

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-58

DATE: September 18, 2009

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Advance Copy - Hospice State Operations Manual (SOM) Sections 2080-2089

Memorandum Summary

- **Guidance for Revised Conditions of Participation (CoPs):** The attached advance copy of the hospice sections of Chapter Two of the SOM includes revised interpretive guidance related to the revised Hospice CoPs that were effective December 2, 2008.

The attached SOM Sections 2080-2089 represent the most recent material related to the 42CFR Part 418 Conditions of Participation for Hospice. This information should replace all previously-released versions.

Attachment A is an advance copy of the revised SOM. This information will ultimately be published in Chapter Two of the SOM. The final Chapter Two of the SOM may differ slightly from this advance copy as the document is still in the formal clearance process.

Effective Date: Immediately. Please ensure that all appropriate staff is fully informed within 30 days of the date of this memorandum.

Training: The information contained in this letter should be shared with all Survey and Certification staff, their managers, and the State/RO training coordinators. If you have additional questions or concerns, please contact Kim Roche through e-mail at kim.roche@cms.hhs.gov.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management
Attachment

CMS Manual System		Department of Health & Human Services (DHHS)
Pub. 100-07 State Operations Provider Certification		Centers for Medicare & Medicaid Services (CMS)
Transmittal	Date: xxxx 2009	

SUBJECT: Revisions to Chapter 2, Sections 2080 – 2089 - “Hospices”

I. SUMMARY OF CHANGES: Chapter 2, Sections 2080 – 2089 has been revised to reflect changes in policies and procedures related to the new regulations at 42 CFR 418.52-116.

- 2080B – Has been revised to include the regulatory definition of hospice care and palliative care.
- 2080C – Has been revised and now contains hospice core services information.
- 2080C.1 – Has been added to include the waiver of staffing requirements available to hospices.
- 2080C.2 – Has been added to include information on when a hospice may contract for highly specialized services of a registered professional nurse.
- 2080C.3 – Has been added to include the temporary provisions that CMS has instituted for hospices that are unable to hire a sufficient number of nurses directly due to the hospice nursing shortage.
- 2080D – Has been added to include the requirements for hospice services. It also contains the waivers permitted by law for the provision of some of these services.
- 2080D.1 – Has been added to include information on the role of the hospice interdisciplinary group.
- 2081 – Has been revised and now includes information about revoking the election of hospice care.
- 2082 – Has been revised and now includes information on discharge from hospice care.
- 2083 – Has been revised to include the conditions that are necessary to determine eligibility for Medicare and Medicaid patients but that may not be a requirement for other payment sources.
- 2084 – Has been revised to include the updated regulations on providing hospice inpatient services.
- 2084.1 – Has been added to include information concerning hospices providing inpatient care directly.
- 2084.2 – Has been added to include information concerning hospices providing inpatient care under arrangements.
- 2085 – Has been revised to include updated policy information on hospices operating across state lines.
- 2086 – Has been revised to include guidance on hospices that intend to move to a new location.

- 2086.1 – Has been added to include the effective date information if CMS approves a hospice’s request to change locations.
- 2086.2 – Has been added to include information regarding a hospice’s options if the change of location has been denied by CMS.
- 2086.3 – Has been added to include information regarding hospices that move to a new location after a survey but before certification activities are completed.
- 2087 – Has been changed to include information on simultaneous surveys.
- 2088 – Has been added to include information on hospice multiple locations.
- 2089- Has been added to include information on when the hospice provides care to residents of a SNF/NF or ICF/MR.

**NEW/REVISED MATERIAL - EFFECTIVE DATE*: xxxx, 2009
IMPLEMENTATION DATE: xxxx, 2009**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revise information only, and not the entire table of contents.

