Manual will be cited as SMM.

9505.0297 HOSPICE CARE SERVICES.

Subpart 1. **Applicability.** This subpart is necessary to inform the reader of the services covered by the rule and other laws governing the provision of hospice services.

Subp. 2. **Definitions.**

A. "Business days." It is necessary to define "business days" because the rule requires that providers forward to the local agency (defined in parts 9505.0175, subpart 21, and 9505.0015, subpart 27) copies of elections and revocations of hospice within two business days of their receipt by the hospice. This definition is reasonable because it includes those days on which government offices and many private offices are open for business, and excludes those days on which those offices are closed.

B. "Cap amount." This term is used by the Medicare regulations to refer to a predetermined limit on reimbursement. It is necessary to incorporate this definition to be consistent with Medicare, in 42 CFR 418.308 and 418.309.

C. "Employee." Although defined by part 9505.0175, subpart 12, the term is used in this part in a somewhat more specialized way. It is necessary to adopt the definition of 42 CFR 418.3 to be consistent with Medicare.

D. "Home." Because "home" is used to refer to any place at which the recipient resides, it is necessary to define the term to clarify its usage. It is reasonable to define "home" as a place of residence, since hospice services are available to a recipient regardless of where the recipient lives.

E. "Hospice." It is necessary to establish what is meant by "hospice" to clarify its meaning. Because hospice services can only be provided in Minnesota by a licensed entity, it is reasonable to be consistent with the licensure definition. Subpart 3 of this part provides that a provider of hospice services may be certified only if it is licensed or registered by the Department of Health under Minnesota Statutes, section 144A.48.

F. "Hospice care." It is necessary to define "hospice care" because the term is used throughout the rule and needs clarification to inform the persons subject to this rule of its meaning. Defining "hospice care" as the services provided by a hospice is reasonable because Minnesota Statutes, section 144A.48, subdivision 1, clause (4), in defining "hospice program", sets forth the services that constitute hospice care.

G. "Inpatient care." It is necessary to define "inpatient care" because the term is used in the rule and does not have a precise meaning in common usage. It is reasonable to define the term as care provided in an inpatient facility because such a facility is designed to provide medical care that needs to be administered in an institutional setting. The American Heritage Dictionary defines "inpatient" as a "patient staying in a hospital for treatment." The rule's definition broadens this definition to include long-term care and hospice facilities because these facilities can administer the palliative services covered under the rules. In addition, long-term care and hospice facilities can generally provide the care in a more cost effective manner and more appropriate environment which is beneficial to both the state taxpayer and the individual receiving the care.

H. "Inpatient facility." It is necessary to define "inpatient facility" because the term is used in the rule and does not have a precise meaning in common usage. It is reasonable to define the term as a hospital, long-term care facility, or hospice facility, because these three types of institutional settings are available for inpatient care, and are included in Medicare's definition of inpatient facility, in 42 CFR 418.98.

I. "Interdisciplinary group." The term "interdisciplinary group" is used by the Medicare regulations, 42 CFR 418.68, to refer to a group of professionals who establish policies of the hospice and supervise the care. The licensure statute, Minnesota Statutes, section 144A.48, subdivisions 1(5) and 2(4), uses the term "interdisciplinary team" for the same function. It is necessary to be consistent with Medicare to comply with federal law and with state licensure because all hospices must conform to the licensure requirements in order to be certified.

J. "Palliative care" is defined to clarify what is meant by that term which defines the nature of hospice services and distinguishes it from non-hospice "curative" services. Because all hospices must conform to the licensure requirements of Minnesota Statutes, section 144A.48, in order to be paid by the Medical Assistance program, it is reasonable to adopt the definition provided by Minnesota Statutes, section 144A.48, subdivision 1, clause (6).

K. "Representative." The Medicare regulations, 42 CFR 418 et seq., and these rules allow a "representative" of an incapacitated recipient to elect or revoke an election of hospice services on behalf of the recipient. The law in Minnesota is unclear as to who may act for a recipient (see Appendix B). Therefore, it is necessary and reasonable to define a representative as one who has such authority under current or future law.

L. "Respite care" is used to identify a category of reimbursement under part 9505.0446, subpart 2. It is necessary to adopt the Medicare definition in 42 CFR 418.204(b) to be consistent with that program.

M. "Social worker." A social worker is required by subpart 16 to provide medical social services. Medicare, 42 CFR 418.3, defines a social worker as one who has at least a bachelor's degree from an accredited school. It is necessary to adopt Medicare's definition to be consistent

with that program. In addition, Minnesota Statutes, sections 148B.21 to 148.28, require licensure of social workers in some cases. It is necessary that a social worker complies with the statute.

N. "Terminally ill." The hospice program is limited to those recipients who are terminally ill. It is necessary to define the term to establish a precise criterion for determining who is eligible. To be consistent with Medicare, the definition of 42 CFR 418.3 is adopted.

Subp. 3. **Provider eligibility.** It is necessary to establish who is eligible under Minnesota law to provide hospice services under the Medical Assistance program to conform to state licensure law and certification requirements. It is necessary and reasonable to require licensure or registration because hospice services can only be provided in Minnesota by a provider in compliance with the licensure statute, Minnesota Statutes, section 144A.48, or with the temporary interim procedures provided by Minnesota Statutes, section 144A.49 pending promulgation of rules by the Department of Health. It is also reasonable to require certification by Medicare to maximize health coverage for those patients eligible for Medicare as well as Medical Assistance, thereby reducing the cost to the State, a policy established by Minnesota Statutes, Section 256B.04, subdivision 2. And, since these proposed Medical Assistance rules are largely identical to the Medicare regulations, a hospice in compliance with these rules and licensure standards will, in almost all cases, be in compliance with Medicare.

Subp. 4. **Recipient eligibility.** It is necessary to define which recipients of medical assistance are eligible for hospice care in order to identify those for whom hospice services are appropriate. It is reasonable to limit the service to those who are terminally ill because the service is specifically intended and structured for those who have a limited time to live. The Medicare regulations, 42 CFR 418.20, and SMM, section 3580, limit eligibility to those who have six months or less to live. It is reasonable to conform these rules to Medicare and HCFA's guidelines to comply with the federal law.

Subp. 5. **Certification of terminal illness.** For a hospice provider and the department to determine who meets the eligibility criteria for hospice services, it is necessary for the hospice to assess the patient's health status. It is reasonable to use the Medicare method of requiring a written certification that the recipient is terminally ill by both the recipient's doctor, if available, and the hospice's medical director. For those recipients who have a personal physician, the certification by the medical director of the hospice is in the nature of a second opinion, confirming the diagnosis and controlling eligibility to those who are appropriate for the service. For those recipients who have no personal physician, the medical director performs the required assessment. This is the same method as required by Medicare, 42 CFR 418.22, and SMM, section 4305.1.

Subp. 6. **Election of hospice care.** To receive hospice services, a recipient must make an explicit, written election, which invokes the recipient's waiver of various services discussed in subpart 9. This election is necessary to establish a legal waiver of benefits for which the recipient would otherwise be eligible and to make it clear to the recipient that the hospice services are palliative rather than curative. It also is

reasonable to require the election to contain the identification of the hospice, the effective date, and the recipient's signature in order to clearly document the election. These requirements are the same as those in 42 CFR 418.24 and 418.26, and SMM, sections 4305.2 and 4305.3.

Subp. 7. **Election by representative.** The federal regulation, 42 CFR 418.24(a), and SMM, section 4305.3, provide that a "representative" of the recipient may make the election for the recipient. "Representative" is defined by the Medicare regulations as "...a person, who is, because of the individual's mental or physical incapacity, authorized in accordance with State law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual." Because some recipients, as a result of incapacity, may be unable to make the election, it is reasonable to provide some mechanism for allowing other persons to decide what medical care should be given. It is reasonable to simply provide by rule that a person who has such decision-making authority under Minnesota law may make the hospice election. This approach does not add to nor detract from existing or developing state law on the matter.

