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State/Territory Name: The United States Virgin Islands

State Plan Amendment (SPA) #: 22-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 16, 2022

Gary Smith
Medicaid Director
Department of Human Services
Medical Assistance Program
1303 Hospital Ground
Knur Hansen Complex, Building A
St. Thomas, Virgin Islands 00802

RE: United States Virgin Islands State Plan Amendment (SPA) # 22-0005

Dear Mr. Smith:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA)submitted under transmittal number (TN) VI-22-0005. This amendment brings the territory into compliance with the requirements of Section 2302 of the Affordable Care Act (ACA) (concurrent care for children).

We conducted our review of your submittal according to statutory requirements in Title XlX of the Social Security Act and implementing regulations Section 1861(dd) and 1905 (o). This letter informs you that the U.S. Virgin Islands Medicaid SPA 22-0005 was approved on December 14, 2022, with an effective date of August 9, 2022.

If you have any questions, please contact Ivelisse Salce at 212-616-2411 or via e-mail at Ivelisse.Salce@CMS.HHS.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

cc: James Moreth
Alexandra Eitel

THE DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0005

2. STATE: VI

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 09, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Section 1861(dd) and 1905(o) SSA & 42 CFR 418

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 166,749
b. FFY 2023 $ 930,955

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19B Pages 3-5 (New)
Supplement 1 to Attachment 3.1-A Pages 3-3D (New)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 1 to Attachment 3.1-A Pages 7-7D (New)
Attachment 4.19B Pages 3-5 (New)

9. SUBJECT OF AMENDMENT

Adds New Hospice benefit coverage for the Categorically Needy and the Medically Needy.

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF THE GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Gary A. Smith

13. TITLE
Medicaid Director

14. DATE SUBMITTED
11-15-2022

15. RETURN TO
Gary A. Smith,
Medicaid Director
VI Department of Human Services
1303 Hospital Ground
Knud Hansen Complex, Building A
St. Thomas, USVI 00802

FOR CMS USE ONLY

16. DATE RECEIVED
05/13/2022

17. DATE APPROVED
12/14/2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
08/09/2022

19. SIG [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

Hospice Care (under Section 1905(o) of the Act).

I. GENERAL PROVISIONS

Hospice services are provided under a comprehensive set of services, described in Section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill beneficiary and family members, as delineated in a specific, written plan of care. Any eligible Medicaid beneficiary may receive hospice benefits under this section.

A. Hospice Providers

1. A Hospice provider is a public agency or private organization, or a subdivision of either that is primarily engaged in providing care to terminally ill beneficiaries.
2. A provider participating in the Virgin Islands (VI) Medicaid program shall meet the Medicare conditions of participation for hospices, 42 CFR Part 418, Subparts C, D, and F, be enrolled in the Medicare program, and be enrolled as a VI Medicaid provider.
3. For purposes of Hospice, "attending physician" refers to a qualified The physician who is identified by the beneficiary at the time of election to receive Hospice care, as the provider with the most significant role in determining and delivering the beneficiary's medical care.

B. Beneficiary Eligibility, Election, and Physician Certification of Terminal Illness

1. General Eligibility: Hospice services shall be reasonable and necessary for the palliation or management of terminal illness and related conditions and shall be available to beneficiaries who meet the following criteria:

a. Enrolled in the VI Medicaid Program
b. Resides in a home setting, a nursing facility, or ICF/IID;
c. Is certified as terminally ill with a life expectancy of six (6) months or less, and
d. Has elected to receive Hospice care.

2. Beneficiary Election:

a. By 42 C.F.R. § 418.21, Hospice election periods under the VI Medicaid program are organized as follows:

i. Initial: Ninety (90) day period;
ii. Second: Ninety (90) day period;
iii. Third: Sixty (60) day period; and
iv. Unlimited Subsequent: Sixty (60) day periods.

b. A beneficiary must complete and sign an election statement to receive Hospice services. An election to receive Hospice care is considered to continue through the initial election period and any

subsequent election periods, without a break in care, as long as the beneficiary remains in the care of an enrolled Hospice provider, does not revoke the election and is not discharged from Hospice care.

c. An Hospice physician or nurse practitioner must have a face-to-face encounter with each beneficiary whose total stay in hospice is anticipated to exceed one hundred eighty (180) days. The face-to-face meeting must occur before, but no more than thirty (30) calendar days back, the third election period recertification and every benefit period recertification after that to gather clinical findings to determine continued eligibility for Hospice care.