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)**

R/N/D	CHAPTER/SECTION/SUBSECTION/ TITLE
R	2/2080A/Citations
R	2/2080B/Description
R	2/2080C/Hospice Core Services
N	2/2080C.1/Waiver of Certain Staffing Requirements
N	2/2080C.2/Contracting for Highly Specialized Services
N	2/2080C.3/Hospice Nursing Shortage Provision
N	2/2080D/Hospice Required Services
N	2/2080D.1/Hospice Interdisciplinary Group (IDG)
R	2/2081/Revoking Election of Hospice Care
R	2/2082/Discharge from Hospice Care
R	2/2083/Hospice Regulations and Non-Medicare Patients
R	2/2084/Hospice Inpatient Services
N	2/2084.1/Hospice Provides Inpatient Care Directly
N	2/2084.2/Hospice Provides Inpatient Services Under Arrangements
R	2/2085/Operation of Hospice Across State Lines
R	2/2086/Hospice Change of Address
N	2/2086.1/Effective Date
N	2/2086.2/Administrative Review
N	2/2086.3/Move after Certification Survey
R	2/2087/Simultaneous Surveys

N	2/2088/Multiple Locations
N	2/2089/Survey Requirements When the Hospice Provides Care to Residents of a SNF/NF or ICF/MR

III. Funding: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2009 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One Time Notification
	Recurring Update Notification

*** Unless otherwise specified, the effective date is the date of service.**

State Operations Manual

Chapter 2 – Hospices

Transmittals for Chapter 2

Crosswalk to old sections 2080-2087

Crosswalk to Old Sections 2080-2087

CROSSWALK TO THE OLD CHAPTER 2

A crosswalk from sections 2080-2084 of the State Operations Manual Chapter Two published 5-21-2004 to the revised Chapter Two is as follows:

Name of Old Section	Old Section Number	New Section Number	Name of New Section
Hospice - Citations and Description	2080	2080	Hospice - Citations and Description
Citations	2080A	2080A	Citations
Description	2080B	2080B	Description
Termination of Hospice Services	2080C	2081 2082	Revoking Election of Hospice Care Discharge from Hospice Care
Hospice Multiple Locations	2081	2088	Multiple Locations
Election of Hospice Benefit by Resident of SNF, NF, ICF/MR, or Non-Certified Facility	2082 (A-D)	N/A	
Hospice Regulations and Non-Medicare Patients	2083	2083	Hospice Regulations and Non-Medicare Patients
Hospice Inpatient Services Furnished Directly or Furnished Under Arrangements	2084	2084-2084.2	Hospice Inpatient Services, Hospice Provides Inpatient Services under Arrangement
Hospice Provides Inpatient Care Directly	2084A	2084.1	Hospice Provides Inpatient Care Directly
Hospice Provides Inpatient Services Under Arrangement	2084B	2084.2	Hospice Provides Inpatient Services Under Arrangement
Operation of Hospice Across State Lines	2085	2085	Operation of Hospice Across State Lines
Hospice Home Visits	2086	N/A	N/A
Compliance with Advance Directives	2087	N/A	N/A

2080 - Hospice - Citations and Description

2080A – Citations

(Rev.)

Section 1861(u) of the Act *establishes* hospices as a provider *of services*. Section 1861(dd) of the Act defines hospice care and the hospice program. 42 CFR 418 sets forth *the Conditions of Participation (CoPs) that hospices must meet and applies to a hospice as an entity as well as to the services provided to each individual under hospice care*. 42 CFR Part 418.110 is a condition applicable only to hospices that provide short-term inpatient care and respite care directly, rather than under arrangements with other participating providers. Section 1866(a)(1)(Q) of the Act requires hospices, among other providers, to file an agreement with the Secretary to comply with the requirements found in §1866(f) of the Act regarding advance directives.

The *Centers for Medicare & Medicaid Services (CMS)* has a *Web* site for *survey and certification information including hospice policy memos, hospice State Operations Manual, §§2080-2087 and Appendix M, Hospice Survey Procedures and Interpretive Guidelines*. *This information is available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/>*