Subp. 8. **Notification of the election.** Because an election of hospice services requires a waiver of certain other Medical Assistance benefits, the recipient's local agency must be informed of the election in order to administer and enforce the waiver. Since the local agency is the department's agent responsible for processing the service needs of the recipient, it is necessary to establish a method by which the local agency is notified. Since the hospice obtains the election and waiver from the recipient, it is reasonable to require the hospice to notify the local agency. It is reasonable to require that the local agency be notified within two business days, because the effort required to mail or deliver copies of the election is minimal, and because the state is at risk of incurring duplicate billings until the local agency is notified. The duplicate billings can result from nursing homes and hospices billing for the same room and board charges, and from services that had been waived by the election. It is therefore important for the notice to be given as soon as is practicable.

Subp. 9. **Waiver of other benefits.** 42 CFR 418.24(e), and SMM, section 4305.2, provide that a Medicare patient who elects the hospice benefit must waive the right to receive other services intended to treat the terminal illness or a related condition. This is consistent with the nature and intent of hospice services to provide palliative care for pain and other symptoms rather than curative or heroic medical measures. It is necessary to require the waiver to prevent costly and unnecessary duplication or overlap of services by other providers, and to prevent the receipt of services that are contradictory to the hospice care. The waiver must be made only for the duration of the recipient's participation in the hospice program, and may be revoked at any time under subparts 10 to 12.

The specific services waived are listed in items A and B.

Item A. It is necessary to limit the election to one hospice at a time to prevent duplication of services and to be consistent with 42 CFR 418.24(e)(1) and SMM, section 4305.3, item A.

Item B. This item specifies the waiver for (1) services related to treatment of the terminal condition, or for (2) services that duplicate the hospice's services, with certain exceptions, consistent with 42 CFR 418.24(e)(2) and SMM, section 4305.3, item B.

Item C. Personal care service is a special home care service provided by part 9505.0335. Since the hospice is the exclusive manager of the recipient's health care, it is necessary to exclude use of personal care services to substitute for a recipient's care givers, except for those services provided by the hospice.

Subp. 10. **Duration of hospice services.** This subpart provides that no time limit is imposed on a recipient's eligibility. Although Medicare, 42 CFR 418.3 and 418.24, limits eligibility to 210 days in three periods, the advisory committee and the department concluded that a limitation on eligibility for the service is unnecessary, since the requirement of a diagnosis of terminal illness and the payment cap is a sufficient control on the duration of participation by the recipient in the program. The committee also reported that hospice patients, on average, live approximately one month following admission to the program. SMM, section 4305 notes that the 210 day limit is optional and may be broadened. It is necessary to specify that no time limit is imposed on participation to inform providers and recipients of the time that the service is available.

Subp. 11. **Revoking the election.** Since hospice care is an alternative to traditional Medical Assistance health care, and a recipient waives various medical services upon electing hospice care, it is necessary to allow the recipient to change his or her mind at any time and obtain those services previously waived. It is reasonable to allow revocation simply by executing a written revocation statement, consistent with 42 CFR 418.28 and SMM, section 4305.3.

Subp. 12. **Notification of revocation.** If a recipient revokes the election of hospice services under subpart 11, he or she is entitled to immediately receive the Medical Assistance benefits previously waived by the election. It is necessary for the local agency to be promptly notified of the revocation in order that it may reinstate the recipient's benefits status and also control the hospice provider's reimbursement. It is reasonable to require that the local agency be notified within two business days for the same reasons given for subpart 8 of this part.

Subp. 13. **Effect of revocation.** To clarify the function and effect of an election revocation under subpart 11, it is necessary to list the consequences. Since the purpose of a revocation is to reinstate the Medical Assistance benefits previously waived, the revocation results in the termination of the hospice benefit, resumption of the benefits waived, and the option to elect the hospice benefit again in the future. This subpart is consistent with 42 CFR 418.28(c) and SMM, section 4305.3.

Subp. 14. **Change of hospice.** To allow a recipient free choice of provider, a policy established by Minnesota Statutes, section 256B.01, it is necessary to allow the recipient to change hospices without altering the election and waiver. To document and record the change, maintain continuity of care, and ensure accurate reimbursement, it is reasonable to require the recipient to execute a written statement with both the old and new hospice identifying the change and the effective date. This requirement is consistent with 42 CFR 418.30 and SMM, section 4305.3.

Subp. 15. **Requirements for medical assistance payment.** This subpart sets forth general standards for hospice services in order for the hospice to qualify for reimbursement. The standards are derived from 42 CFR 418.200 and are necessary to be consistent with Medicare and SMM, section 4305.4.

Subp. 16. **Covered services.** This subpart lists the services in items A to I which are covered as hospice services and must be provided to patients. It is necessary to specify these services to be consistent with the hospice services covered under Medicare, and enumerated in 42 CFR 418.202, and SMM, section 4305.5, and to give notice to providers and recipients of what services are covered. The covered services are reasonable because they constitute the core of services needed to adequately care for terminally ill patients and provide assistance to their families, within the purposes and philosophy of hospice programs. They are designed to manage the symptoms of a recipient's terminal illness or a related condition and to enhance the quality of the recipient's life rather than cure the illness. It is necessary to require that the services of Items A to D, nursing, medical social services, services of a medical practitioner, and counseling, be provided by hospice employees to be consistent with Medicare, 42 CFR 418.80. It is also necessary to require that inpatient care provided by a unit of the hospice, Item E, comply with 42 CFR 418.100 (a) and (f) to conform to the Medicare standards.

Subp. 17. **Services provided during a crisis.** Medicare regulation, 42 CFR 418.204(a), and SMM, section 4305.6, allow reimbursement for continuous home care during periods of medical crisis. This subpart adopts the Medicare definition of "period of crisis" and the criteria for nursing and aide or homemaker coverage. This subpart is necessary to define what services make the provider eligible for continuous home care day reimbursement. It is necessary and reasonable to be consistent with Medicare to comply with the statutory payment requirements.

Subp. 18. **Respite care.** Medicare regulation, 42 CFR 418.204(b), and SMM, section 4305.6, provide reimbursement for inpatient respite care to relieve family caregivers for occasional, brief periods. This subpart adopts the Medicare requirements for respite care, and is necessary to establish the limits on respite care reimbursement as provided by Medicare, as well as provide the same level of service as Medicare. It is reasonable to not allow respite care payment for a recipient residing in a long-term care facility because no caregiver requires relief when a facility provides 24-hour a day care.

Subp. 19. **Bereavement counseling.** Bereavement counseling after the recipient's death is a service that must be provided to a deceased recipient's family or significant others. This requirement is necessary to be consistent with 42 CFR 418.204(c) and SMM, section 4305.6. Although the service is required, no payment is made by Medicare, and therefore none by Medical Assistance, after the death.

Subp. 20. **Medical assistance payment for hospice care.** Since payment rates are set forth in rule parts separate from eligibility and service requirements, it is necessary and reasonable to inform the persons subject to these rules in which part the reimbursement rules are established.

Part 9505.0446. HOSPICE CARE PAYMENT RATES AND PROCEDURES.

Section 1902(a)(13)(D) of the Social Security Act (42 USC 1396a (a)(13)(D)), requires that payments to hospices be "in the same amounts, and using the same methodology..." as used by Medicare under 42 CFR, part 418, subpart E. The following rules implement the Federal regulations and SMM, section 4306.

Subpart 1. **Rate categories.** This subpart is necessary to inform the reader about the payment system which will be used to pay providers of hospice services.

Subp. 2. **Long-term care facility as residence.** Section 1902(a)(13)(D) of the Social Security Act provides that "...a separate rate may be paid for hospice care which is furnished to an individual who is a resident of a skilled nursing facility or intermediate care facility, and who would be eligible under the plan for skilled nursing facility services or intermediate care facility services if he had not elected to receive hospice care, to take into account the room and board furnished by such facility." SMM, section 4308.2 states: "You must establish and pay to the hospice an additional per diem amount for routine home care and continuous home care days for hospice care that is furnished to an individual living in an SNF or ICF." Because of these provisions, it is necessary to make it clear that, for purposes of payment rates, an SNF or ICF in which a recipient resides will be considered the recipient's home. Subpart 5 provides the payment rates for the room and board component of long-term care facilities.