3. Election Statement. An election statement shall include the following information:

a. Identification of the Hospice provider that will care for the beneficiary;
b. The beneficiary's or authorized representative's acknowledgment that the beneficiary has been given a full explanation of the palliative rather than curative nature of hospice care as it relates to the beneficiary's terminal illness; and
c. The beneficiary's or authorized representative's acknowledgment that the beneficiary fully understands that an election to receive hospice care is a waiver of the right to Medicaid coverage for the following services for the duration of the election to receive hospice care:

i. Hospice care provided by a hospice other than the hospice designated by the beneficiary (unless provided under arrangements made by the designated hospice); and
ii. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected; or a related condition; or services that are equivalent to hospice care, except for:
(a) Services provided by the designated hospice;
(b) Services provided by another hospice under arrangements made by the designated hospice; and
(c) Services provided by the beneficiary's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

4. Certification of Terminal Illness:

a. Hospice services shall only be initiated based on a written certification of terminal illness that is obtained by the hospice within two (2) calendar days of commencing hospice services.
b. For all subsequent election periods, the hospice shall obtain written certification within two calendar days of the first day of the new election period.
c. The written certification of terminal illness shall include a statement that the beneficiary's medical prognosis is a life expectancy of six (6) months or less if the terminal illness runs its

Normal course. This statement shall be located immediately above the certifying physicians' signatures. It shall also state whether the determination was based on a medical chart review or a face-to-face encounter.

d. For each election period, the written certification shall be signed by:
i. The hospice medical director or the physician member of the hospice interdisciplinary team; and
ii. The beneficiary's attending physician, specialty care, or primary care physician.

e. Certifications and recertifications shall be completed by fifteen (15) calendar days before the effective date of the election period.

f. No payment is available for Hospice care days that a beneficiary accrues before the hospice obtains physician certification of a terminal illness.

C. Plan of Care Requirements: A Hospice provider shall ensure that all beneficiaries have a written plan of care before delivering Hospice services. The written plan of care shall be developed by the Hospice's interdisciplinary team, which must include at least one (1) of each of the following:

1. Doctor of medicine or osteopathy;
2. Registered nurse (RN);
3. Licensed clinical social worker (LICSW); and
4. Pastoral or another counselor.

D. Revocation of Election & Coverage Limitations

1. A beneficiary or authorized representative may revoke an election to Hospice during any election period by providing a signed statement memorializing the revocation and the effective date to the Hospice provider.
2. A beneficiary may change to a different Hospice provider a maximum of one (1) time during any particular election period. In such circumstances, the beneficiary will not begin a new election period. Each Hospice provider shall be required to coordinate the provision of services during the beneficiary's transition to ensure the continuity of care.
3. If a beneficiary has both Medicare and Medicaid coverage ("dually eligible"), the beneficiary must elect and revoke the Hospice benefit simultaneously under both programs.
4. A beneficiary electing to receive Hospice care may receive other medically necessary Medicaid-covered services unrelated to the terminal condition for which hospice care was elected.
5. A beneficiary electing to receive Hospice care may not simultaneously receive covered hospice services under a home and community-based services (HCBS) waiver authorized under Section 1915(c) of the Social Security Act.

II. HOSPICE SERVICES

Hospice services shall be provided to eligible Medicaid beneficiaries who elect to receive Hospice care. Hospice services shall be consistent with the beneficiary's plan of care and reasonable and necessary for the palliation or management of terminal illness and related conditions.

Hospice services shall be delivered by qualified practitioners operating under 42 C.F.R. § 418.114.

