Table of Contents

State/Territory Name: District of Columbia

State Plan Amendment (SPA) #: 19-008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 0300
Kansas City, Missouri 64106-2898

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

Medicaid and CHIP Operations Group

March 19, 2020

Melisa Byrd
Medicaid Director
Department of Health Care Finance
441 4th Street, N.W., 9th floor, South
Washington, D.C. 20001

Dear Ms. Byrd:

I am writing to inform you that we have reviewed the District of Columbia's State Plan Amendment (SPA) 19-008, entitled Adult Hospice Services. This SPA will update the District's hospice care reimbursement methodology to align with federal requirements and enable the District to improve monitoring and oversight of the delivery of hospice services.

We are pleased to inform you that, after extensive review, this amendment is approved March 19, 2020, with an effective date of February 15, 2020. A copy of the approved SPA pages and signed CMS-179 form are included under this cover.

If you have any further questions regarding this SPA, please contact LCDR Frankeena McGuire at (215) 861-4754 or by email at Frankeena.McGuire@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosure

cc:
Alice Weiss, DHCF
Eugene Simms, DHCF
Nicole McKnight, CMS

DEPARTMENT OF HEALTH AND HUMAN 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: **19-008**

2. STATE: **District of Columbia**

3. PROGRAM IDENTIFICATION: **Title XIX of the Social Security Act**

TO: Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

4. PROPOSED EFFECTIVE DATE: **January 1, 2019**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *Se arate Transmittal for each amendment*

6. FEDERAL STATUTE/REGULATION CITATION:

42 U.S.C. § 1396d(o)

42 C.F.R. § 418.302

7. FEDERAL BUDGET IMPACT:

FFY20: $ 4,842,839.00
FFY21: $ 3,012.989.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1 to Attachment 3.1-A, pages 22, 23-23G, 24
Supplement 1 to Attachment 3.1-B, pages 21, 22–22G

Attachment 4.19-B, pages 8–8C, 9–9A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 1 to Attachment 3.1-A, pages 22 - 24
Supplement 1 to Attachment 3.1-B, pages 21 -23

Attachment 4.19-B, a es 8–8A, 9–9A

10. SUBJECT OF AMENDMENT:

Adult Hospice Services

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
D.C. Act: 22-434

12. SIGNATURE OF STAT AGENCY OFFICIAL

1 [redacted]

Melisa Byrd

14. TITLE

Senior Deputy Director/Medicaid Director

15. DATE SUBMITTED DEC 3 1 2019

16. RETURN TO

Melisa Byrd
Senior Deputy Director/Medicaid Director
Department of Health Care Finance
441 4th Street, NW, 9th Floor, South
Washington, DC 20001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED December 31, 2019

18. DATE APPROVED March 19, 2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
February 15, 2020

20. SIG [redacted] REGIONA [redacted]

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations

17. Nurse Midwife Services are provided in accordance with D.C. Law 10-247.

18. Hospice Care (in accordance with Section 1905(c) of the Act).

I. GENERAL PROVISIONS

Hospice care is 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/or family members, as delineated in a specific, written plan of care.

Adult Hospice care is limited to beneficiaries twenty-one (21) years of age and older, who reside in home settings. For purposes of Medicaid coverage, a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) may be considered the home setting of a beneficiary electing Adult Hospice. An Adult Hospice provider delivering services to an individual residing in a nursing facility or ICF/IID shall also adhere to the specific requirements outlined in Item 14 of Attachment 4.19-B, Part I of the State Plan.

A. Adult Hospice Provider Overview

1. An Adult Hospice provider is a public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill adult beneficiaries.

2. An Adult Hospice provider participating in the District of Columbia's 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 District Medicaid provider with DHCF.

3. For purposes of Adult Hospice, "attending physician" refers to a qualified physician who is identified by the beneficiary, at the time of election to receive Adult 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: Adult 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 District Medicaid;

b. Aged twenty-one (21) years or older;

c. Resides in a home setting, or a nursing facility or ICF/IID;

d. Is certified as terminally ill with a life expectancy of six (6) months or less, in accordance with Section B.4; and

e. Has elected to receive Adult Hospice care.