Subp. 3. **Categories of service.** The reimbursement method and limits for hospice care are set forth in 42 CFR, part 418, subpart E, and in SMM, sections 4306 to 4308. 42 CFR 418.302(b) defines the four categories of care on which the four payment rates are based. It is necessary to define these categories to provide notice to providers and recipients of the payment categories. The definitions are derived from and are consistent with the Code of Federal Regulations.

Subp. 4. **Payments and limitations.** The method of reimbursement for hospice services under the Medical Assistance program is identical to that of Medicare, as required by section 1902(a)(13)(D) of the Social Security Act (42 USC 1396a(a)(13)(D)). This subpart incorporates the payment methodology and limits, and the payment cap contained in 42 CFR 418.301 to 418.309, and gives notice that the rates are computed by HCFA and published in the Federal Register. Since the Medical Assistance payment rates are identical to Medicare, it is unnecessary to restate the payment rules provided by the Medicare regulations. Federal law prohibits the state program from applying certain federal Medicare cap amounts to individuals suffering from acquired immunodeficiency syndrome (AIDS). It is necessary to set out the AIDS exclusion to inform recipients and providers of its existence. Similarly, federal law provides for the payment of an additional fee to a hospice for the room and board costs of hospice patients residing in long-term care facilities. It is necessary to inform the public that these payments are not subject to the cap amounts. Since no reimbursement is paid for bereavement counseling following a recipient's death (42 CFR 418.204(c), SMM, section 4305.6), it is necessary to make that requirement explicit to avoid ambiguity.

HCFA, in the State Medicaid Manual, asserts, without citing authority, that the cap amount is optional with the states. Nevertheless, the advisory committee concluded, based on its members' experiences, that the Medicare cap has not been a problem for hospices, as it is sufficiently high to accommodate all but the rarest cases. This experience, the lack of statutory authority, and the mandate of Minnesota Statutes, section 256B.04, subdivision 2, to be "efficient" and "economical", leads the department to conclude that, as a matter of policy, the Medical Assistance hospice benefit should be limited by the Medicare cap. This decision is also consistent with the statutory mandate to provide payment in the same amounts and using the same methodology as Medicare.

Subp. 5. **Payment for physician services.** Items A and B. These items delineate which physician services are covered under the hospice rates and which are to be reimbursed separately. These requirements are necessary to implement 42 CFR 418.304(a) and (b), and SMM, section 4307. Item C is necessary to make clear that reimbursement of a recipient's attending physician is not subject to the waiver or cap amount, as provided by 42 CFR 418.304(c), and SMM, section 4307.

Subp. 6. **Payment for room and board in long-term care facilities** and

Subp. 7. **Payment to hospice for residents of long-term care facilities.** Section 1902(a)(13)(D) of the Social Security Act (42 USC 1396a(a)(13)(D)), and SMM, section 4308.2, require that a hospice be paid a per diem fee, in addition to its regular fee for routine and continuous home care days, for hospice care furnished to a recipient living in a skilled nursing facility or intermediate care facility. The additional per diem fee is paid to the hospice for the room and board of a recipient who resides in a long-term care facility. In such cases, the hospice assumes the long-term care facility's responsibility for managing the recipient's care. Rather than reimbursing the facility for the care, the Medical Assistance program pays the room and board fee to the hospice, which in turn pays the facility whatever rate it has negotiated with the facility. It is reasonable to pay the hospice the room and board part of the rate that the nursing home would receive for the recipient's care under the case mix system of Minnesota Rules, chapter 9549, because that system provides the methodology currently in use for computing payment rates to long-term care facilities and is based on cost information subject to audit.

The State Medicaid Manual, section 4308.2, defines room and board as including: "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." Since Medical Assistance payments made to long-term care facilities, under parts 9549.0010 to 9549.0080, purchase services beyond room and board, it is necessary to determine what part of the payments are for room and board. It is reasonable to identify the elements of the long-term care facilities' costs that fit HCFA's definition in SMM, 4308.2, by analyzing the audited Medical Assistance cost reports, because these reports provide the most complete, accurate, and current information available about the allocation of costs by the industry.

The department has determined that the room and board component of the payment rates comprises 83% of medical assistance payment rates to nursing homes. This amount was determined by the following analysis of all Medical Assistance nursing home payment rates in Minnesota for the latest audited data available (September 30, 1986 cost report), as determined under Minnesota Rules, parts 9549.0010 to 9549.0080:

a. Approximately 60 hospital-attached nursing homes, which do not report costs on a line item basis, were excluded because "room and board" costs cannot be extracted from their cost reports. These costs are not available because hospital-attached homes are not required to separately report room and board costs to Medicare or to the department under Minnesota Rules, parts 9549.0020, subpart 26, and 9549.0041, subpart 4. Therefore, it is reasonable to compute the averages using the other 388 facilities.

b. property payment rates (under Minnesota Rules, part 9549.0060), were multiplied by resident days to obtain an approximate statewide average for "property costs";

c. allowable operating costs and reported real estate tax costs (under Minnesota Rules, parts 9549.0020, subpart 32, and 9549.0040) were summed for all homes to obtain an approximate statewide average for "operating costs";

d. total "expenses" is the property costs plus operating costs (computed from the 1986 cost report to be $764,220,308);

e. allowable professional nursing costs (salaries of registered nurses and licensed practical nurses) were excluded from "room and board" costs, because the hospice is responsible for providing all professional nursing services, and the HCFA definition of "room and board" includes hands-on, maintenance level nursing, such as personal care. The costs of the directors of nursing were included in room and board, because nurses aides (and similar non-professional nursing personnel) require administrative supervision and management. Thirty percent of the total payroll taxes and fringe benefits were also excluded from the total costs because the approximate proportion of professional nursing salaries to all salaries is 30 percent. The sum of professional nursing costs, excluding those of the directors of nursing, and 30 percent of the payroll taxes and fringe benefits, was subtracted from the total expenses. (The resulting professional nursing costs, constituting the non-room and board costs, were computed from the 1986 cost reports to be $133,199,590).

The aggregate "room and board" cost is the difference between total expenses and non-room and board costs ($764,220,308 - $133,199,590 = $631,020,718). The room and board rate is therefore the room and board costs divided by the total expenses ($631,020,718 / $764,220,308 = 83%).

It is reasonable to compute a statewide average room and board percentage because it is expected that relatively few nursing home residents will elect hospice. It would be administratively burdensome to

compute a room and board rate for each facility each year, and would be impossible to do so for the hospital-attached nursing homes. It is also unlikely that the room and board percentage would vary significantly from the statewide average.

Expert Witnesses

If this rule goes to public hearing, the department does not plan to solicit outside expert witnesses to testify on behalf of the department.

November 2, 1988

SANDRA S. GARDEBRING, Commissioner
Department of Human Services

APPENDIX A

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Health Programs

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Long-term Care Management

APPENDIX ¢B

¶30,127 HOSPICE PROJECTS

Hospice, HEW Pamphlet, 12 pps. [1979].

Medicare and Medicaid—Hospice projects.—Below is the text of a pamphlet issued by HEW giving general information about the hospice as an emerging source of care for terminally ill patients and their families. The material below discusses hospice function, history, organization, and range of services. Also discussed are unresolved issues and federal involvement in hospice care. *Back reference:* ¶13,650.

Hospice programs provide health and supportive services to help dying patients and their families live their lives as fully as possible during the final months of a terminal illness.

In almost all hospice programs, an interdisciplinary team of health and support service workers assesses the physical, emotional and spiritual needs of the patient and family. The team develops an overall plan of care for patient and family and provides coordinated services in the patient's home or an institution.

Team members may include paid workers and volunteers, some of whom may be trained professionals. Family members often play a major role in caring for the patient.

Pain and other symptoms of the patient's disease are controlled, but no heroic efforts are made to cure the patient. Services are available around the clock, and counseling is provided to the family after death to help alleviate emotional suffering.

History

The concept of hospice care began when a group of Catholic widows established a hospice in Lyon, France, in 1842 for poor women with incurable and inoperable cancer. In the mid-1800s, the Irish Sisters of Charity established a hospice for the dying in Dublin, Ireland.