Definition

A hospice is a public agency or private organization or a subdivision of either *of these* that is primarily engaged in providing care *and services* to terminally ill individuals, meets the *CoPs* for hospices, and has a valid Medicare provider agreement. The law governing the provision of Medicare hospice services is found at §1861(dd) of the Act. The law further clarifies that “terminally ill individuals” are individuals having a “medical prognosis that *the individual’s* life expectancy is 6 months or less.” *This definition is further clarified at §418.3 to provide for a life expectancy of 6 months or less “if the illness runs its normal course.”* Although the law does not explicitly define its expectations for “primarily engaged,” CMS has interpreted it to mean exactly what it says, that a hospice provider must be primarily engaged in providing hospice care and services (§1861(dd)(2)(A)(i)). “Primarily” does not mean “exclusively.” This requirement does not preclude *the hospice from providing* services to terminally ill individuals who have not *elected* the hospice *benefit* or *providing* services to individuals who are not terminally ill, *as* long as the primary activity of the hospice is the provision of hospice services to terminally ill individuals and the hospice meets all requirements for participation in Medicare.

Hospice Benefit Periods

An individual may elect to receive Medicare hospice *benefits for two periods of 90 days and an unlimited amount of periods for 60 days each*. (*See §418.21.*)

Eligibility Requirements

In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. (*See §418.20.*) An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

Referrals may come from any source, but patients must be assessed by the hospice medical director for appropriateness of admission in consultation with the patient’s attending physician (if the individual has one). The hospice medical director must consider the diagnosis of the

terminal condition of the patient, other health conditions, whether related or unrelated to the terminal illness, and current clinically relevant information supporting all diagnoses. The medical director may consult with the attending physician directly or through information obtained indirectly. Information could be obtained through the hospice nurse or others who would bring the attending physician's knowledge of the patient to the medical director when the admission decision is being made.

The hospice must obtain written certification of terminal illness within 2 calendar days for each of the benefit periods listed in §418.21, even if a single election continues in effect for an unlimited number of periods. If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain oral certification within 2 calendar days and written certification before a claim for payment is submitted.

For the initial 90-day period, certification of terminal illness must be obtained from the medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG) and the individual's attending physician (if the individual has one). Recertification for subsequent periods only requires the certification of the hospice medical director or the physician member of the IDG. Certification statements must be on file and dated by the physician before the hospice submits a claim for payment. (See §418.22.)

2080B – Description

(Rev.)

Hospice care means a comprehensive set of services described in §1861(dd)(1) of the Act, identified and coordinated by the individual's attending physician, medical director and by an interdisciplinary group to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill patient and family members, as delineated in a specific patient plan of care.

Hospice uses an interdisciplinary approach to caring for terminally ill individuals that stresses palliative care as opposed to curative care. Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. The emphasis of hospice care is on effective symptom management, with the goal of making the patient as physically and emotionally comfortable as possible, and enabling the patient to remain at home as long as possible with minimal disruption to normal activities. Counseling and respite services are available to the family of the hospice patient. Hospice considers both the patient and the family as the unit of care.

Although some hospices are located as part of a hospital, *skilled nursing facility* (SNF), and *home health agency* (HHA), hospices must meet specific CoPs and be separately certified and approved for Medicare participation *as a hospice provider of services*. (See [Exhibit 129](#) for "Hospice Survey and Deficiencies Report," Form CMS-643 and [Exhibit 72](#) for "Hospice Request for Certification in the Medicare Program," Form CMS-417.)

2080C - Hospice Core Services

(Rev.)

With the exception of physician services, substantially all core services must be provided directly by hospice employees on a routine basis. These services must be provided in a manner consistent with acceptable standards of practice. The following are hospice core services:

- Physician services.*
- Nursing services, (routinely available and/or on call on a 24-hour basis, 7 days a week) provided by or under the supervision of a registered nurse (RN) functioning within a plan of care developed by the hospice IDG in consultation with the patient's attending physician, if the patient has one.*
- Medical social services by a qualified social worker under the direction of a physician.*
- Counseling (including, but not limited to, bereavement, dietary, and spiritual counseling) with respect to care of the terminally ill individual and adjustment to death. The hospice must make bereavement services available to the family and other individuals identified in the bereavement plan of care up to 1 year following the death of the patient.*

The hospice may contract for physician services as specified in §418.64(a).

A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances.

