MEMORANDUM

Texas Department of Human Services * Long Term Care/Policy

TO: Long Term Care -Regulatory
Regional Directors, State Office Section Managers and
HCSSA Program Administrators

FROM: Marc Gold, Director
Long Term Care Policy
State Office MC: W-519

SUBJECT: Regional Survey & Certification Letter #01-09

DATE: May 18, 2001

The attached RS&C Letter is being provided to you for information purposes and should be shared with all professional staff.

- RS&C Letter No. 01-09 -- Hospice Questions and Answers (Taken From S&C Letter 01-13 From Steven Pelovitz); Call Geri Bischoff, R.N., HCSSA, at (512) 438-2100.

~Original Signature on File~

Marc Gold

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Medicaid and State Operations, Region VI

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April 30, 2001

REGIONAL SURVEY AND CERTIFICATION LETTER NO: 01-09

To: All State Survey Agencies (Information)
All Title XIX Single State Agencies (Information)

Subject: Hospice Questions and Answers (Taken From S&C Letter 01-13 From Steven Pelovitz)

The purpose of this letter is to provide you with the responses to questions received from the Hospice Association of America. This information was delivered by Health Care Financing Administration's (HCFA's) Central Office staff as part of their presentation at the National 2001 Policy Conference in March. The information is being sent for inclusion in your files.

Question # 1: What are the top ten survey deficiencies?

Answer: Of the 10 most frequently cited tags in the year ending in February 2001, eight are for regulations pertaining to the plan of care:

- L137 - Plan fails to state scope, frequency of services (15%)
- L136 - Plan fails to include assessment of needs (12.6%)
- L135 - Plan fails to be reviewed, updated at intervals (12.2%)
- L134 - Plan not established prior to providing care (10.7%)
- L133 - Written plan of care not established (10.6%)
- L210 - RN supervisory visits not made every 2 weeks (9.3%)
- L200 - No plan of care for bereavement service (7.8%)
- L142 - Failure to conduct self assessment of quality (6.5%)
- L209 - Services not available/adequate in frequency (6.3%)
- L211 B No written instructions for patient care (6.2%)

Question # 2: How long must a provider care for terminally ill patients before seeking their initial survey to become certified for the Medicare hospice benefit? How many patients must they have on service?

Answer: At the time of the survey, the hospice must be operational, have accepted patients (who are not required to be Medicare patients,) be providing all services needed by the patients actually being served, and have demonstrated the operational capability of all facets of its operations. To be considered fully operational, initial applicants must be serving a sufficient number of patients, for a sufficient period of time, so that surveyors can be reasonably assured that that the hospice is able to comply with all requirements. This may be as few as one patient, but only if in the surveyor's judgement, compliance can be determined by reviewing a single patient record.

In the event that the hospice patients presently being served do not require the full scope of hospice services, surveyors will need to verify that the hospice is fully prepared to provide all services necessary to meet the hospice conditions of participation (CoPs.)

Surveyors do not have to schedule another survey to inspect the arranged-for inpatient services if the contracts have been reviewed and there is no doubt that the hospice is providing the service or is fully prepared to provide the service when needed. However, the effective date of Medicare participation can be no earlier than the date the hospice is prepared to provide all of the required services and meets all the hospice CoPs. In no case can the effective date be earlier than the date of the survey.

Question # 3: May a Medicare hospice patient also receive support services through a State=s home and community-based care program?

Answer: If an individual is dually-eligible (receives both Medicare and Medicaid) and is a 1915(c) home and community based waiver recipient, he/she can elect the Medicare hospice benefit and continue to receive waiver services as long as the services are not equivalent to Medicare services. Under no circumstance should Medicaid pay for a hospice service already provided under the Medicare hospice benefit.

States have often argued that providing personal care services is duplicative to the home health aide and homemaker services that must be provided under the hospice benefit. The hospice is required by Federal regulation to provide the home health aide and homemaker services in an amount that is adequate to meet the needs of the patient. These needs are determined by the hospice interdisciplinary team and should be noted and a part of the plan of care provided by the hospice.

To prevent duplication of services, it is up to the State to define the Medicaid personal care services option benefit and to determine if the benefit is more extensive than the homemaker/ home health aide benefit provided under the Medicare hospice benefit. If the personal care benefit is more extensive than what is offered under the Medicaid hospice benefit, then the State must pay for these services when a need for such services is indicated in the hospice patient?s plan of care.

Question # 4: Is there a HCFA web site specifically for historic and current hospice material on the survey and certification issues?

Answer: Yes. The address is www.hcfa.gov/medicaid/hospice/hospice.htm. This site contains the recent policy memos, hospice provisions enacted by the Balanced Budget Act of 1997, Transmittal No. 265 December 1994, HCFA-Pub 7: Hospice- Sections 2080-2087 and Appendix M Hospice Survey Procedures & Interpretive Guidelines

Question # 5: Will HCFA provide training on the new COPs when they are released?

Answer: Yes, HCFA will provide training to both the State survey agencies and the hospice providers when the final CoPs are published. We will also issue new interpretive guidelines for the new CoPs at that time.

Question # 6: What services must a Medicare approved hospice provide on a 24-hour basis?

Answer: The hospice is required by the CoP at 42 CFR 418.50 to make nursing services, physician services, drugs and biologicals routinely available on a 24-hour basis. They also have to make all other covered services available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

Question # 7: If a patient does not follow a hospice=s plan of care, can the hospice threaten to terminate services?