The most widely known of the modern hospices, St. Christopher's in London, was founded in 1967 to provide care for terminally ill patients. St. Christopher's is a separate, free-standing facility with a home care program, not part of a hospital. It gained wide recognition for developing advanced techniques in using drugs to manage pain and other symptoms associated with terminal illness.

Hospices in the United States

The first U.S. hospice program was established in 1971, but the concept of

country only during the past three years. Most U.S. hospice programs have emphasized home care programs, although some hospice programs are located in hospitals or free-standing facilities.

In March 1979, the Government Accounting Office reported that there were 59 functioning hospice programs located throughout the nation, with another 73 in the planning stages. However, because the hospice movement is growing so rapidly, the GAO figure probably understates the actual number of hospices now in operation.

U.S. hospices are organized in several different ways, including:

- Home care programs, which may be affiliated with a hospice facility, hospital, or other health organization;
- Free-standing hospice facilities that provide inpatient services;
- Free-standing hospices affiliated with hospitals or medical schools;
- Hospice units within a hospital, which may range from several beds to an entire ward or floor.
- Hospice teams working inside a hospital that provide services to dying patients wherever they are located in the hospital.

Hospice programs may combine several organizational structures. For example, free-standing hospices may provide services in home care programs, operate a small inpatient facility, and have some affiliation with a hospital.

The vast majority of patients served by U.S. hospices are suffering from terminal cancer. The GAO reports that most are between 60 and 70 years old, and almost all die within a few months of admission to a hospice program.

Range of Services

The precise combination of hospice services delivered to individual patients and their families varies depending on the nature of the patient's illness and the needs of the family.

Health services provided by a hospice may include home health care, including skilled nursing; physician services; psychiatric consultation; control of pain and other symptoms; physical, speech, and occupational therapy; and inpatient care in a hospital or free-standing hospice.

Supportive services may include day care for the patient, homemaker services, meal preparation at home, transportation to and from treatment centers, respite care (to give family members time off from caring for the patient), education about death, emotional counseling, spiritual support, and bereavement counseling after the patient has died.

To provide these services, hospices rely on a team of paid and volunteer health and support service workers who are available to both the patient and the family. The team is usually directed by a physician, and includes one or more nurses; it may also include a social worker, psychologist, physical therapist, nutritionist, member of the clergy, and professionals from other backgrounds. Volunteers may include trained health professionals and providers of supportive services.

Most hospices believe that helping patients live their last days as fully as possible requires control of pain and other symptoms. Therefore, the hospice team assesses the patient's level of pain and provides medication to maintain the patient in an alert but pain-free condition until death. In most cases, the medication is administered regardless of the potential for addiction.

Major Issues

The hospice movement in the United States is relatively new—small, innovative and still evolving. U.S. experience with hospices has raised a number of significant issues, which are complicated by the wide variety of hospice programs and organizations. These issues include:

- Quality of care. What is the proper role of Federal, State and local governments in making sure that hospices provide a reasonably high level of care? How should hospices be regulated and licensed?
- Costs. Hospice services are labor-intensive, but they generally do not require expensive machinery and life-prolonging drugs. How do the costs of hospice care compare with the costs of standard medical care for terminally ill patients? What is the impact of hospice services on current efforts to control health care costs?
- Utilization rates. How many patients will choose to use hospice services? Utilization rates may be affected by such factors as different cultural attitudes toward death, the attitude of an attending physician, a patient's willingness to admit he or she is dying, and cost consideration.
- Reimbursement policies. Private insurance companies generally do not pay for some hospice services. Under certain

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conditions, Medicare pays for some hospice services, such as inpatient hospital care, care in a skilled nursing facility, or home health services. Current legislation and regulations, however, make many hospice services ineligible for reimbursement. For example, by law, Medicare cannot pay for home health care unless the patient is completely confined to the home. It does not pay for custodial care or services unless they are medically necessary, or for drugs if they are administered in a home health care program. Reimbursement for some supportive services may be available under the Medicaid program in some States, and under Title XX, of the Social Security Act, commonly known as the Social Services program. Should the Federal government reimburse patients for the costs of some or all hospice services? How would the availability of Federal reimbursement affect these services now provided on a voluntary basis? What is the potential cost of such a change in reimbursement policy?

- Training. Many health, social service, psychological and religious workers need special training in working with dying patients and their families. What role should the government play in the training of hospice workers, both professional and volunteer?

- Integration. How should hospice care be incorporated into existing health care delivery systems? Do we need a separate class of health care providers called hospices? Should the existing system be changed to provide hospice care?

Federal Involvement in Hospice

Because the hospice movement is so new, the Federal government has been concerned about imposing overly restrictve regulations that could stifle innovation and unnecessarily limit the effectiveness of hospice programs. The risk of inappropriate regulation is increased by the lack of hard data on vital aspects of hospice programs, including costs and utilization rates.

At the same time, however, the hospice movement is growing rapidly and is beginning to serve a significant number of patients with terminal illnesses. Precisely because they are dying, hospice patients are uniquely vulnerable to exploitation, fraud and inadequate care. Government therefore has a clear responsibility to help ensure a high quality of care for hospice patients.

To date, the Federal government's attitude to hospices has been cautious and investigatory. Federal activities have been aimed at developing a body of informatin that will help shape future Federal involvement in the hospice movement. HEW has taken the lead in these activities, although other agencies have also become involved.

Although there is no funding available to support the planning or operation of new hospice programs, HEW is supporting a number of research and demonstration projects related to hospices. Ongoing research activities are being coordinated out of seven HEW program areas:

- The National Cancer Institute is funding three 3-year demonstration projects to field-test several aspects of the hospice care concept. Each project is a free-standing hospice that operates a relatively large home care program and a small inpatient facility. Between 1974 and 1977, NCI also funded a 3-year demonstration of a home health care hospice program.

- The Health Care Financing Administration has selected 26 hospice programs as demonstration projects. The 2-year demonstration projects will waive certain restrictions that have limited Medicaid and Medicare reimbursement for hospice services. Organizations selected for this demonstration range from visiting nurses associations to free-standing hospices, hospitals, home health care associations and university medical schools. The results of the demonstration projects will be used to compare the quality of services under hospices programs to those provided in traditional settings; evaluate the cost and utilization of hospice services and assess their impact on the overall costs of Medicare and Medicaid; and suggest alternative reimbursement methods.

- The Administration on Aging is funding five research projects to develop information on how hospice services fit into traditional systems of care for the aging. The research projects cover a broad range of subjects, including: the kind of buildings necessary for hospice services; demonstration of hospice programs; and a comparison of different ways of organizing hospice programs and the impact of differences in organization on the quality and cost of hospice care.

- The Administration for Public Services in the Office of Human Development Services is conducting a survey to identify and define social services provided within hospice programs, such as homemaker and counseling services. Among other things, the survey will attempt to identify hospice services that may be eligible for reimburse-

ment under Title XX of the Social Security Act.

- The Health Resources Administration is funding two projects concerned with training for hospice workers. One examines the way in which members of hospice teams learn to work with each other in providing humanistic care to patients and their families. The project will develop a training program for hospice team members. The second project focuses on the role nurses play in hospice care; it will develop, implement and evaluate a curriculum to prepare nurses for delivery of hospice services.

- The National Institute of Mental Health has funded three projects focusing on psychological training for hospice workers and counseling for the terminally ill. Two of the projects will develop training materials for hospice workers.

- The National Institute on Aging operates a grant-supported research program to assess the social and health impact of bereavement on older people, particularly widows. NIA is currently funding three studies in this area.

Other Federal involvement in the hospice movement includes:

- The Veterans Administration is establishing a 15-bed hospice-like program in a veterans' hospital in Los Angeles.

- ACTION, the Federal volunteer program, is supplying a small number of volunteers for a few hospice programs.

- In May 1979, the Interagency Committee on New Therapies for Pain and Discomfort issued its final report on all aspects of pain and pain control. One of its three subcommittees focused on public health issues related to terminal illness.

Future government policy concerning hospices will be shaped by the results of these and other research projects.