2080C.1 - Waiver of Certain Staffing Requirements

(Rev)

Hospices are prohibited from contracting with other hospices and non-hospice agencies on a routine basis for the provision of the core services of nursing, medical social services and counseling to hospice patients. A hospice may, however, enter into arrangements with another hospice program or other entity for the provision of these core services in extraordinary, exigent, or other non-routine circumstances. An extraordinary circumstance generally would be a short-term temporary event that was unanticipated. Examples of such circumstances might include unanticipated periods of high patient loads, caused by an unexpectedly large number of patients requiring continuous care simultaneously, temporary staffing shortages due to illness, receiving patients evacuated from a disaster such as a hurricane or a wildfire, or temporary travel of a patient outside the hospice's service area. The hospice that contracts for services must maintain professional management responsibility for all services provided under arrangement or contract at all times and in all settings. Regulations at §418.100(e) discuss the professional management responsibilities of the hospice for services provided under arrangement.

Hospices must maintain evidence of the extraordinary circumstances that required them to contract for the core services and comply with the following:

- (a) The hospice must assure that contracted staff is providing care that is consistent with the hospice philosophy and the patient's plan of care and is actively participating in the coordination of all aspects of the patient's hospice care.*

(b) Hospices may not routinely contract for a specific level of care (e.g., continuous care) or during specific hours of care (e.g., evenings and week-ends).

2080C.2 - Contracting for Highly Specialized Services

(Rev.)

A hospice may contract for the services of a registered nurse if the services are highly specialized, provided non-routinely, and so infrequently that the provision of such services directly would be impracticable and prohibitively expensive. Highly specialized services are determined by the nature of the service and the nursing skill level required to be proficient in the service. For example, a hospice may need to contract with a pediatric nurse if it cares for pediatric patients infrequently and employing a pediatric nurse would be impracticable and expensive. Continuous care is not a highly specialized service, because while time intensive, it does not require highly specialized nursing skills.

2080C.3 – Hospice Nursing Shortage Provision

(Rev.)

CMS has instituted a temporary measure for hospices that are unable to hire a sufficient number of nurses directly due to the nursing shortage¹. During the time period from October 1, 2008 – September 30, 2010, in order to qualify for an “extraordinary circumstance” exemption, a hospice must notify the state agency (SA) responsible for licensing and certification that it intends to elect an exception under the “extraordinary circumstance” authority. This may be accomplished by providing written notification to the SA when it believes that the nursing shortage has become an “extraordinary circumstance” in its ability to hire nurses directly, and it must estimate the number of nurses it believes it will currently need to employ under contract. Notification may be made prior to September 30, 2010, and should address the following:

- *An estimate of the number of potential patients that the hospice has not been able to admit during the past three months due to the nursing shortage and provide the current and desired patient/nurse ratio for the agency;*
- *Evidence that the hospice has made a good faith effort to hire and retain nurses, including:*
 - *Copies of recent advertisements (e.g., in local newspapers, Web sites, etc.,) that demonstrate recruitment efforts.*
 - *Copies of reports of telephone contacts with potential hires, professional schools and organizations, recruiting services, etc.*
 - *Job descriptions for nurse employees.*
- *Evidence that salary and benefits are competitive for the area;*
- *Evidence of any other recruiting activities (e.g., recruiting efforts at health fairs, educational institutions, health care facilities, and contacts with nurses at other providers in the area);*
- *Ongoing self-analyses of the hospice’s trends in hiring and retaining qualified staff; and*
- *Evidence that the hospice has a training program in place to ensure that contracted staff are trained in the hospice philosophy and able to provide palliative care prior to patient contact;*

¹ *CMS has instituted a temporary measure to allow individual hospices to contract for nurses until September 30, 2010, if the hospice can demonstrate that the nursing shortage is creating an extraordinary circumstance that prevents it from hiring an adequate number of nurses.*

Contracted nurses may only be used to supplement the hospice nurses employed directly and should not be used solely to provide the continuous nursing level of care or on call service. The hospice is expected to continue its recruitment efforts during the period that it is contracting for nurses.

