**Section 140.469 Hospice**

a) Hospice is a continuum of palliative and supportive care, directed and coordinated by a team of professionals and volunteer workers who provide care to terminally ill persons to:

1) reduce or abate pain or other symptoms of mental or physical distress; and

2) meet the special needs arising out of the stresses of terminal illness, dying or bereavement.

b) Hospice care is a covered service for all eligible clients, including residents of intermediate and skilled care facilities, when provided by a Medicare certified hospice provider and in accordance with provisions contained in section 1902(a)(13)(B), 1905(o)(1) and 2110(a)(23) of the Social Security Act (42 USC 1396a(a)(13)(B), 1396d(o)(1) and 1397jj(a)(23)).

c) Covered services include:

1) Nursing care;

2) Physician services;

3) Medical social services;

4) Short term inpatient care;

5) Medical appliances, supplies and drugs;

6) Home health aide services;

7) Occupational, physical and speech-language therapy services to control symptoms; and

8) Counseling services.

d) Reimbursement shall be at the rate established by the Centers for Medicare and Medicaid Services for the specific level of care into which each day of care is classified. The Medicaid hospice payment rates are calculated based on the annual hospice rates established under section 1814(i)(1)(C)(ii) of the Social Security Act and 42 CFR 418.306. The four levels of care are:

1) Routine Home Care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. Effective with dates of service on and after January 1, 2016 and, for patients who have hospice elections on file with a beginning date on or after January 1, 2016, routine home care rates are differentiated between days 1 through 60 and days 61 and beyond.

2) Continuous Home Care. The continuous home care rate will be paid when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

3) Inpatient Respite Care. The inpatient rate will be paid each day on which the beneficiary is in the approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth day and any subsequent days is to be made at the routine home care rate.

4) General Inpatient Care. The inpatient rate will be paid when general inpatient care is provided. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives hospice inpatient care except for the day of discharge from an inpatient unit. In which case, the appropriate home care rate is to be paid unless the patient dies as an inpatient.

e) When the individual resides in an ICF or SNF facility, the Department shall provide payment of an add-on amount to the hospice on routine home care and continuous home care days. The add-on amount will constitute a portion of the facility rate the State would be responsible for as mandated by 42 CFR 418.1 through 418.205. The add-on amount for county-owned/operated nursing facilities shall be based on the rates established pursuant to Section 140.530(c)(1).

f) The hospice shall receive an add-on amount for other physician services such as direct patient care when physician services are provided by an employee of the hospice or under arrangements made by the hospice unless those services are performed on a volunteer basis. These add-on amounts will be utilized when determining the hospice cap amount.

g) In accordance with 42 CFR 418.302, effective with service dates on and after January 1, 2016, a service intensity add-on payment may be billed for visits by a social worker or registered nurse as defined in 42 CFR 418.114, when provided during routine home care during the last seven days of life.

h) Medicaid payment to a hospice provider for care furnished over the period of a year shall be limited by a payment cap as set forth in 42 CFR 418.309. Any overpayment shall be refunded by the hospice provider.

i) Effective with dates of service on and after July 1, 2012, the following services will not be covered outside of the hospice program benefit for patients 21 years of age and older electing hospice care. The following services will not be paid separately:

1) Dental services;

2) Optometric services and eyewear;

3) Nursing services provided by registered nurses and licensed practical nurses;

4) Physical therapy services;

5) Occupational therapy services;

6) Speech therapy services;

7) Audiology services;

8) General clinic services;

9) Psychiatric clinic Type A services;

10) Psychiatric clinic Type B services;

11) Hospital outpatient physical rehabilitation;

12) Healthy Kids services;

13) Mental health rehabilitation option;

14) Alcohol and substance abuse rehabilitation services;

15) Medical equipment;

16) Medical supplies;

17) Social work services;

18) Psychological services;

19) Home health services;

20) Homemaker services; and

21) Palliative drugs.

(Source: Amended at 41 Ill. Reg. 999, effective January 19, 2017)