For more information about hospices, contact:

The National Hospice Organization

301 Tower Suite 506

301 Maple Avenue West

Vienna, Virginia 22108

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE STATE DEPARTMENT OF HUMAN SERVICES GOVERNING MEDICAL ASSISTANCE PAYMENT FOR HOSPICE SERVICES, MINNESOTA RULES, PARTS 9505.0297 AND 9505.0446.

AFFIDAVIT OF MAILING

Nancy Bishop, being first duly sworn, deposes and says:

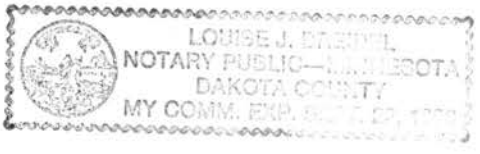
That on the 16th day of November, 1988, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of hearing by this Department.

Nancy L. Bishop

Subscribed and sworn to before me

this 16 day of November, 1988

Louise J. Brevik



Department of Human Services

In the Matter of the Proposed Adoption of the Rule of the State Department of Human Services Governing Medical Assistance Payment for Hospice Services, Minnesota Rules, parts 9505.0297 and 9505.0446

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING

Notice is hereby given that the State Department of Human Services intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minnesota Statutes, section 256B.02, subdivision 8, clause (20).

All persons have 30 days or until 4:30 p.m. on December 21, 1988, in which to submit comments in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Chris Kiefer
Rules Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
Telephone (612) 297-1461

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

The proposed rule adds hospice to the services that will be paid for by the Medical Assistance program, under Minnesota Rules, parts 9505.0170 to 9505.0475 (Rule 47). The hospice services will be available under the same terms as provided by Medicare, except that the annual limit (cap) on payments to each hospice program imposed by Medicare will not be imposed by Medical Assistance. The rule provides for election and revocation of hospice by a recipient who has a life expectancy of six months or less, or by the recipient's representative; waiver of benefits for services related to the terminal illness; no limit on the duration of services; requirements that the hospice provide all necessary services; requirements for services during a medical crisis, respite care, and bereavement counseling for survivors. The rule also sets forth the categories of service for purposes of payment, limitations on payment, and provides for payment to hospices for the room and board of recipients who reside in long-term care facilities. The rule also has provisions defining terms. The rule will affect hospice programs and recipients of Medical Assistance by providing to them the option of hospice services under the Medical Assistance program. The rule may also affect long-term care facilities, in that they will receive payment from hospices for their residents who elect hospice services, rather than from the Department of Human Services.

A free copy of the rule is available upon request from Chris Kiefer at the address noted above. A copy of the rule may also be viewed at any of the 87 county welfare or human services agencies in the State of Minnesota.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Chris Kiefer at the address noted above upon request.

Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request

notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Chris Kiefer at the address noted above.

November 2, 1988

SANDRA S. GARDEBRING
Commissioner

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE STATE DEPARTMENT OF HUMAN SERVICES GOVERNING MEDICAL ASSISTANCE PAYMENT FOR HOSPICE SERVICES, MINNESOTA RULES, PARTS 9505.0297 AND 9505.0446.

AFFIDAVIT OF ADDITIONAL MAILING

Nancy Bishop, being first duly sworn, deposes and says:

That on the 16th day of November, 1988, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to the following parties:

-The 87 Minnesota County Human Services Agencies

-The 10 Human Services Regional Treatment Centers

-Hospice Organizations in Minnesota

-Hospice Advisory Committee Members

Nancy L. Bishop

Subscribed and sworn to before me

this 16 day of November, 1988

Louise J. Breitel



Department of Human Services

In the Matter of the Proposed Adoption of the Rule of the State Department of Human Services Governing Medical Assistance Payment for Hospice Services, Minnesota Rules, parts 9505.0297 and 9505.0446

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING

Notice is hereby given that the State Department of Human Services intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minnesota Statutes, section 256B.02, subdivision 8, clause (20).

All persons have 30 days or until 4:30 p.m. on December 21, 1988, in which to submit comments in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Chris Kiefer
Rules Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816
Telephone (612) 297-1461

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

The proposed rule adds hospice to the services that will be paid for by the Medical Assistance program, under Minnesota Rules, parts 9505.0170 to 9505.0475 (Rule 47). The hospice services will be available under the same terms as provided by Medicare, except that the annual limit (cap) on payments to each hospice program imposed by Medicare will not be imposed by Medical Assistance. The rule provides for election and revocation of hospice by a recipient who has a life expectancy of six months or less, or by the recipient's representative; waiver of benefits for services related to the terminal illness; no limit on the duration of services; requirements that the hospice provide all necessary services; requirements for services during a medical crisis, respite care, and bereavement counseling for survivors. The rule also sets forth the categories of service for purposes of payment, limitations on payment, and provides for payment to hospices for the room and board of recipients who reside in long-term care facilities. The rule also has provisions defining terms. The rule will affect hospice programs and recipients of Medical Assistance by providing to them the option of hospice services under the Medical Assistance program. The rule may also affect long-term care facilities, in that they will receive payment from hospices for their residents who elect hospice services, rather than from the Department of Human Services.

A free copy of the rule is available upon request from Chris Kiefer at the address noted above. A copy of the rule may also be viewed at any of the 87 county welfare or human services agencies in the State of Minnesota.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Chris Kiefer at the address noted above upon request.

Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request

notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Chris Kiefer at the address noted above.

November 2, 1988

SANDRA S. GARDEBRING
Commissioner

Proposed Rules

Pursuant to Minn. Stat. §§ 14.22, an agency may propose to adopt, amend, suspend or repeal rules without first holding a public hearing, as long as the agency determines that the rules will be noncontroversial in nature. The agency must first publish a notice of intent to adopt rules without a public hearing, together with the proposed rules, in the *State Register.* The notice must advise the public:

1. that they have 30 days in which to submit comment on the proposed rules;
2. that no public hearing will be held unless 25 or more persons make a written request for a hearing within the 30-day comment period;
3. of the manner in which persons shall request a hearing on the proposed rules; and
4. that the rule may be modified if the modifications are supported by the data and views submitted.

If, during the 30-day comment period, 25 or more persons submit to the agency a written request for a hearing of the proposed rules, the agency must proceed under the provisions of §§ 14.14-14.20, which state that if an agency decides to hold a public hearing, it must publish a notice of intent in the *State Register.*

Pursuant to Minn. Stat. §§ 14.29 and 14.30, agencies may propose emergency rules under certain circumstances. Proposed emergency rules are published in the *State Register* and, for at least 25 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Human Services

Proposed Permanent Rules Relating to Medical Assistance Hospice Care Services

Notice of Intent to Adopt a Rule Without a Public Hearing

NOTICE IS HEREBY GIVEN that the State Department of Human Services intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules set forth in the Administrative Procedure Act for adopting rules without a public hearing in *Minnesota Statutes*, sections 14.22 to 14.28. The statutory authority to adopt the rule is *Minnesota Statutes*, section 256B.02, subdivision 8, clause (20).

All persons have 30 days or until 4:30 p.m. on December 21, 1988, in which to submit comments in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to *Minnesota Statutes*, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Chris Kiefer
Rules Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3832
Telephone (612) 297-1461

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

The proposed rule adds hospice to the services that will be paid for by the Medical Assistance program, under *Minnesota Rules*, parts 9505.0170 to 9505.0475 (Rule 47). The hospice services will be available under the same terms as provided by Medicare, except that the annual limit (cap) on payments to each hospice program imposed by Medicare will not be imposed by Medical Assistance. The rule provides for election and revocation of hospice by a recipient who has a life expectancy of six months or less, or by the recipient's representative; waiver of benefits for services related to the terminal illness; no limit on the duration of services; requirements that the hospice provide all necessary services; requirements for services during a medical crisis, respite care, and bereavement counseling for survivors. The rule also sets forth the categories of service for purposes of payment, limitations on payment, and provides for payment to hospices for the room and board of recipients who reside in long-term care facilities. The rule also has provisions defining terms. The rule will affect hospice programs and recipients of Medical Assistance by providing to them the option of hospice services under the Medical Assistance program. The rule may also affect long-term care facilities, in that they will receive payment from hospices for their residents who elect hospice services, rather than from the Department of Human Services.