No approval action is required on the SA's part when it receives written notification from a hospice for an exemption, as long as the hospice provides the appropriate information. The SA will maintain copies of each exception notification and validate the hospice's stated need for an exemption during complaint and re-certification surveys. Of particular importance will be the extent to which the hospice nurses have been trained in the hospice philosophy and are able to effectively provide care to the patients consistent with the patient specific plan of care established by the IDG.

2080D - Hospice Required Services

(Rev.)

Requirement for 24-Hour Services

The hospice is required by the CoPs at §418.100 to make nursing services, physician services, drugs, and biologicals routinely available on a 24-hour basis, 7 days a week. It also has to make all other covered services available on a 24-hour basis, 7 days a week, when reasonable and necessary to meet the needs of the patient and family.

In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), the following services must be provided by the hospice, either directly or under arrangements, to meet the needs of the patient and family:

- Physical and occupational therapy and speech-language pathology services;*
- Hospice aide services. A hospice aide employed by a hospice, either directly or under contract, must meet the qualifications required by §1891(a)(3) of the Act and implemented at §418.76;*
- Homemaker services;*
- Volunteers;*
- Medical supplies (including drugs and biologicals on a 24-hour basis) and the use of medical appliances related to the terminal diagnosis and related conditions;*
- Short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid participating facility;*
- Continuous home care provided during a period of crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis, as necessary to maintain the patient at home. §418.204(a) defines a crisis as the period in which an individual requires continuous care for as much as 24 hours to achieve palliation or management of acute medical symptoms. The care provided must require at least 8 hours of care in a 24 hour period, and the care must be provided predominantly by a licensed nurse (RN, LVN, LPN). Homemaker or hospice aide services or both may also be covered if needed.*

Section 1861(dd)(5) of the Act allows CMS to permit certain waivers of the requirements that the hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling available (as needed) on a 24-hour basis. CMS is also allowed to waive the requirement that hospices provide dietary counseling directly. These waivers are available only to an agency or organization that is located in an area which is not an urbanized area (as defined by the Bureau of Census) and that can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel. These waivers are codified at §418.74.

2080D.1 - Hospice Interdisciplinary Group (IDG)

(Rev.)

Hospices participating in the Medicare program must use an interdisciplinary approach to assessing and meeting the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. The hospice IDG members include, but are not limited to, the hospice physician (doctor of medicine or osteopathy) who must be an employee of or under contract with the hospice, registered nurse, social worker, and pastoral or other counselor. The IDG is required to conduct a comprehensive assessment of the patient and update the assessment at required time points. In addition, the group, in consultation with the patient's attending physician, if the patient has one, must prepare a written plan of care for each patient that reflects patient and family goals and interventions based on the needs identified in the initial, comprehensive, and updated assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.

The attending physician may be either a doctor of medicine or osteopathy or a nurse practitioner. This person is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. In the event that a beneficiary's attending physician is a nurse practitioner, the hospice medical director and/or physician designee must certify or re-certify the terminal illness. Nurse practitioners cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs its normal course, or re-certify a terminal diagnosis or prognosis.

The hospice IDG is responsible for developing and maintaining a system of communication, coordination and integration of services that ensures that the plan of care is reviewed and updated no less frequently than every 15 calendar days. It is not permissible for either the attending physician or the hospice medical director to provide the sole guidance for the plan of care. The law and regulations require that it be the combined work of the IDG.

2081 – Revoking Election of Hospice Care

(Rev.)

The hospice patient or representative may revoke the patient's election of hospice care at any time during the election period according to §418.28. Revocation is a voluntary action taken by the patient or representative. 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. It is important for the hospice to educate the patient and family before the start of care that hospice entails certain limits in the way care will be provided, including restrictions on obtaining care outside the care arranged for or provided by the hospice, and the patient's liability for care received without the hospice's involvement. The hospice should neither request nor pressure the patient/family or representative in any way to revoke his/her election.

2082 – Discharge from Hospice Care

(Rev.)

