Comments for Chapter 509 Hospice Services

Effective Date: May 1, 2020

Number	Date Received	Comment	Status Result
1	7/23/19	**Background:** I would propose an addition to the end of this sentence to read: *"the possibilities of curative medicine have been exhausted or are too burdensome for the patient".* There are times when a treatment may be available to a patient but the burden and/or risks associated with that treatment out- weighs the benefit. RE: …the possibilities of curative medicine have been exhausted. We respectfully suggest the addition of a phrase such as *'or are not desired'* as some patients prefer a more comfort-oriented approach although curative options such as dialysis are available to them.	Policy has been updated to reflect this change.
2	7/24/19	Change language to "or are not desired" after exhausted	Policy has been updated to reflect this change.
3	8/8/19	RE: …the possibilities of curative medicine have been exhausted. We respectfully suggest the addition of a phrase such as *'or are not desired'* as some patients prefer a more comfort-oriented approach although curative options such as dialysis are available to them.	Policy has been updated to reflect this change.
4	7/23/19	**509.1 - Provider Participation Requirements:** First bullet: Remove *"accreditation"* from statement. Accreditation is not required in WV so I would propose that this should be removed.	Policy has been updated to reflect this change.
5	7/24/19	Accreditation is not required in WV; [provider] proposed that this word should be removed.	Policy has been updated to reflect this change.
6	8/8/19	As accreditation is not a requirement, we suggest this be deleted.	Policy has been updated to reflect this change.

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7	7/12/19	**509.3.2-Hospice Service Requirements:** Other Hospice Services #2. The sentence reads, "A Hospice provider must make available are not considered "core services". There seems to be a word or words missing here -are they core services they must provide or are they not core services that they must make available? Wording is unclear. Add: *"services that"*	Policy has been updated to reflect this change.
8	7/23/19	Add: *"services that"*	Policy has been updated to reflect this change.
9	7/24/19	Add: *"services that"*	Policy has been updated to reflect this change.
10	8/8/19	**Other Hospice Services: Drugs and Biologicals -** Re: Home Health program services, drugs, and biologicals obtained through the WV Medicaid Pharmacy program for the palliation and management of symptoms related to the member's terminal illness. We believe that clarification is needed as this added bullet is confusing in this section. Should this state that the *WV Medicaid Pharmacy program will continue to provide drugs that are* ***unrelated*** *to the member's terminal illness?*	Policy has been updated to reflect this change.
11	7/12/19	**509.3.5 – Hospice Volunteers:** 2nd paragraph – "Volunteer hours of service must equal at least five percent of the hours of direct-member care furnished by paid personnel, employed or contract." What is the intent here? They have to use volunteers for at least 5% of services? Or does it mean volunteer services may comprise no more that 5% of services? Or something else? Intent is unclear here.	No Change as stated in 42 CFR §418.78(e) and clarification from the Centers for Medicare and Medicaid Services.
12	7/23/19	**509.4 Benefit Periods:** In 2013 the Medicaid Manual was revised in order to be consistent with the Medicare regulations re: benefit periods. A portion of this section needs to be removed in order to be consistent with this previous change. The previous change also eliminates the need for the example; [provider] suggests the example also be removed.	No Change made at this time.
13	7/24/19	Same language as above and in addition: The periods of care are available in the order listed and may be elected separately at different	No Change made at this time.

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		times. Having once elected Hospice, it is not necessary for a member to elect Hospice again after the initial election unless he or she revokes Hospice care or is discharged from Hospice Care.	
14	8/8/19	We understand that no more than 4 revocations are allowed, per state Plan, but members still have concerns about pediatric patients, who may revoke multiple times, and we ask whether exceptions might be made for children. This was a comment we also made in November 2013.	No Change made at this time.
15	7/23/19	**509.5.2 Physician Certification Timeline:** Recommends striking the 8-day limit and adding the statement "before it submits a claim for payment, and also striking the following statement: "If these requirements are not met within the set timeline, the provider is not eligible for reimbursement of Hospice services furnished before the date on which written certification is obtained.	No Change: This rule is according to the WV State Plan – Supplement 2 to Attachment 3.1-A & 3.1-B, page 10, #1.
16	7/24/19	Has the same recommendation as above.	No Change: This rule is according to the WV State Plan – Supplement 2 to Attachment 3.1-A & 3.1-B, page 10, #1.
17	8/8/19	The attachments that are referred to, do not specifically mention the 8-day requirement. This has been something we have commented on before and we would like clarification as to whether the Hospice Medical Director's written certification satisfies this 8- day requirement, in which case 'by one of the certifying physicians' would help if this is a State requirement. The Federal regulations are as follows: Exception. If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.	No Change: This rule is according to the WV State Plan – Supplement 2 to Attachment 3.1-A & 3.1-B, page 10, #1.
18	8/8/19	**509.5.3 Enrolling the Member in Hospice:** When an election period ends, the Hospice discharges a member according to reasons for	Policy has been updated to reflect this change.