A free copy of the rule is available upon request from Chris Kiefer at the address noted above. A copy of the rule may also be viewed at any of the 87 county welfare or human services agencies in the State of Minnesota.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Chris Kiefer at the address noted above upon request.

Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of *Minnesota Statutes*, section 14.11.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Chris Kiefer at the address noted above.

Dated: 29 November 1988

Sandra S. Gardebring
Commissioner

Rules as Proposed (all new material)

9505.0297 HOSPICE CARE SERVICES.

Subpart 1. **Applicability.** Parts 9505.0297 and 9505.0446 must be read in conjunction with *United States Code*, title 42, section 1396a, and *Code of Federal Regulations*, title 42, part 418.

Subp. 2. **Definitions.** For purposes of this part and part 9505.0446, the following terms have the meanings given them.

A. "Business days" means every day except Saturday, Sunday, and legal holidays in Minnesota.

B. "Cap amount" means the limit on overall hospice reimbursement provided by part 9505.0446, subpart 4, and *Code of Federal Regulations*, title 42, sections 418.308 and 418.309, as amended through October 1, 1987.

C. "Employee" means an employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice unit. Employee also includes a volunteer under the supervision of the hospice.

D. "Home" means the recipient's place of residence.

E. "Hospice" has the meaning given to hospice program in *Minnesota Statutes*, section 144A.48, subdivision 1, clause (4).

F. "Hospice care" means the services provided by a hospice to a terminally ill recipient under this part.

G. "Inpatient care" means the services provided by an inpatient facility to a recipient who has been admitted to a hospital, long-term care facility, or facility of a hospice that provides care 24 hours a day.

H. "Inpatient facility" means a hospital, long-term care facility, or facility of a hospice that provides care 24 hours a day.

I. "Interdisciplinary group" has the meaning given to interdisciplinary team in *Minnesota Statutes*, section 144A.48, subdivision 1, clause (5).

J. "Palliative care" has the meaning given in *Minnesota Statutes*, section 144A.48, subdivision 1, clause (6).

K. "Representative" means a person who, because of the terminally ill recipient's mental or physical incapacity, may execute or revoke an election of hospice care on behalf of the recipient under Minnesota law.

L. "Respite care" means short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient.

M. "Social worker" means a person who has at least a bachelor's degree in social work from a program accredited or approved by the Council of Social Work Education and who complies with *Minnesota Statutes*, sections 148B.21 to 148B.28.

N. "Terminally ill" means that the recipient has a medical prognosis that life expectancy is six months or less.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Subp. 3. **Provider eligibility.** A provider of hospice services is eligible for medical assistance payments if the provider is:

A. licensed or registered as a hospice under *Minnesota Statutes*, section 144A.48 or 144A.49; and

B. certified as a provider of hospice services under Medicare, in accordance with title XVIII of the Social Security Act, and *Code of Federal Regulations*, title 42, part 418.

Subp. 4. **Recipient eligibility.** To be eligible for medical assistance coverage of hospice care, a recipient must be certified as being terminally ill in the manner required by subpart 5.

Subp. 5. **Certification of terminal illness.** Within two calendar days after hospice care is initiated, the hospice must obtain written statements certifying that the recipient is terminally ill, signed by:

A. the medical director of the hospice or the physician member of the hospice's interdisciplinary group; and

B. the recipient's attending physician, if the recipient has one.

Within two calendar days after the recipient's first 90 days of hospice care and within two calendar days after the beginning of each subsequent 90-day period, the hospice must obtain a written statement certifying that the recipient is terminally ill, signed by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.

Subp. 6. **Election of hospice care.** A recipient who is eligible for hospice care under subpart 4 and elects to receive hospice care, must submit an election statement to the hospice. The statement must include:

A. designation of the hospice that will provide care;

B. the recipient's acknowledgement that the recipient fully understands that the hospice provides palliative care rather than curative care with respect to the recipient's terminal illness;

C. the recipient's acknowledgement that the services under subpart 9 are waived by the election;

D. the effective date of the election, which must be no earlier than the date that the election is signed; and

E. the recipient's signature.

Subp. 7. **Election by representative.** A representative of the recipient may make the election and sign and submit the election statement to the hospice for the recipient according to subpart 6.

Subp. 8. **Notification of the election.** The hospice must mail or deliver a copy of the election statement required by subpart 6 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date the hospice receives the signed election statement.

Subp. 9. **Waiver of other benefits.** A recipient who elects hospice care under subpart 6 or for whom a representative elects hospice care under subpart 7 waives the right to medical assistance payments during the recipient's hospice stay for the following services:

A. Hospice care provided by a hospice other than the hospice designated by the recipient or the recipient's representative, unless the care is provided under arrangements made by the designated hospice.

B. Health services related to treatment of the terminal illness for which hospice care was elected or a condition related to the terminal illness, or services that are equivalent to hospice care, except for services:

(1) provided by the designated hospice;

(2) provided by another hospice under arrangements made by the designated hospice; and

(3) provided by the recipient's attending physician if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services.

C. Personal care services, under part 9505.0335.

Subp. 10. **Duration of hospice services.** A recipient may receive hospice care until the recipient revokes the election under subpart 11 or no longer is eligible for hospice care under subpart 4.

Subp. 11. **Revoking the election.** A recipient or the recipient's representative may revoke the election of medical assistance coverage of hospice care at any time. To revoke the election, the recipient or representative must submit a statement to the hospice that includes:

A. a signed statement that the recipient or representative revokes the recipient's election of medical assistance coverage of hospice care; and

B. the date that the revocation is to be effective, which must be no earlier than the date on which the revocation is signed.

Subp. 12. **Notification of revocation.** The hospice must mail or deliver a copy of the revocation statement submitted under subpart

11 to the local agency of the recipient's county of service, as defined by part 9505.0015, subpart 27, within two business days after the date that the hospice receives the signed statement revoking the election.

Subp. 13. **Effect of revocation.** A recipient, upon revoking the election of medical assistance coverage of hospice care under subpart 11:

A. is no longer covered under medical assistance for hospice care;

B. resumes medical assistance coverage of the benefits waived under subpart 9; and

C. may elect to receive medical assistance coverage of hospice care at a later time, if eligible under this part at that time.

Subp. 14. **Change of hospice.** A recipient or the recipient's representative may change the designation of the hospice from which the recipient will receive hospice care. The change of the designated hospice is not a revocation of the election of medical assistance coverage of hospice care. To change the designation of the hospice, the recipient or the recipient's representative must submit both to the hospice where care has been received and to the newly designated hospice a signed statement that includes the following information:

A. the name of the hospice where the recipient has received care and the name of the hospice from which the recipient plans to receive care; and

B. the date the change is to be effective.

Subp. 15. **Requirements for medical assistance payment.** To be eligible for medical assistance coverage, hospice care must be:

A. reasonable and necessary for the palliation or management of the terminal illness and conditions related to the terminal illness;

B. in compliance with *Minnesota Statutes,* sections 144A.43 to 144A.49, and with the rules adopted under *Minnesota Statutes,* section 144A.48; and

C. consistent with the recipient's plan of care, established by the hospice.

Subp. 16. **Covered services.** As required by the recipient's plan of care, the services listed in items A to D must be provided directly by hospice employees, except that the hospice may contract for these services under the circumstances provided for in *Code of Federal Regulations,* title 42, section 418.80. As required by the recipient's plan of care, the services listed in items E to I must be provided directly or be made available by the hospice.

A. Nursing services provided by or under the supervision of a registered nurse.

B. Medical social services provided by a social worker under the direction of a physician.

C. Services performed by a physician, dentist, optometrist, or chiropractor.

D. Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided both to train the recipient's family or other caregiver to provide care, and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

E. Inpatient care, including procedures necessary for pain control or acute or chronic symptom management provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care. Inpatient care must conform to the written plan of care. A hospice that provides inpatient care must meet the standards in *Code of Federal Regulations,* title 42, sections 418.100(a) and (f), as amended through October 1, 1987.