2. Beneficiary Election:

a. In accordance with 42 C.F.R. § 418.21, Adult Hospice election periods under the District's 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 in order to receive Adult Hospice services. An election to receive Adult 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 Adult Hospice provider, does not revoke the election, and is not discharged from Adult Hospice care.

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

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

a. Identification of the Adult Hospice provider that will care for the beneficiary;

b. The beneficiary's or authorized representative's acknowledgement 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 acknowledgement 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 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. Adult 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 (2) 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 and shall also state whether the determination was based on medical chart review or a face-to-face encounter conducted in accordance with Section B.2.c.

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 no earlier than fifteen (15) calendar days prior to the effective date of the election period.

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

C. Plan of Care Requirements: An Adult Hospice provider shall ensure that all beneficiaries have a written plan of care before delivering Adult Hospice services. The written plan of care shall be developed by the Adult 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) or advanced practice registered nurse (APRN);

3. Licensed clinical social worker (LICSW); and

4. Pastoral or other counselor.

D. Revocation of Election & Coverage Limitations

1. A beneficiary or authorized representative may revoke election to Adult Hospice during any election period by providing a signed statement memorializing the revocation and the effective date to the Adult Hospice provider.

2. A beneficiary may change to a different Adult Hospice provider a maximum of one (1) time during any individual election period. In such circumstances, the beneficiary will not begin a new election period. Each Adult Hospice provider shall be required to coordinate the provision of services during the beneficiary's transition in order to ensure continuity of care.

3. If a beneficiary has both Medicare and Medicaid coverage ("dually eligible"), the beneficiary must elect and revoke the Adult Hospice benefit simultaneously under both programs.

4. A beneficiary electing to receive Adult 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 Adult 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. ADULT HOSPICE SERVICES

Adult Hospice services shall be provided to eligible Medicaid beneficiaries who elect to receive Adult Hospice care. Adult 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.

Adult Hospice services shall be delivered by qualified practitioners operating in accordance with 42 C.F.R. § 418.114 and requirements set forth in the District of Columbia Health Occupations Revision Act of 1985, as amended effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq*.), implementing rules, and any subsequent amendments thereto.

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 provided by or under the supervision of a registered nurse.

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 both for the purpose of training the beneficiary's family or other caregivers to provide care, and for the purpose of helping the beneficiary and those caring for him or her to adjust to the beneficiary's approaching death. Counseling Services shall not be available to nursing facility or ICF/IID personnel who care for beneficiaries receiving Adult 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, and may also be furnished as a means of providing respite for the individual's family or others caring for the beneficiary at home. Respite care must be furnished 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 as specified in Item 14 of Attachment 4.19-B, Part I of the State Plan.

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 Adult Hospice provider for use in the beneficiary's home.

7. Prescription Drugs used primarily for the relief of pain and symptom control related to the beneficiary's terminal illness.

8. Physical, Occupational, and Speech Therapy Services 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 and 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 maintenance of a safe and healthy environment and other services that enable the beneficiary, caregiver(s), and Adult 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 Adult Hospice provider shall ensure coordination between home health aide and homemaker services under Adult 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 DHCF or its designated agent and for

integrating the plan of care prepared by the PCA provider into the Adult Hospice plan of care.

10. 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. Standards for Service Delivery

1. Core Services. An Adult Hospice shall routinely provide all core services directly by hospice employees, except that the hospice may contract for physician services. These services must be provided in a manner consistent with acceptable standards of practice. An Adult Hospice may use contracted staff for core services, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. An Adult Hospice may also enter into a written arrangement with another Adult Hospice provider that meets the criteria set forth in Section I.A. for the provision of core services to supplement hospice employees to meet the needs of patients.

Circumstances under which an Adult Hospice may enter into a written arrangement for the provision of core services include unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care, and temporary travel of a patient outside of the hospice's service area.

Core Adult Hospice services include:

a. Physician Services;

b. Nursing Care;

c. Medical Social Services; and

d. Counseling.

2. Non-Core Services. An Adult Hospice shall ensure that the following non-core services are provided directly by, or under arrangements made by, the hospice provider as specified in 42 CFR § 418.100. These services must be provided in a manner consistent with current standards of practice.

Non-core services include:

a. Short-Term Inpatient Care;

b. DME and Medical Supplies;

c. Prescription Drugs;

d. Physical, Occupational, and Speech Therapy;

e. Home Health Aide and Homemaker Services; and

f. Other services 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.

