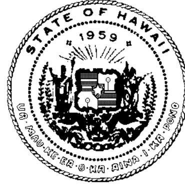
DAVID Y. IGE
GOVERNOR



CATHY BETTS
DIRECTOR

JOSEPH CAMPOS II
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, Hawaii 96709-0190

May 28, 2021

MEMORANDUM

MEMO NO.
QI-2109

TO: QUEST Integration Health Plans
Hospice Providers

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division (MQD) Administrator

SUBJECT: HOSPICE FOR MEMBERS RECEIVING HOME AND COMMUNITY BASED SERVICES (HCBS)

The purpose of this memorandum is to provide guidance to health plans and hospice providers regarding Medicaid members 21 years and older receiving HCBS who have elected hospice.

Hospice Services

Medicare licensed hospice providers must meet Medicare conditions of participation for hospices, as detailed in 42 C.F.R. part 418, in the delivery of hospice services to terminally ill patients. Further, as detailed in HAR §§ 17-1737-101 and 102, the hospice provider shall retain professional management responsibility for services related to the terminal illness and shall ensure that they are furnished in a safe and effective manner by persons qualified to provide services, and in accordance with a written plan of care (POC) based on a comprehensive assessment.

The hospice provider is responsible for conducting a comprehensive assessment to identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice member's well-being, comfort, and dignity throughout the end-of-life process. The hospice provider shall develop a written POC with the member and/or designated/authorized representative to meet the member and family-specific needs identified in the comprehensive assessment (see Appendix A). The POC must be patient-driven and developed

in a person-centered manner in order to meet the needs and the wants of the member's end-of-life goals. The POC developed by the hospice provider with the hospice member shall take into consideration the community setting in which the hospice member resides and the type and amount of available natural supports. The POC shall also include identification of existing services and providers, including HCBS and the agencies or individuals that provide these services. Regular review and updating of the POC shall occur every 15 days. This guidance also applies to members receiving Consumer Direct Services that elect hospice.

Common deficiencies related to hospice POCs can be found in Appendix B and should be avoided.

Home and Community Based Services

Medicaid members receiving HCBS as described in their person-centered health action plan (HAP) may continue to receive certain HCBS as needed while in hospice, as detailed in HAR § 17-1737-105. The type, amount and frequency of the HCBS provided to a Medicaid member who elects hospice, is driven by the member's needs as identified in the HAP. This is the direct result of the member's assessment as conducted by the health plan or its designee, to meet the member and family-specific needs. The HAP may be adjusted to meet the needs of the Medicaid member as the hospice provider POC is developed and evolves. The health plan HAP is a separate document from the hospice POC.

Communication and Coordination of Care

Before the initiation of hospice services and during the initial convening of the Interdisciplinary Group (IDG) meeting, the hospice provider shall include the health plan in a meeting to collaboratively discuss the member's care. Health plans shall also be included in subsequent IDG meetings that review and update the POC. This process shall continue to be person-centered and focus on the needs and wants of the member. The communication, coordination, and decisions made with the health plan during the IDG meetings shall be recorded in the written POC and the HAP.

The goal of these meetings are to establish clarity on the specific services contained in the POC and the HAP, the frequency of these services, which services will be provided by the hospice provider, the services that will continue to be provided by the QI HCBS provider(s), and all other services including the providers of these services. Hospice providers shall use the IDG meetings to address concerns around coordination of services and potential gaps in care. As a starting point, HCBS included in an existing HAP shall continue to be provided by the QI health plan when the QI member begins to receive hospice services in the community as appropriate. If the member requires additional personal care services to maintain a safe and sanitary environment in areas of the home used by the member, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the member, this shall be provided by the hospice provider.

When a member begins to receive hospice services in the community, and similar to when a member receives hospice in an institution, the hospice POC shall be considered the primary driver of care and the hospice provider is considered responsible for coordinating with the approved HAP services.

Coordination of Benefits

When a Medicaid member elects the hospice benefit and has a non-Medicaid primary payor, including Medicare, the primary payor's hospice coverage must be fully utilized before the Medicaid health plan begins paying for hospice services.

Health plans are advised to review federal and state regulations on hospice providers and associated payment service/level(s) methodology, and revise hospice contracts as required. Should there be questions on this memo, please contact Jon Fujii at jfujii@dhs.hawaii.gov.

Appendix A

PLAN OF CARE (POC)

All hospice care and services offered to hospice patients and their families must follow an individualized written POC. The hospice Interdisciplinary Group (IDG) creates the POC in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs.

The POC should reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The POC must include all services necessary for the palliation and management of the terminal illness and related conditions of the individual.

The hospice POC should link with the needs identified in the initial/comprehensive assessment.

Hospices may identify needs in the comprehensive assessment that are not related to the terminal illness and related conditions. The assessment should document that the hospice is aware of these needs and if warranted, note who is addressing them. The hospice must ensure that each patient and their primary caregiver(s) are provided education and training as appropriate to their responsibilities for the care and services identified in the plan of care.

Source: The Centers for Medicare & Medicaid Services (CMS) August 2020 Medicare Learning Network fact sheet titled "CREATING AN EFFECTIVE HOSPICE PLAN OF CARE"; page 2
https://www.cms.gov/files/document/creating-effective-hospice-plan-care.pdf

Appendix B

COMMON DEFICIENCIES RELATED TO POC IMPLEMENTATION

The Centers for Medicare & Medicaid Services (CMS) analyzed 2019 hospice survey deficiency data at the Condition of Participation (CoP) for Interdisciplinary group, care planning, and coordination of services (42 CFR §418.56). Common survey deficiencies were related to plan of care (POC) implementation.

For example, CMS found that:

- POCs were not individualized
- Hospice staff missed direct-care visits
- Documentation of visits did not meet requirements (for example, wound care)
- POCs were incomplete (for example, not inclusive of all needed services)
- IDG meetings were inconsistent, with POCs not being updated

Source: The Centers for Medicare & Medicaid Services (CMS) August 2020 Medicare Learning Network fact sheet titled “CREATING AN EFFECTIVE HOSPICE PLAN OF CARE”; page 3
https://www.cms.gov/files/document/creating-effective-hospice-plan-care.pdf