F. Inpatient care, as a means of providing respite for the recipient's family or other persons caring for the recipient at home, provided in a Medicare or medical assistance certified hospital, skilled nursing facility, or hospice unit that provides inpatient care, or in a medical assistance certified intermediate care facility, subject to subpart 18.

G. Medical equipment and supplies, including drugs. Only drugs approved by the commissioner under part 9505.0340, subpart 3, item A, and used primarily to relieve pain and control symptoms of the recipient's terminal illness are covered. Medical equipment includes durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical equipment must be provided by the hospice for use in the recipient's home while the recipient is under hospice care. Medical supplies include those specified in the written plan of care.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

H. Home health aide services and homemaker services. Home health aides may provide personal care services as described in part 9505.0335, subparts 8 and 9. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the recipient's bed linens or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

I. Physical therapy, occupational therapy, and speech-language pathology services provided to control symptoms or to enable the recipient to maintain activities of daily living and basic functional skills.

Subp. 17. **Services provided during a crisis.** A hospice may provide nursing services, including homemaker or home health aide services, to a recipient on a continuous basis for as much as 24 hours a day during a crisis as necessary to maintain a recipient at home. More than half of the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. A crisis is a period in which the recipient requires continuous care for palliation or management of acute medical symptoms.

Subp. 18. **Respite care.** A hospice may provide respite care to a recipient only on an occasional basis and may not be paid for more than five consecutive days of respite care at a time. A hospice shall not provide respite care to a recipient who resides in a long-term care facility.

Subp. 19. **Bereavement counseling.** Bereavement counseling services must be made available by the hospice to the recipient's family until one year after the recipient's death. For purposes of this subpart, family includes persons related to the recipient or those considered by the recipient to be family because of their close association.

Subp. 20. **Medical assistance payment for hospice care.** Medical assistance shall be paid to a hospice for covered services according to part 9505.0446.

9505.0446 HOSPICE CARE PAYMENT RATES AND PROCEDURES.

Subpart 1. **Rate categories.** Providers of hospice care as described in part 9505.0297 are paid at one of four fixed daily rates that apply to each of the four categories of services in subpart 3. The fixed daily rates apply to all services, except for certain physician services as described in subpart 5, and room and board in a long-term care facility as described in subparts 6 and 7.

Subp. 2. **Long-term care facility as residence.** For purposes of this part, a recipient who resides in a long-term care facility is considered to live at home.

Subp. 3. **Categories of service.** Except as otherwise provided by subparts 4 to 6, no payments shall be made for specific services provided by the hospice. Fixed daily rates are calculated under subpart 4 for each of the following categories of services:

A. Routine home care day, which is a day on which a recipient who has elected to receive hospice care is at home and is not receiving continuous care as defined in item B.

B. Continuous home care day, which is a day on which a recipient who has elected to receive hospice care has not been admitted to a facility that provides inpatient care, except when a long-term care facility is the recipient's residence under subpart 2, and the recipient receives hospice care consisting of nursing services, including home health aide or homemaker services, on a continuous basis at home, as provided by part 9505.0297, subpart 17. No fewer than eight hours a day of nursing care must be provided by a registered nurse or licensed practical nurse. Continuous home care may be furnished only during periods of crisis as described in part 9505.0297, subpart 17, and only as necessary to maintain the terminally ill recipient at home.

C. Inpatient respite care day, which is a day on which the recipient who has elected hospice care receives inpatient care in an inpatient facility certified for medical assistance on a short-term basis for respite. This item is subject to the limits provided by part 9505.0297, subpart 18. This item does not apply to a recipient whose residence is a long-term care facility under subpart 2.

D. General inpatient care day, which is a day on which a recipient who has elected hospice care receives general inpatient care in a hospital or skilled nursing facility that provides inpatient care for control of pain or management of acute or chronic symptoms that cannot be managed in other settings. This item does not apply to a recipient who receives inpatient care in a long-term care facility in which the recipient is a resident under subpart 2.

Subp. 4. **Payments and limitations.** Medical assistance will pay a hospice for each day a recipient is under the hospice's care. Payment is in the same amounts, uses the same methodology, and is subject to the same limits and cap amount used by Medicare under *Code of Federal Regulations*, title 42, sections 418.301 to 418.309, as amended through October 1, 1987, except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS), as provided by *United States Code*, title 42, section 1396d(o)(1)(B). The rates are determined by the Health Care Financing Administration (HCFA), United States Department of Health and Human Services, as provided by *Code of Federal Regulations*, title 42, section 418.306, as amended through October 1, 1987, and as adjusted by HCFA for the Medicare co-pay amounts not allowed under medical assistance. Payments to long-term care facilities under subparts 6 and 7 are not included in the cap amount. Changes in rates are announced in the *Federal Register*. No payment will be made for bereavement counseling under part 9505.0297, subpart 19.

Subp. 5. **Payment for physician services.** Physician services are paid according to items A to C.

A. The services specified in subitems (1) and (2) are included in the rates provided by subpart 4:

(1) general supervisory services of the hospice's medical director; and

(2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the hospice's interdisciplinary group.

B. Other than for services described in item A, medical assistance shall pay the hospice for physician services furnished by physicians who are employees of the hospice or who provide services under arrangements with the hospice, at the rate provided by part 9505.0445, item E. Payment for these physician services is included in the amount subject to the cap amount in subpart 4. No payment will be made to the hospice for services donated by physicians who are employees of the hospice or who provide services under arrangements with the hospice.

C. Services of the recipient's attending physician, if the physician is not an employee of the hospice or is not providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the cap amount in subpart 4. These services are reimbursed according to parts 9505.0345 and 9505.0445, item E.

Subp. 6. **Payment for room and board in long-term care facilities.** If a recipient resides in a long-term care facility under subpart 2 that is certified as a medical assistance provider and the recipient has elected medical assistance coverage of hospice services, the long-term care facility shall not be paid by medical assistance under parts 9549.0010 to 9549.0080, but shall be paid by the hospice at a rate negotiated by the long-term care facility and the hospice.

Subp. 7. **Payment to hospice for residents of long-term care facilities.** The commissioner shall establish the payments to hospices for the room and board of medical assistance recipients who reside in long-term care facilities certified by medical assistance, as provided by items A and B.

A. The daily room and board payment rate shall be either:

(1) 83 percent of the long-term care facility's daily payment rate for the recipient's resident class, as determined under parts 9549.0010 to 9549.0080; or

(2) 83 percent of the long-term care facility's daily payment rate for the recipient's certification level, if the long-term care facility is not subject to parts 9549.0010 to 9549.0080.

B. The payment to the hospice is the product of the hospice's daily room and board payment rate determined in item A and the number of days for which the recipient resides in the long-term care facility in the month, less the recipient's spend-down amount for that month under part 9505.0065, subpart 11, item F.

Department of Natural Resources

Proposed Permanent Rules Relating to Water Permit Fees

Notice of Intent to Adopt Rule Amendments Without a Hearing

NOTICE IS HEREBY GIVEN that the Minnesota Department of Natural Resources intends to adopt the above entitled amendments without a public hearing, following the procedures set forth in *Minnesota Statutes*, § 14.21-14.28.

Changes are proposed to sections concerning fees for permit applications, amendments and transfers, and field inspection fees. New material covers water appropriation processing fee exemptions. The rules are authorized by *Minnesota Statutes* section 105.44 subdivision 10. The amendments are being made to conform the rule to changes in the statute made by *Laws of Minnesota 1988*, chapter 686, article 1, section 56.

Persons interested shall have 30 days to submit comments on the proposed amendments. The proposed amendments may be modified in final adoption if modifications are supported by the data and views submitted to the Department of Natural Resources and do not result in a substantial change in the proposed language.

Unless twenty-five or more persons submit written requests for a public hearing on the proposed amendments within the 30-day comment period, a public hearing will not be held. The written request must be specific on which amendment(s) a hearing is desired.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of the Rule of the Minnesota Department of Human Services Governing Medical Assistance Payment for Hospice Services, Minnesota Rules, parts 9505.0297 and 9505.0446

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULE WITHOUT PUBLIC HEARING

Notice of the Commissioner's intent to adopt the above-entitled rule was published in the State Register on November 21, 1988 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22, on November 16, 1988. The statement of need and reasonableness was prepared before the notice of intent to adopt a rule without a public hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

All persons were given the opportunity to submit comment on the rule for 30 days after notice of proposed rulemaking. No requests for a public hearing on the rule were received by the agency. No submissions or comments suggesting modifications to the rule were received by the agency. No requests for notice of submission to the attorney general were received by the agency.