A. Covered Services

1. Physician Services performed by a physician as defined in 42 C.F.R. § 410.20, except that the services of the hospice medical director or the physician member of the interdisciplinary team shall be performed by a doctor of medicine or osteopathy.
2. Nursing Care is provided by or under a registered nurse's supervision.
3. Medical Social Services provided by a licensed clinical social worker practicing under the direction of a physician.
4. Counseling Services provided to the terminally ill beneficiary, family members, and others who care for the beneficiary at home. Counseling, including dietary counseling, may be provided to train the beneficiary's family or other caregivers to provide care and help the beneficiary and those caring for them adjust to the beneficiary's approaching death. Bereavement counseling will be provided as defined below. Counseling Services shall not be available to a nursing facility or ICF personnel who care for beneficiaries receiving Hospice care in the facility.
5. Short-Term Inpatient Care provided in a participating Medicare or Medicaid hospice inpatient unit, hospital, or nursing facility that additionally meets hospice staffing and space requirements described in 42 C.F.R. Part 418, Subparts C and D. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. It may also provide respite for the individual's family or others caring for the beneficiary at home. Respite care must be given as specified in 42 C.F.R. § 418.108(b). Payment for inpatient care will be made at the rate appropriate to the level of care.
6. Durable Medical Equipment (DME) and Medical Supplies for the palliation and management of terminal illness or related conditions, which shall be part of the written plan of care and provided by the Hospice provider for use in the beneficiary's home.
7. Prescription Drugs are used primarily to relieve pain and symptom control related to the beneficiary's terminal illness.
8. Physical, Occupational, and Speech Therapy Services are provided for symptom control and to enable a beneficiary to maintain activities of daily living and basic functional skills.
9. Home Health Aide and Homemaker Services

    a. Home health aides shall provide personal care services. They may also perform household chores necessary to maintain a safe and sanitary environment in areas of the home used by the beneficiary. Home health aides shall deliver services under the general supervision of a registered nurse.

    b. Homemaker services may include assistance in maintaining a safe and healthy environment and other services that enable the beneficiary, caregiver(s), and Hospice provider to carry out the plan of care.

c. A beneficiary may receive personal care aide (PCA) services consistent with the scope of services covered under the Medicaid State Plan PCA benefit.
d. The Hospice provider shall ensure coordination between home health aide and homemaker services under Hospice with PCA services provided under the Medicaid State Plan PCA benefit, and shall be responsible for submitting a request for a PCA Service Authorization to VI Medicaid for integrating the plan of care prepared by the PCA provider into the Hospice plan of care.

11. Bereavement Counseling Services are services provided to an individual's family after death. This service is provided but is not reimbursed.

12. Any other service specified in the beneficiary's plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions and for which payment may otherwise be made under Medicaid.

B

IV. PEDIATRIC HOSPICE CARE

J. Pediatric hospice care under Section 2302 of the Act shall be unlimited so long as the child remains eligible for and elects the hospice benefit, and all the procedural service and coverage requirements detailed above apply.

LIMITATIONS

Hospice Services

1. Prior Authorization by the Department of Human Services (DHS) is required for all hospice services delivered to eligible Medicaid beneficiaries. Prior Authorization for dual-eligible beneficiaries (i.e., suitable for both Medicare and Medicaid) is not necessary from DHS and is based on the approval of hospice services by Medicare.

2. Hospice services are available both on-island and off-island as long as they are provided by a Medicare-certified provider enrolled in the United States Virgin Islands Medicaid Program.

3. A beneficiary may only receive Hospice services from one Hospice provider at a time.

11. Methods and Standards for Establishing Rates – Hospice Services

General:

The Virgin Islands (VI) Medicaid Program will pay for hospice services to designated hospice providers based upon the Medicaid hospice rates published annually in a memorandum issued by the Centers for Medicare & Medicaid Services, Center for Medicaid, and CHIP Services (CMCS). These rates can be found at Hospice Payments | Medicaid.

These rates will be adjusted by the appropriate final Medicare local wage index for the Virgin Islands CBSA Code 99948. The Medicare wage index can be found at FY 2022 Final Hospice Wage Index | CMS.

The final rates will be computed annually by the Department of Human Services and published on the MMIS portal. The MMIS hospice payment rates can be found at Health PAS-OnLine (vimmis.com).