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		discharge under 42 CFR §418.26 (a thru d), or the member's waiver of other Medicaid benefits expires. Also, regular Medicaid coverage is reinstated if the member revokes Hospice care for the subsequent election period (in accordance with 42 CFR §418.24 and §418.28). We respectfully suggest that this is confusing and 'or' could be moved and changed too:- "When an election period ends or the Hospice discharges a member……..(a thru d), the member's waiver of other Medicaid benefits expires."	
19	8/8/19	**509.8 Billing and Reimbursement:** Reimbursement by the BMS for covered Hospice services will be at rates set by the Centers For Medicare and Medicaid Services (CMS) for the following categories of care: • Routine Home Care (RHC) • RHC Service Intensity Add-on Payments (SIA) • Continuous Home Care (CHC) • Inpatient Respite Care (IRC) • General Inpatient Care (GIC) We suggest GIP instead of GIC to be consistent with customary practice. We seek clarification about the two tier payment for RHC and think this should perhaps be added as well as the SIA.	No Change: These five categories are determined by CMS. Regarding the clarification request about the two tier payment for RHC: On 8/22/16, BMS sent a Memorandum to all Hospice Providers regarding the new Hospice payment methodology that was implemented by CMS including a web link to refer to, how our fiscal agent (Molina/DXC) were going to process claims, and the updated Hospice policy provided the appropriate information on Billing & Reimbursement. It also, recommended that hospice providers contact Molina Provider Relations with any questions. We believe the above information is sufficient and does not need further explanation in the policy.
20	7/23/19	**509.14.1 Home and Community-Based Waivers:** Members who have been determined eligible for and are enrolled in a HCBS 1915c	Updated language to include the following;

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		Waiver programs may receive services from a Hospice provider that (*Numbers added for illustration purposes)* (1) do not duplicate the Wavier services. (2) Hospice services must be coordinated by the coordination/case management agency. (3) and an agreement between the case management/coordination agency and the Hospice provider must be on record. (4) In general, Hospice services may only include skilled nursing care or therapy services for post hospitalization stays or acute episodes of chronic conditions. (5) The need for Hospice services must be documented in the member's plan of care or Individual Program Plan(IPP). (6) Documentation of the referral from the member's attending physician must be maintained in the member's records of both coordination/case management agency and the Hospice provider. Recommendations: 1. The same type of service may be provided by both programs but not at the same time.- Suggest clarifying this section by adding "at the same time." 2. Medicare regulations require a hospice to coordinate care. Requiring the HCBS to coordinate would be in conflict with the hospice federal regulation. 3. While the coordination of these services is important, a contract should not be required. Since there is no financial relationship between hospice and the HCBS provider, there is little incentive for the HCBS provider to enter into a contract. If a contract must be required, then this requirement must also be part of the HCBS Medicaid Manual. 4. This list of services is consistent with home health and not consistent with the hospitalized, need therapy or be in an acute episode of a chronic condition. 5. Since this manual addresses hospice services, a requirement for the HCBS should not be included here. 6. Same as #5. 7. While hospices control documentation in our record, we cannot assure this referral documentation is in HCBS records. **We recommend striking the highlighted section.**	Note: "Operating a program of services under the authority of Section 1915 (c) of the Social Security Act, known as the Home and Community Based Waiver services, require that BMS have authority over the services. If the member is receiving any other Medicaid service, the Waiver service is considered primary."
21	7/24/19	Same language & recommendations as above	Updated language to include the following;

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			Note: “Operating a program of services under the authority of Section 1915 (c) of the Social Security Act, known as the Home and Community Based Waiver services, require that BMS have authority over the services. If the member is receiving any other Medicaid service, the Waiver service is considered primary.”
22	8/8/19	Same language & recommendations as provided by HCBS waiver programs, but not at the same time. Requiring the HCBS to coordinate the care hospices provide would be in direct conflict with federal regulations that require hospices to do so. Hospices do collaborate with the agencies and coordinate services, but since there is no financial relationship we question the need for a contract. #2 appears to be referencing home health requirements when mentioning need for therapy or skilled nursing. #3 Hospices would not be able to control whether the agencies documented a referral and if this is a requirement, this should be moved to the HCBS Provider Manual. We recommend deleting the highlighted section.	Updated language to include the following; Note: “Operating a program of services under the authority of Section 1915 (c) of the Social Security Act, known as the Home and Community Based Waiver services, require that BMS have authority over the services. If the member is receiving any other Medicaid service, the Waiver service is considered primary.”
23	7/23/19	**509.14.2 Personal Care Services (PCS):** Members who are receiving direct-care services through the PCS program may also receive services from a Hospice provider that (*Numbers added for illustration purposed)* 1. Do not duplicate PCS services 2. Hospice services are limited to services which can only be performed by a skilled nurse and/or a licensed therapist for Physical Therapy (PT), Occupational Therapy (OT) and/or Speech Therapy (ST). 3. The Hospice provider must maintain documentation regarding the need for both services as well as the plan of care for the member. The PCS RN must reflect the Hospice services on the PCS plan of care. Documentation of the PCS referral from the member’s attending physician must be maintained in	Policy has been updated to reflect this change.

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		the member's records of both the PCS and the Hospice provider. Please refer to Chapter 517, Personal Care Services for additional information. Recommendations: 1. The same type of service may be provided by both programs but not at the same time. Suggest clarifying this section by adding "at the same time" 2. This list of services is consistent with home health and not consistent with the management of hospice patients at home who may or may not have been recently hospitalized, need therapy or be in an acute episode of a chronic condition. 3. While we can control documentation in our record, we cannot assure this referral and other documentation is in HCBS records. We recommend striking the highlighted section.	
24	7/24/19	Same language and recommendations as stated above	Policy has been updated to reflect this change.
25	8/8/19	Same language as above. Recommendations: This is more consistent with home health regulations and the above comments for HCBS Waivers apply. We suggest that instead of "do not duplicate PCS services" above "at the same time" would reflect that members can have both. The remaining highlighted section should be deleted.	Policy has been updated to reflect this change.
26	8/8/19	**509.15 Managed Care Organizations:** We suggest that clarification here that prior authorization is not needed when a hospice changes a level of care would be helpful.	No Change at this time.