ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable n/a

Previous Agency Name, If Applicable n/a

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Name of Rule Hospice-1-19;SPA# 2020-0010

Newspaper Name Arkansas Democrat Gazette

Date of Publishing March 22, 2020

Final Date for Public Comment April 20, 2020

Location and Time of Public Meeting n/a

213.000 Benefit Limits

~~12-1-07~~7-1-20

A. Arkansas Medicaid hospice coverage is based on providers' furnishing medical and other services and on their providing specified categories of care during renewable election periods of mandated duration.

1. Election periods are of ninety-day and sixty-day duration.
2. Each of the first and second election periods is ninety (90) days. Any additional election period, beyond the initial one hundred eighty (180) calendar day period of coverage, will consist of sixty (60) calendar days and require prior authorization.~~, followed by an unlimited number of sixty-day election periods.~~
3. Having once elected hospice, a patient is not required to elect hospice again, unless he or she revokes hospice care or is discharged from hospice care, in which case the patient may re-elect hospice care only after the last day of the election period in which the revocation or discharge occurred.
4. The conditions set forth in Section 210.200 are required for initial hospice election and for hospice re-election.

B. Continuous Home Care coverage is limited to periods of crisis.

C. Inpatient Respite Care is limited to two (2) periods of no more than five (5) consecutive days each.

1. The Arkansas Medicaid Program will not extend the Inpatient Respite Care benefit beyond five (5) days per stay; counting the admission day but not counting the discharge day, which is covered as a Routine Home Care day or a Continuous Home Care day, as applicable.
   a. A discharge day is covered as an Inpatient Respite Care day only if the patient is discharged deceased on that date.
   b. When, as infrequently happens, the beneficiary is not discharged by the end of the sixth day, Medicaid covers the sixth and subsequent days (if any) as Routine Home Care days.
2. The Arkansas Medicaid Program will consider extending the Inpatient Respite Care benefit to permit additional stays. Send ~~written~~ benefit extension requests to the **Arkansas Division of Medical Services, Utilization Review ~~Section~~.** ~~**View or print the Arkansas Division of Medical Services, Utilization Review Section contact information.**~~ Prior authorization shall be submitted through the **Arkansas Medicaid Provider Portal in MMIS.**
3. The request must justify the need for an additional period of Inpatient Respite Care, specify the number of days of respite (up to five (5)) needed, and include the names, addresses and telephone numbers of the caregivers requesting the additional Inpatient Respite Care.

230.000 PRIOR AUTHORIZATION

~~10-13-03~~7-1-20

Hospice services beyond the initial one hundred eighty (180) calendar day period of coverage require prior authorization (PA) for any additional sixty (60) calendar day election period for ages twenty-one (21) years and above. Exclusions include beneficiaries under age twenty-one (21) years or beneficiaries age twenty-one (21) years and above who have a cancer diagnosis, are living in a nursing facility, or are living in an ICF/IIDs.

Mark-Up

Send requests for hospice prior authorization to the **Arkansas Division of Medical Services, Utilization Review.** Prior Authorization shall be submitted through the **Arkansas Medicaid Provider Portal in MMIS**.

The PA request must be submitted at least ten (10) business days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends. If this requirement is not met and the preceding period ends, reimbursement will not be available for the days prior to receipt of the new request. Reimbursement will be effective the date the PA is received and approved.~~Prior authorization is not required for hospice services furnished by providers located and licensed in the State of Arkansas.~~

For existing clients, a prior approval will need to be sixty (60) calendar days after the first day the new policy changes.

Reconsideration of Prior Authorization Determination

Reconsideration of a denial may be requested within thirty (30) calendar days of the denial date. Requests must be made in writing and must include additional documentation to substantiate the medical necessity of the request.

Appealing an Adverse Action

Please see Section 190.003 of the Arkansas Medicaid provider manual for information regarding administrative appeals.

Mark-Up

213.000 Benefit Limits 7-1-20

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1. Election periods are of ninety-day and sixty-day duration.
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18. Hospice Care

- The hospice patient must be terminally ill which is defined as having a medical prognosis with a life expectancy of six months or less. The terminal illness must be certified by the patient's attending physician and hospice services prescribed.

- Patients must voluntarily elect to receive hospice services and choose the hospice provider. Hospice election is by "election periods". Election periods in the Arkansas Medicaid Hospice Program correspond to the election periods established for Medicare. The initial hospice election period is of 90 days duration and is followed by a second 90-day election period. The patient is then eligible for ~~an unlimited number of~~ additional 60-day election periods with prior authorization.

- Hospice services beyond the initial one hundred eighty (180) calendar day period of coverage require prior authorization (PA) for any additional sixty (60) calendar day election period for ages 21 years and above. Exclusions include beneficiaries under age 21 years or beneficiaries age 21 years and above who have a cancer diagnosis, are living in a nursing facility, or are living in an ICF/IID.

- Election of the hospice benefit results in a waiver of the **beneficiary's** rights to payment for only those services which are related to the treatment of the terminal illness or related conditions and common to both Title XVIII and Title XIX. The **beneficiary** does not waive rights to payment for services related to the terminal illness that are unique to Title XIX.

