DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

MEMORANDUM

DATE: April 20, 2000

FROM: Director
Survey and Certification Group
Center for Medicaid and State Operations

SUBJECT: Response to Questions From the Hospice Association of America

TO: Associate Regional Administrators
Division for Medicaid and State Operations
Regions I - X

The purpose of this memorandum is to inform you that we recently provided the following answers in response to questions submitted from the Hospice Association of America at the National Association for Home Care=s Policy Conference on April 3, 2000. We are including them for your files.

1 Q. Have there been any changes in the Skilled Nursing Facility/Nursing Facility (SNF/NF) regulations this year or current problems that hospice programs should be aware of in providing hospice services to residents of long term care (LTC) facilities?

1 A. There have been no changes to the SNF/NF requirements at 42 CFR 483(ff) this year. However, we remain concerned about the care that some residents who elect the hospice benefit are receiving.

We added guidance to surveyors of LTC facilities several years ago that mirrors the guidance we have for hospice surveyors. Specifically, the State Operations Manual (SOM) for LTC surveyors states that surveyors will review the care of a resident receiving hospice care. When a facility resident has elected the Medicare hospice benefit, the hospice and the nursing facility must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual=s needs and unique living situation in the facility.

Surveyor=s major concerns with hospice care in the LTC facility include the following:

1. The provision of care and services which does not reflect the hospice philosophy.

2. Problems with the coordination, delivery and review of the plan of care between the hospice and the LTC facility.

3. Ineffective systems in place to monitor/assure that the plan of care is meeting the resident=s needs in the area of pain management and symptom control.

4. Poor communication between the hospice and nursing home staff:

- nursing home staff are often not aware of the hospice philosophy;
- plan of care does not reflect the hospice philosophy or adequately address pain management and symptom control; and
- hospice and LTC staff do not communicate problems encountered with the pain management assessments and make needed revisions to the plan of care in an effective and timely manner.

2 Q. If a hospice program has adopted the National Hospice Organization=s (NHO) standards of care, which state that the hospice social worker is an MSW and the hospice program has employed a BSW, can the hospice be cited?

2 A. We expect that hospices will develop their policies and procedures, and we expect that they will follow them. The Federal requirement for a social worker is for a BSW, which is less stringent than the NHO standards. So the hospice is in compliance with the Federal requirement for social work, but the larger issue surrounds the hospice=s failure to follow its own policies/standards. If the hospice tells the surveyor that their policy follows the NHO standards for an MSW and the surveyor discovers that this is not true, it is a finding. Surveyors will look at the total picture during a survey and observe the hospice=s total operations. They will also review their survey Afindings.@ This particular finding could in fact lead to a citation under the governing body--which is charged with assuming responsibility for determining, implementing and monitoring the hospice=s policies.

3 Q. What are the top ten survey problems?

3 A. The ten most frequently cited tags include regulations pertaining to the development and updating of the plan of care and required records:

L137 - Plan states scope and frequency of services needed	16.18%
L136 - Plan includes assessment of individual needs	14.07%
L135 - Plan is reviewed and updated at intervals	12.01%
L134 - Plan established prior to providing care	10.74%
L210 - RN visits the home site at least every 2 weeks	9.07%
L133 - Written plan of care established	8.94%
L200 - Plan of care for bereavement service	7.67%
L209 - Home health aide and homemaker services available	6.97%
L211 - RN prepares written instructions for home health aide	6.40%

L185 - Record contains documentation of all services 6.36%

4 Q. A hospice program is admitting patients and awaiting their initial survey. Should the hospice program have these patients sign a Medicare benefit election statement during the admission process even though the hospice is not certified to offer the Medicare benefit at that time?

4 A. No. The Medicare beneficiary can only elect hospice from a Medicare approved hospice. A hospice awaiting its initial survey is not Medicare approved.

5 Q. During an initial hospice survey the hospice program was told that "your program is responsible for paying for all of the medications for the hospice patients". Is that correct?

5 A. Until a hospice is Medicare approved, it would not be expected to pay for the required drugs for Medicare beneficiaries.

We would also like to note that the condition of participation at 42 CFR 418.56 requires the Medicare approved hospice to maintain professional management responsibility for the services it provides under arrangement. The standard at 42 CFR 418.56(d), requires the hospice to retain responsibility for payment for those services. A Medicare approved hospice is reimbursed for all covered services it provides, whether directly or under arrangement. It is the responsibility of the hospice to pay for those services provided to Medicare beneficiaries under arrangement. When a hospice provides services under arrangements to non-Medicare beneficiaries, the hospice is responsible for establishing how payment for those services will occur, but the standard does not require the hospice to pay for those services directly or to pay for services for which there is no reimbursement or for which another insurer is obligated to pay.

6. Q. A three program agency (HHA/hospice/ private pay) provides services in a several hundred square mile rural area. Can this agency share its staff to cover on-call service for all three programs?

6. A. If the staff are all employed by one corporation or organization, and that organization is responsible for issuing the W2 form on their behalf, employees could divide work time between the parent organization and the hospice or HHA if they were also appropriately trained to do the work. The hospice and the HHA need to maintain a record of the individual's assigned time to each program. However, if these Acorporate@ employees provide services to the HHA or hospice outside of their own usual working hours or shifts (i.e., "moonlight" as HHA or hospice employees, as opposed to working overtime for the corporation,) they would be considered contract employees and would not meet the core service requirement for hospice or the direct service requirement for HHAs.

7 Q. Can an HHA and hospice use contract nurses to staff the agency=s on-call needs if the contract nurse is functioning in the role of Aanswering service only@ for hospice calls?

7 A. A hospice cannot use a contract nurse unless it is to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances (e.g., half the nursing staff is out with the flu.) These circumstances are unexpected and for a finite period of time.

An HHA may use contract nurses if nursing is not the one service that it provides in its entirety directly by its own employees.

8 Q. A Medicare hospice patient is receiving support service through the State's home and community-based care (HCBC) program. The services are for home health aides for personal care and related support. Currently, the state HCBC programs nurses are approving the delivery of this care, through the waiver program. Is this double-dipping?

8 A. 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.

9 Q. Over the years a variety of clarification memos have been released, how and where can a new hospice program access this information so they can provide the correct information when issues arise during a survey.

9 A. We have developed a web site specifically for hospice material related to survey and certification issues. This site contains our recent memos, frequently asked questions, as well as links to the regulations and State Operations Manual. This web site can be accessed at www.hcfa.gov/medicaid/hospice/hospice.htm.

If you would like to discuss any of these issues further, please contact Mavis Connolly at (410) 786-6707.

/s/

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cc: Tom Hoyer, CHPP