3. For any services delivered by other providers, the Adult Hospice shall have current, written agreements memorializing the nature its relationship with these providers (contractors). The written agreement shall clearly describe the contractor's duties on behalf of Medicaid beneficiaries.

4. An Adult Hospice provider shall ensure that nursing care, physician services, and prescription drugs are routinely available on a twenty-four (24) hour basis, seven (7) days per week. Other covered Adult Hospice services shall be made available on a twenty-four (24) hour basis when reasonable and necessary to meet the needs of the beneficiary and the beneficiary's family or other caregivers.

III. QUALITY REPORTING

A. An Adult Hospice enrolled as a District Medicaid provider shall perform the following actions related to quality reporting and improvement:

1. Demonstrate compliance with all federal quality of care standards, in accordance with 42 C.F.R. § 418.58;

2. Document the availability of a quality management program plan that meets federal quality of care standards in accordance with 42 C.F.R. § 418.58;

3. Demonstrate compliance with all data submission requirements of the Hospice Quality Reporting Program, in accordance with 42 C.F.R. § 418.312; and

4. Appoint a multidisciplinary Quality Management Committee (QMC) that reflects the Adult Hospice's scope of services.

B. The QMC shall develop and implement a comprehensive and ongoing quality management and peer review program that evaluates the quality and appropriateness of patient care provided, including the appropriateness of the

level of service received by patients. The QMC shall establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria shall be based on accepted standards of care and shall include, at a minimum, systematic reviews of:

1. Appropriateness of admissions, continued stay, and discharge;

2. Appropriateness of professional services and level of care provided;

3. Effectiveness of pain control and symptom relief;

4. Patient injuries, such as those related to falls, accidents, and restraint use;

5. Errors in medication administration, procedures, or practices that compromise patient safety;

6. Infection control practices and surveillance data;

7. Patient and family complaints and on-call logs;

8. Inpatient hospitalizations;

9. Staff adherence to the patient's plans of care; and

10. Appropriateness of treatment.

C. The Adult Hospice shall submit its quality management and peer review program findings to DHCF or its designee by no later than June 30, annually.

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.

1. An election to receive hospice care under Section 2302 of the Patient Protection and Affordable Care Act is provided in accordance with a written plan of care for each beneficiary. The initial Hospice election period shall be for ninety (90) days, followed by a second ninety (90) day period. A third period of sixty (60) days, and then one or more sixty (60) day extended election periods may also be available. In the case of the initial Hospice election period of one hundred eighty days (180), the provider shall obtain written certification from the beneficiary's attending physician, specialty care, or primary care physician authorizing the need for services. In the case of election periods of sixty (60) days, the provider shall obtain written certification from the beneficiary's attending physician, specialty care, or primary care physician authorizing the need for services before each sixty (60) day election period. In all cases, the beneficiary's medical prognosis is for a life expectancy of six months or less and must be verified.

17. Nurse Midwife Services are provided in accordance with D.C. Law 10-247.

18. Hospice Care (in accordance with Section 1905(c) of the Act).

I. GENERAL PROVISIONS

Hospice care is 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/or family members, as delineated in a specific, written plan of care.

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

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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 acknowledgement 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 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;

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4. Certification of Terminal Illness:

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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 and shall also state whether the determination was based on medical chart review or a face-to-face encounter conducted in accordance with Section B.2.c.

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.

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C. Plan of Care Requirements: An Adult Hospice provider shall ensure that all beneficiaries have a written plan of care before delivering Adult Hospice services. The written plan of care shall be developed by the Adult 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) or advanced practice registered nurse (APRN);

3. Licensed clinical social worker (LICSW); and

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B. Revocation of Election & Coverage Limitations

1. A beneficiary or authorized representative may revoke election to Adult Hospice during any election period by providing a signed statement memorializing the revocation and the effective date to the Adult Hospice provider.

2. A beneficiary may change to a different Adult Hospice provider a maximum of one (1) time during any individual election period. In such circumstances, the beneficiary will not begin a new election period. Each Adult Hospice provider shall be required to coordinate the provision of services during the beneficiary's transition in order to ensure continuity of care.

3. If a beneficiary has both Medicare and Medicaid coverage ("dually eligible"), the beneficiary must elect and revoke the Adult Hospice benefit simultaneously under both programs.