FINDINGS OF FACT

Based on the comments and evidence in the record before the agency, I find that no modifications in the rule as proposed are necessary.

CONCLUSIONS

I hereby conclude that:

1. The rules are necessary and reasonable.

2. Any duplication in these rules of language contained in Minnesota Statutes is crucial to the ability of persons affected by the rules to comprehend their meaning and effect.

3. The Department has complied with all applicable provisions of law and rule in the promulgation of these rules.

4. If any finding or part of a finding, above, is properly characterized as a conclusion, it is adopted as a conclusion.

The above-captioned rule is needed and reasonable.

NOW, THEREFORE, IT IS ORDERED that the rule identified as Medical Assistance Payment for Hospice Services, Minnesota Rules, parts 9505.0297 and 9505.0446 is adopted this 27th day of December, 1988, pursuant to authority vested in me by Minnesota Statutes, section 256B.02, subdivision 8, clause (20).

for Julie M. Brunner
SANDRA S. GARDEBRING
Commissioner

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38___

Rec'd 12/28/88 BR

TO: Rita Desmond
515 Transportation Building
St. Paul, MN 55155

12-27-88

FROM: Bob Hamper
Rules Division
Department of Human Services

SUBJECT: Review of a Rule Adopted Without a Public Hearing;
Medical Assistance Hospice Care Services Rule

Enclosed are the documents required to be submitted under Minnesota Rules, part 2010.0300 for your review of a rule adopted without a public hearing for the above entitled matter.

Official documents in this submitted material include:

1. A copy or photocopy of the notice of solicitation of outside information or opinions as published in the State Register.

2. A copy of the proposed rule with a certificate of approval as to form by the revisor of statutes attached.

3. The notice of intent to adopt a rule without a public hearing as mailed.

4. The statement of need and reasonableness in support of the proposed rule complying with part 2010.0700.

5. The affidavit of mailing the notice of intent to adopt a rule without a public hearing. The affidavits state that the mailing list maintained by the agency pursuant to Minnesota Statutes, sections 14.22 and 14.14, subdivision 1a is accurate, complete, and current and that the notice of intent to adopt the rule without a public hearing was mailed to all persons and groups whose names appear on the list.

6. A copy or photocopy of the notice of intent to adopt the rule without a public hearing as published in the State Register.

7. Four copies of the rule as adopted. Any modification made to the proposed rule is reflected on the rule as adopted and is approved as to form by the revisor of statutes.

8. The findings of fact, conclusions, and order adopting the rule.

9. All written requests, submissions, or comments on the rule received by the agency except requests solely for copies of the rule or of the statement of need and reasonableness.

10. The declaration of the attorney in the attorney general's office who represents the agency.

11. The notice of submission of the rule to the attorney general, if applicable.

12. The affidavit of mailing notice of submission of the rule to the attorney general, if applicable.

Note: Please note that no requests were received for notification of submittal to the Attorney General.

If you have any questions on this submitted material, please call me at 296-2794.

MINNESOTA
CHIROPRACTIC
ASSOCIATION

2353 Rice Street, Suite 125 ■ St. Paul, Minnesota 55113 ■ Phone 612 / 482-1434 ■ MN WATTS 1-800-592-9530

December 14, 1988

Chris Kiefer
Rules Division
MN Dept. of Human Services
444 Lafayette Road
St. Paul, MN 55155-3832

Dear Ms. Kiefer:

This association is writing to comment on the proposed permanent rules relating to medical assistance hospice care services.

Proposed Rule 9505.0297 Subp. 16 states that, among other covered services required by the recipient's plan of care, chiropractic care is to be provided directly by hospice employees. The Minnesota Chiropractic Association wholeheartedly supports this proposed rule. Chiropractic care which has been provided to individuals with certain terminal illnesses has been instrumental in easing pain symptoms and improving the patient's comfort levels.

If the department seeks additional information regarding chiropractic care, or needs assistance in the implementation of the proposed rule, please do not hesitate to contact the undersigned.

Sincerely,

Scott L. Mayer
Director of Professional Affairs

In the Matter of the Adoption
of the Rules of the Minnesota
Department of Human Services
Governing Medical Assistance
Payment for Hospice Services,
Minnesota Rules, parts 9505.0297
and 9505.0446

DECLARATION OF
COUNSEL

I, Pat Sonnenberg, Special Assistant Attorney General, do hereby declare that I have examined the above-captioned rule and the supporting rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0866.

Pat Sonnenberg

Pat Sonnenberg
Special Assistant
Attorney General

Dated: 12-28-88

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE STATE DEPARTMENT OF HUMAN SERVICES GOVERNING MEDICAL ASSISTANCE PAYMENT FOR HOSPICE SERVICES, MINNESOTA RULES, PARTS 9505.0297 AND 9505.0446.

CERTIFICATE

I hereby certify that the list of persons, associations and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subdivision 1a, and 14.22 or 14.30, that their names be placed on the State Department of Human Services rulemaking mailing list is accurate, complete, and current as of this 16th day of November, 1988.

Nancy L. Bishop

data or views in writing or orally. Written statements should be addressed to: Mary Jo Verschay, Mental Health Division, Department of Human Services, 4th Floor Centennial Office Building, 658 Cedar, St. Paul, Minn. 55155. Oral statements will be received during regular business hours over the telephone at (612) 297-2831 and in person at the above address.

All statements of information and opinions shall be accepted until further notice is published in the *State Register* or the Notice of Hearing or Notice of Intent to Adopt Rules Without a Hearing is published in the *State Register*. Any written material received by the State Department of Human Services shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Department of Human Services

Health Care Programs Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Amendments to Rules Governing Eligibility to Receive Payments as a Provider in the Medical Assistance Program, under *Minnesota Rules*, Parts 9505.0170 to 9505.0475

Notice is hereby given that the State Department of Human Services is seeking information or opinions from sources outside the agency in preparing to propose the adoption and amendment of rules governing the eligibility of providers to receive medical assistance payments under *Minnesota Rules*, parts 9505.0170 to 9505.0475, for case management for brain impaired persons (*Minnesota Rules*, part 9505.0242), case management for mentally ill persons (part 9505.0243), community mental health services (part 9505.0260), day treatment services (part 9505.0265), hospice care (part 9505.0297), psychological services (part 9505.0370), psychotherapy services (part 9505.0375), rehabilitation agency services (part 9505.0385), rehabilitative and therapeutic services (part 9505.0390), rehabilitative engineering and assistive communication devices (part 9505.0392), and long-term care facilities—rehabilitation and therapeutic services to residents (part 9505.0410), and amendments to rules setting criteria and payment rates for transportation by air ambulance and rules setting eligibility for payment of home health services such as homebound, home and respite care, private duty nursing, and extended hour nursing. The adoptions of the rules and amendments are authorized by *Minnesota Statutes*, section 256B.02, subdivision 8, in conjunction with Public Law Number 99-272, section 9505, which permits the agency to make medical assistance payments for hospice care services, and *Minnesota Statutes*, section 256B.02, subdivision 8, and section 256B.04, subdivision 2.

The State Department of Human Services requests information and opinions concerning the subject matter of the rules. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

Larry Woods
Health Care Programs Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

Oral statements will be received during regular business hours over the telephone at (612) 296-2846 and in person at the above address.

All statements of information and opinions shall be accepted until further notice is published in the *State Register* or the Notice of Hearing or Notice of Intent to Adopt Rules Without a Hearing is published in the *State Register*. Any written material received by the State Department of Human Services shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Department of Human Services

Licensing Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rules Governing the Licensure of Child Foster Homes and Family Day Care and Group Family Day Care Homes

Notice is hereby given that the State Department of Human Services is seeking information or opinions from sources outside the