These hospice rates are effective from October 1 of each year through September 30 of the following year, corresponding to the Federal Fiscal Year (FFY), and are the same for both public and private providers. Payment for hospice care will be paid at a predetermined rate for each day on which a beneficiary is under the supervision of the hospice for the following categories or levels of care into which Medicaid hospice is classified.

There are the categories or levels of care into which Medicaid hospice are classified:

A. Routine Home Care (RHC)

Hospice providers are paid at one of two tiers of RHC. The higher RHC rate is paid for day one (1) through day sixty (60) hospice care. The decreased RHC rate is paid for hospice days 61 and beyond. A minimum of sixty (60) days gap in hospice services must elapse before the hospice day count resets to the higher level of RHC reimbursement.

B. Continuous Home Care (CHC)

CHC is to be provided only during a period of crisis. CHC is covered when a patient requires primarily nursing care to achieve palliation or management of acute medical symptoms. This care need not be continuous (i.e., 4 hours could be provided in the morning and another 4 hours provided in the evening of that day). A minimum of eight hours of daily care must qualify as continuous home hospice care. At least half of the hours of CHC must predominantly be that of nursing care provided by either a registered nurse or licensed practical nurse in a crisis. Home health aide or homemaker services may be provided in addition to nursing care. Payment is made for the hours of continuous care provided, up to 24 hours in one day. The steady constant rate is divided by 24 hours to arrive at an hourly rate. The CHC will be paid at the Medicare CHC hourly rate for the VI.

C. Inpatient Respite Care

Inpatient Respite Care is defined as short-term inpatient care to relieve the primary caregiver(s)

Providing at-home hospice care for the beneficiary. Hospice care may be provided in a licensed hospice residence, hospital, or nursing facility meeting hospice standards for staffing and patient areas. Medicaid inpatient respite care will pay for a maximum of 5 days at a time, including the date of admission, but not counting the date of discharge. Medicaid will pay for the sixth and subsequent days at the routine home care rate. Inpatient Respite care may not be provided when the hospice patient is a nursing home resident. Inpatient respite care will be paid at the Medicaid inpatient respite care rate for the Virgin Islands.

D. General Inpatient Care

General inpatient care is covered when the beneficiary's condition is such that their symptoms cannot be adequately treated under the routine hospice care benefit. It is defined as short-term inpatient care provided in a licensed hospice residence, hospital, or Nursing Facility meeting hospice standards for staffing and patient areas. This brief episode of care is usually for pain control or acute or chronic symptom management, which cannot be reasonably treated in another setting. General inpatient care cannot be used solely if a beneficiary requires care in a facility setting. Available inpatient care will be paid at the medicare available inpatient care per diem rate for the VI.

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12 months beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied year at the end of the hospices cap period.

E. **Hospice Nursing Facility Room and Board**

Hospice nursing facility room and board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income amount (the amount an individual in an institution can contribute to the cost their/her care) for Medicaid clients who are receiving hospice services. The hospice provider passes the room and board payment through the nursing facility.

F. Service Intensity Add-On

A Service Intensity Add-on (SIA) rate will be reimbursed to hospice agencies for services provided by a Registered Nurse (RN) or Social Worker in the last seven days of a hospice beneficiary's life under the following conditions:

1) The SIA payment is provided for visits of a minimum of 15 minutes but up to four hours combined in a day.

2) During the last seven days of a beneficiary's life, in-person visits made by an RN and Social worker when the beneficiary is receiving routine home care.
3) The SIA payment is made in addition to the routine home care rate for the day. However, the total combined time rendered by an RN and Social Worker will not be reimbursed for more than four hours daily.

Direct patient care provided by the hospice medical director, hospice-employed physician, or consulting physician must be billed by the hospice using the appropriate Common Procedure Coding System code(s). It will be reimbursed at the applicable Medicaid fee screen.

For each year, failure to submit Medicare-required quality data shall result in a 2-percentage point reduction to the market basket percentage increase for that fiscal year.

Except as otherwise noted in the plan, fee schedule rates are the same for services provided on and after August 09, 2022.