4. A beneficiary electing to receive Adult Hospice care may receive other medically necessary Medicaid-covered services unrelated to the terminal condition for which hospice care was elected.

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II. ADULT HOSPICE SERVICES

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Adult Hospice services shall be delivered by qualified practitioners operating in accordance with 42 C.F.R. § 418.114 and requirements set forth in the District of Columbia Health Occupations Revision Act of 1985, as amended effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*), implementing rules, and any subsequent amendments thereto.

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2. Nursing Care provided by or under the supervision of a registered nurse.

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 both for the purpose of training the beneficiary's family or other caregivers to provide care, and for the purpose of helping the beneficiary and those caring for him or her to adjust to the beneficiary's approaching death. Counseling Services shall not be available to nursing facility or ICF/IID personnel who care for beneficiaries receiving Adult 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, and may also be furnished as a means of providing respite for the individual's family or others caring for the beneficiary at home. Respite care must be furnished 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 as specified in Item 14 of Attachment 4.19-B, Part I of the State Plan.

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7. Prescription Drugs used primarily for the relief of pain and symptom control related to the beneficiary's terminal illness.

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   a. Home health aides shall provide personal care services and 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 maintenance of a safe and healthy environment and other services that enable the beneficiary, caregiver(s), and Adult 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 Adult Hospice provider shall ensure coordination between home health aide and homemaker services under Adult 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 DHCF or its designated agent and for

integrating the plan of care prepared by the PCA provider into the Adult Hospice plan of care.

10. 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. Standards for Service Delivery

1. Core Services. An Adult Hospice shall routinely provide all core services directly by hospice employees, except that the hospice may contract for physician services. These services must be provided in a manner consistent with acceptable standards of practice. An Adult Hospice may use contracted staff for core services, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. An Adult Hospice may also enter into a written arrangement with another Adult Hospice provider that meets the criteria set forth in Section I.A. for the provision of core services to supplement hospice employees to meet the needs of patients.

Circumstances under which an Adult Hospice may enter into a written arrangement for the provision of core services include unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care, and temporary travel of a patient outside of the hospice's service area.

Core Adult Hospice services include:

a. Physician Services;

b. Nursing Care;

c. Medical Social Services; and

d. Counseling.

2. Non-Core Services. An Adult Hospice shall ensure that the following non-core services are provided directly by, or under arrangements made by, the hospice provider as specified in 42 CFR § 418.100. These services must be provided in a manner consistent with current standards of practice.

Non-core services include:

a. Short-Term Inpatient Care

b. DME and Medical Supplies;

c. Prescription Drugs;

d. Physical, Occupational, and Speech Therapy;

e. Home Health Aide and Homemaker Services; and

f. Other services 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.

3. For any services delivered by other providers, the Adult Hospice shall have current, written agreements memorializing the nature its relationship with these providers (contractors). The written agreement shall clearly describe the contractor's duties on behalf of Medicaid beneficiaries.

4. An Adult Hospice provider shall ensure that nursing care, physician services, and prescription drugs are routinely available on a twenty-four (24) hour basis, seven (7) days per week. Other covered Adult Hospice services shall be made available on a twenty-four (24) hour basis when reasonable and necessary to meet the needs of the beneficiary and the beneficiary's family or other caregivers.

III. QUALITY REPORTING

A. An Adult Hospice enrolled as a District Medicaid provider shall perform the following actions related to quality reporting and improvement:

1. Demonstrate compliance with all federal quality of care standards, in accordance with 42 C.F.R. § 418.58;

2. Document the availability of a quality management program plan that meets federal quality of care standards in accordance with 42 C.F.R. § 418.58;

3. Demonstrate compliance with all data submission requirements of the Hospice Quality Reporting Program, in accordance with 42 C.F.R. § 418.312; and

4. Appoint a multidisciplinary Quality Management Committee (QMC) that reflects the Adult Hospice's scope of services.

B. The QMC shall develop and implement a comprehensive and ongoing quality management and peer review program that evaluates the quality and appropriateness of patient care provided, including the appropriateness of the

level of service received by patients. The QMC shall establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria shall be based on accepted standards of care and shall include, at a minimum, systematic reviews of:

1. Appropriateness of admissions, continued stay, and discharge;
2. Appropriateness of professional services and level of care provided;
3. Effectiveness of pain control and symptom relief;
4. Patient injuries, such as those related to falls, accidents, and restraint use;
5. Errors in medication administration, procedures, or practices that compromise patient safety;
6. Infection control practices and surveillance data;
7. Patient and family complaints and on-call logs;
8. Inpatient hospitalizations;
9. Staff adherence to the patient's plans of care; and
10. Appropriateness of treatment.