Answer: Once a hospice chooses to admit a Medicare beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements. The election of the hospice benefit is the beneficiary's choice rather than the hospice's choice, and the hospice cannot revoke the beneficiary's election. Neither should the hospice request nor demand that the patient revoke his/her election.

In most situations, discharge from a hospice will occur as a result of one the following:

- The beneficiary decides to revoke the hospice benefit;
- The beneficiary moves away from the geographic area that the hospice defines in its policies as its service area;
- The beneficiary transfers to another hospice;
- The beneficiary's condition improves and he/she is no longer considered terminally ill. In this situation, the hospice will be unable to recertify the patient; or
- The beneficiary dies.

We recognize, however, there may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety or hospice staff safety is compromised. The hospice must make every effort

to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must notify the fiscal intermediary and state survey agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.

Question # 8: Does a hospice need a full time team coordinator? May a team coordinator be part time?

Answer: The hospice is required to designate a registered nurse to coordinate the implementation of the plan of care for each patient. There is no requirement that this person work full time - but there must be assurances that the plan of care is coordinated on a 24 hour basis so the patient receives the necessary care and services required in the plan.

Question # 9: When a home health agency (HHA) is preparing to become Medicare certified for hospice, can a home care patient who is receiving hospice care still receive the home care benefits for which he continues to be eligible under home care? If so, may this patient be considered a hospice patient for purposes of the hospice certification survey?

Answer: A terminally ill patient who does not wish to elect the Medicare hospice benefit, and who meets the eligibility criteria for skilled care under the Medicare home health benefit is eligible to receive home health care under a plan of care established by the patient's physician and the HHA If the terminally ill patient does not meet the admission criteria for the Medicare home health benefit, the home health services would not be reimbursed under Medicare.

Terminally ill patients who are admitted by the HHA for skilled services are considered HHA patients. These patients may be selected for the clinical record review and home visit during the HHA certification survey. These patients may not be considered hospice patients during a hospice survey.

In addition, we would like to note that the HHA CoPs are applicable to terminally ill patients of the HHA, since the CoPs apply to all patients of the HHA regardless of diagnosis. Therefore, the HHA, in accordance with 42 CFR 484.10, has a responsibility to clearly inform the patient of his/her rights to Federal services and to protect and promote the exercise of these rights. This responsibility includes an explanation of the care to be furnished and any changes in that care. If the entity is approved for Medicare as both an HHA and a hospice, the explanation should include the difference between the two benefits and the Federal payment(s) that may be expected from either or both.

Question # 10: Must a SNF/NF do a complete assessment on a patient who is admitted to the SNF/NF for short term Medicare hospice benefit inpatient care?

Answer: When the hospice patient is admitted to the SNF/NF for short term inpatient care, the hospice provides the facility with a copy of the patient's plan of care and specifies the inpatient services to be furnished. The SNF/NF must abide by the patient care protocols established by the hospice and use personnel trained in hospice care by the hospice. The SNF/NF is also required to be in compliance with the nursing home regulations. This means they must begin the assessment and care planning process on admission. They would do this in coordination with the hospice and use the information that has been provided by the hospice. After admission, the facility has 14 days to complete the Resident Assessment Instrument with the comprehensive care plan 7 days thereafter. Hospice inpatients may be discharged before these requirements take effect. However, the facility is required to begin the assessment process within the required timeframes completing those portions that can be completed as appropriate.

Question # 11: Do the SNF/NF requirements apply when a resident of a SNF/NF elects the hospice benefit?

Answer: Yes. When a resident of a SNF/NF elects to receive Medicare coverage of services under the hospice benefit, both the Medicare hospice conditions of participation and the SNF/NF requirements apply. This means that the resident must be assessed using the Resident Assessment Instrument, which includes both the Minimum Data Set and the Resident Assessment Protocols (RAPs). RAP guidelines are not meant as prescriptive courses of actions. Rather, they are intended as frameworks for assessment that are clinically indicated depending on the needs of each individual resident. For example, some of the RAP guidelines may include content suggestive of an aggressive work-up to determine causal factors that may not be appropriate for individuals who are terminally ill (e.g., an aggressive work-up to determine the cause of weight loss would generally not be appropriate or expected for a resident receiving hospice care.) Many of the RAPs, however, such as "Activities" or maintenance of the resident's "Activities of Daily Living", should lead to more aggressive patient assessment if they are useful in helping facility staff increase the resident's comfort level and ability to attain or maintain his/her highest practicable well-being and create an atmosphere where the patient will be able to die with dignity. It is important to remember that RAP documentation and the plan of care may also reflect a resident's right to refuse treatment or services. In summary, the RAPs have been developed to assist facilities in planning appropriate and individualized care for residents.

Question # 12: May a SNF/NF medical director order the drugs recommended for treatment of a Medicare hospice benefit patient or would this violate the regulations with regard to hospice professional management of the plan of care?

Answer: The plan of care is developed, reviewed and updated by the hospice medical director or hospice physician and the interdisciplinary group working with the patient's attending physician (who may or may not be the SNF/NF medical director.) This team then decides who will order the drugs and treatments contained in the plan of care, for example, hospice physician or

attending physician. The hospice makes any necessary financial arrangements for the drugs related to the terminal illness and arranges for their provision either directly or under arrangement with a pharmacy. If they are provided under arrangement with another pharmacy, the hospice will also meet the professional management requirements contained in the CoP at 42 CFR 418.56.

If you have any questions, please contact Karen Herbelin at 214-767-4422.

Sincerely,

~Signature on File~

Molly Crawshaw, Chief
Survey and Certification Operations Branch