- Hospice services must be provided primarily in a patient's residence.

  A patient may elect to receive hospice services in a nursing facility **or an intermediate care facility for Individuals with Intellectual Disabilities (ICF/IID)** if the hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the patient's hospice care, and the facility agrees to provide room and board to the patient.

- Hospice services must be provided consistent with a written plan of care.

- Dually eligible (Medicare and Medicaid) **beneficiaries** must elect hospice care in the Medicare and Medicaid hospice programs simultaneously to be eligible for Medicaid hospice services.

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PROPOSED

MEDICALLY NEEDY

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- The hospice patient must be terminally ill which is defined as having a medical prognosis with a life expectancy of six months or less. The terminal illness must be certified by the patient's attending physician and hospice services prescribed.

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- Dually eligible (Medicare and Medicaid) beneficiaries must elect hospice care in the Medicare and Medicaid hospice program simultaneously to be eligible for Medicaid hospice services.

PROPOSED

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT David McMahon
TELEPHONE NO. (501) 396.6421 **FAX NO.** _____ **EMAIL:** David.McMahon@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Hospice-1-19; SPA# 2019-0005

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ____X____ No _____

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes_____X_____ No_____

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes_____X_____ No_____
   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and

   (d) Whether the reason is within the scope of the agency's statutory authority, and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year	**Next Fiscal Year**
General Revenue_____	General Revenue_____
Federal Funds_____	Federal Funds_____
Cash Funds_____	Cash Funds_____
Special Revenue_____	Special Revenue_____

Other (Identify)_____	Other (Identify)_____
Total_____	Total_____

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	($301,885)	General Revenue	($301,885)
Federal Funds	($745,963)	Federal Funds	($745,963)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	($1,047,848)	Total	($1,047,848)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$_____	$_____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ ($301,885)	$ ($301,885)

The implementation of this rule change will result in a cost avoidance to the State.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes_____ No_____X_____

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously

with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary

Hospice-1-19; SPA# 2020-0010

Statement of Necessity:

The Attorney General has investigated fraudulent charges made by hospice providers in Arkansas, confirming, in one case, overbilling by $290,000. The Department of Human Services, Office of Payment Integrity and Audit analyzed the Cognos claims data and found there were no limits to the amount billable from hospice care providers to Medicaid payments. The Department of Human Services, Office of Payment Integrity and Audit researched the Medicaid program policies of several other states, such as South Carolina, North Carolina, Mississippi, Alabama, and Louisiana.

Upon completion of this research, the Department of Human Services, Office of Payment Integrity and Audit determined there could be 50-60 prior authorizations per state fiscal year if they were required after the initial one hundred eighty (180) calendar days election period and excluded individuals under twenty-one (21) who have a cancer diagnosis, beneficiaries living in a nursing facility or ICF/IID, and all individuals under twenty-one (21). Under the previous language, hospice providers could bill without limit, making fraudulent Medicaid claims possible. This change will limit Medicaid billing and provide for medical necessity after the initial one hundred eighty (180) calendar days period has passed. The Department of Human Services contractor has agreed to review and approve the prior authorizations.

All surrounding states have limits, either prior to initiating services or after the initial election period passes. There is no overarching Medicaid rule calling for this change. The State may change the policy to best fit the state's program.

Rule Summary:

Summary: Effective July 1, 2020 the Division of Medical Services of the Department of Human Services is bringing the following rule promulgation:

The State Plan Amendment will consist of the following:

- Provide that any additional hospice election period beyond the initial one hundred eighty (180) calendar days of coverage will consist of sixty (60) calendar day periods, and each additional period will require prior authorization;
- Replace the use of "the mentally retarded" with "individuals with intellectual disabilities"; and
- Exclusions include beneficiaries under age 21 years or beneficiaries age 21 years and above who have a cancer diagnosis, are living in a nursing facility, or are living in an ICF/IID.

The Hospice Manual will be revised as follows:

- Section 213.00, Benefit Limits, revised to:
    - Provide that any additional hospice election period beyond the initial one hundred eighty (180) calendar days of coverage will consist of sixty (60) calendar day periods, and each additional period will require prior authorization;
    - Remove the Arkansas Division of Medical Services Utilization Review section and add Hospice QIO for benefit extension requests;
    - Provide QIO and MMIS information link
- Section 230.00, Prior Authorization, revised to:
    - Provide that any additional hospice election period beyond the initial one hundred eighty (180) calendar days of coverage will consist of sixty (60) calendar day periods, and each additional period will require prior authorization;

- Exclusions include beneficiaries under age 21 years or beneficiaries age 21 years and above who have a cancer diagnosis, are living in a nursing facility, or are living in an ICF/IID;
- Add electronic methods for submitting prior authorization requests;
- Provide that prior authorizations will be requested through the Prior Authorization portal in MMIS;
- Require that the prior authorization request be submitted at least ten (10) business days prior to the end of the current election period;
- Remove "Prior authorization is not required for Hospice services furnished by providers located and licensed in the State of Arkansas."; and
- Add information concerning reconsideration of a denial and appeal of an adverse action.