C. The Adult Hospice shall submit its quality management and peer review program findings to DHCF or its designee by no later than June 30, annually.

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.

1. An election to receive hospice care under Section 2302 of the Patient Protection and Affordable Care Act is provided in accordance with a written plan of care for each beneficiary. The initial Hospice election period shall be for ninety (90) days, followed by a second ninety (90) day period. A third period of sixty (60) days, and then one or more sixty (60) day extended election periods may also be available. In the case of the initial Hospice election period of one hundred eighty days (180), the provider shall obtain written certification from the beneficiary's attending physician, specialty care, or primary care physician authorizing the need for services. In the case of election periods of sixty (60) days, the provider shall obtain written certification from the beneficiary's attending physician, specialty care, or primary care physician authorizing the need for services before each sixty (60) day election period. In all cases, the beneficiary's medical prognosis is for a life expectancy of six months or less and must be verified.

14. HOSPICE CARE REIMBURSEMENT METHODOLOGY: ADULT HOSPICE

a. Reimbursement for Adult Hospice care shall be limited to the services described in Item 18 of Supplement 1 to Attachments 3.1-A and 3.1-B. The Department of Health Care Finance (DHCF) shall pay an Adult Hospice care provider at one (1) of four (4) prospective per diem rates for each day that a beneficiary is under the provider's care.

b. DHCF shall reimburse for Adult Hospice services provided to eligible beneficiaries in each election period only upon receipt of prior authorization from its designated quality improvement organization. Each election period requires a separate prior authorization.

c. Claims Submission Requirements: Claims for Adult Hospice care shall be submitted in accordance with "Timely Claims Payment – Definition of Claims," Attachment 4.19-E of the District of Columbia State Plan for Medical Assistance and procedures established by DHCF.

1. Claims that are not complete, timely, or properly prepared and submitted may be denied and returned to the provider.

2. Final claims for Adult Hospice care shall be submitted to DHCF no later than the fifteenth (15th) day of the month following the date on which any of the following occur:

i. The beneficiary dies;

ii. The beneficiary revokes the election to Adult Hospice care;

iii. The beneficiary's prognosis is no longer six (6) months or less to live; or

iv. The beneficiary chooses to change Adult Hospice providers.

d. Per diem payment rates for routine home, continuous home, general inpatient, and inpatient respite care shall be set in accordance with the amounts established for Medicare hospice providers by the Centers for Medicare and Medicaid Services (CMS), subject to the District of Columbia's wage index and any ceiling established for the Medicare program. Per diem reimbursement categories within Adult Hospice are as follows:

1. Routine Home Care: The base reimbursement category for hospice care representing any of the covered adult hospice services described in Item 18 of Supplement 1 to Attachments 3.1-A and 3.1-B that are necessary to provide palliative care to a beneficiary while the beneficiary is at home

and is not receiving continuous care as defined in paragraph (d)(2) of this section. Routine home care shall be subject to the following requirements:

i. Per diem reimbursement for routine home care days shall be made in accordance with Medicare requirements, resulting in a higher per diem rate for the first sixty (60) days of routine home care provided to a beneficiary, followed by a lower per diem rate for all subsequent routine home care days within an episode of hospice care;

ii. If a beneficiary is discharged and readmitted to hospice within sixty (60) days of the discharge, the prior hospice days shall follow the beneficiary and count toward the beneficiary's routine home care days for the receiving hospice provider;

iii. Routine home care days that occur during the last seven (7) days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment; and

iv. The service intensity add-on payment shall be equal to the continuous home care hourly payment rate, as described in paragraph (d)(2) of this section, multiplied by the amount of direct patient care actually provided by a registered nurse (RN) and/or social worker, as defined in 42 C.F.R. § 418.114, up to four (4) hours total per day.

2. Continuous Home Care: The rate category that applies for any of the covered services described in Item 18 of Supplement 1 to Attachments 3.1-A and 3.1-B that are necessary to maintain a beneficiary at home during a period of crisis, resulting in a per diem rate which shall be divided by twenty-four (24) to yield an hourly rate. Continuous home care shall be subject to the following requirements:

i. The need for continuous care must be documented in the clinical record. Continuous care shall not be billed for more than seventy-two (72) hours without prior authorization from DHCF.

ii. Nursing care, provided by either a registered nurse or a licensed practical nurse, shall account for more than half of the period of continuous home care;

iii. Homemaker and home health aide services shall be available, if needed, to supplement the nursing care;

iv. A period of crisis requires between eight (8) and twenty-four (24) hours of care, not necessarily consecutive, per twenty-four (24) hour period; and

v. The number of hours of continuous care provided during a continuous home care day shall be multiplied by the hourly rate to yield the continuous home care payment for that day.

3. General Inpatient Hospice Care: The rate category that applies for a beneficiary requiring treatment in an inpatient facility for pain control or management of acute or chronic symptoms which cannot be managed in other settings. General Inpatient Hospice Care shall be subject to the following requirements:

i. General inpatient hospice care shall only be provided on a short-term basis;

ii. General inpatient hospice care shall be discontinued once the beneficiary's symptoms are under control;

iii. General inpatient hospice care shall be provided only in the following types of health care facilities, which must meet the hospice staffing and space requirements described in 42 C.F.R. Part 418, Subparts C and D:

(a) Free standing facility owned and operated by a hospice company and staffed with hospice trained staff;

(b) Hospital; or

(c) Nursing Facility.

iv. Payments to a hospice provider for inpatient hospice care (general and respite) shall be subject to a limitation that the total number of inpatient hospice care days provided to Medicaid beneficiaries in any twelve (12) month period may not exceed twenty (20) percent of the total number of days during that period on which Medicaid beneficiaries have hospice care elections in effect.

4. Inpatient Respite Care: The rate category that applies for inpatient care provided for respite on behalf of a family member or other caregiver for a beneficiary living at home. Inpatient hospice respite care shall be subject to the following requirements:

   i. Inpatient respite care is available for beneficiaries who do not meet the criteria for general inpatient or continuous home care, and whose family members or other caregivers are in need of temporary relief from caring for the beneficiary;

   ii. Inpatient respite care shall not exceed five (5) consecutive days and shall be limited to fifteen (15) days per six (6) month period;

   iii. Inpatient respite care shall not be available for beneficiaries residing in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); and

   iv. Payments to a hospice provider for inpatient hospice care (general and respite) shall be subject to a limitation that the total number of inpatient hospice care days provided to Medicaid beneficiaries in any twelve (12) month period may not exceed twenty (20) percent of the total number of days during that period on which Medicaid beneficiaries have hospice care elections in effect.

e. Physician Services

In addition to the services described in Item 18 of Supplement 1 to Attachments 3.1-A and 3.1-B, the following services performed by hospice-employed or contracted physicians are included in the per diem rate:

1. General supervisory services of the 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 interdisciplinary group.

f. Unless provided on a volunteer basis, other physician services focused solely on direct patient care shall be paid in accordance with the D.C. Medicaid fee schedule, updated annually, and available at www.dc-medicaid.com. Payment for other physician services shall be in addition to the per diem reimbursement corresponding to the category of Adult Hospice care.

g. A beneficiary with a health condition that is completely distinct from the terminal condition for which the hospice election was made may receive other medically necessary Medicaid-covered services. These other medically necessary services shall be considered “ancillary services.” Reimbursement for ancillary services shall be made in accordance with the D.C. Medicaid fee schedule.

h. When a beneficiary resides in a nursing facility or ICF/IID, the Adult Hospice provider and the nursing facility or ICF/IID shall enter into a written agreement identifying the parties' responsibilities for patient care, which shall be kept on file by both parties and made accessible for review by DHCF or its agent. The Adult Hospice provider is then entitled to receive the daily reimbursement amounts for room and board in addition to the routine home or continuous home care rates. In accordance with the terms of the written agreement between the Adult Hospice provider and nursing facility or ICF/IID, the Adult Hospice provider shall pass through the full room and board payment to the nursing facility or ICF/IID.

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