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 law. The situations under which a hospice may discharge a patient are addressed in regulation at §418.26 and include the following situations:

- The patient moves out of the hospice's service area or transfers to another hospice;*
- The hospice determines that the patient is no longer terminally ill;*
- The hospice determines under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.*

The hospice must do the following before it seeks to discharge a patient for cause:

- Advise the patient that a discharge for cause is being considered;*
- Make a serious effort to resolve the problem(s) presented by the patient's (or other persons in the patient's home) behavior or situation;*
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services;*
- Document in the clinical record, the problem(s) and efforts made to resolve the problem(s).*

Prior to discharging a patient for any reason stated above, the hospice IDG must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his/her review and decision included in the discharge note.

The hospice notifies its Medicare administrative contractor (MAC) and SA of the circumstances surrounding the impending discharge. The hospice should also consider referrals to other appropriate and/or relevant state/community agencies (i.e., Adult Protective Services) or health care facilities before discharge.

2083 - Hospice Regulations and Non-Medicare Patients

(Rev.)

The hospice CoPs apply to all patients of the hospice (Medicare and non-Medicare), with the exception of the following regulations, which apply only to Medicare beneficiaries:

- §418.100(d) - the continuation of care requirement, and*
- §418.108(d) - the 80-20 inpatient care limitation.*

In addition, the following CoPs regarding the certification and recertification of terminal illness are necessary to determine eligibility for Medicare and Medicaid patients and may or may not be a requirement by other payment sources:

*§418.102(c);
§418.104 (a)(5);
§418.112 (e)(3)(iii).*

2084 - Hospice Inpatient Services

(Rev.)

Hospices must make inpatient care available for pain control, symptom management, and respite purposes. This inpatient care may be provided directly by the hospice or indirectly under arrangements made by the hospice. If services are provided under arrangements, the hospice must ensure that the services are in full compliance with all applicable standards relating to inpatient care found at §418.110 and §418.108.

2084.1 - Hospice Provides Inpatient Care Directly

(Rev.)

When the hospice provides inpatient care directly, it may do so either in space that it owns or leases or in space shared with a Medicare certified hospital, SNF, or Medicaid certified nursing facility (NF).

- If the hospice provides care in its own inpatient facility, the care may be provided in space that the hospice either owns or leases from another facility or building. The inpatient unit may consist of several beds, a group of beds, or a wing and must meet all applicable Federal and State requirements and be surveyed for compliance with §418.110 prior to providing inpatient care to patients. This survey includes a Life Safety Code survey (which has currently adopted the 2000 edition of the Life Safety Code of the National Fire Protection Association) that must be done both at the time of initial certification of the inpatient facility and at the time of recertification surveys.*
- If the hospice provides care directly with hospice staff in space shared with a Medicare-certified Hospital, SNF, or a Medicaid certified NF (for respite care only), the SA reviews the agreement and patient files for compliance with §418.110(b) and §418.110(e) since the location already meets the remaining requirements of §418.110 as a Medicare/Medicaid participating facility.*

2084.2 - Hospice Provides Inpatient Services Under Arrangements

(Rev.)

When the hospice provides inpatient services under arrangements with a Medicare participating hospital or SNF, a Medicaid participating NF (for respite care only), or an inpatient unit of another Medicare-certified hospice, a separate survey of each site is not required. In these cases, the SA reviews the agreement and patient files to assure that the standards in §418.110(b) regarding 24-hour nursing service and §418.110(e) regarding comfort and privacy of patient

and family members are satisfied. However, if in reviewing contracts and other documentation (e.g., clinical records, plans of care), questions arise concerning the contract arrangements, the SA conducts an onsite visit to the institution providing the inpatient services to review the care provided under arrangements, not to inspect the facility. This includes hospitals that are accredited by The Joint Commission or the American Osteopathic Association that are providing inpatient services under arrangements.

Applicability of Inpatient Care CoP §418.110

<i>Location Where Inpatient Care is Provided</i>	<i>Applicability Of Condition</i>
<i>Hospice freestanding inpatient facility</i>	<i>Survey for compliance with § 418.110.</i>
<i>Medicare certified hospital or SNF and/or Medicaid certified NF (for respite care only)</i>	<i>Survey for compliance with §418.110(b) and 418.110(e). The institution already meets the remaining requirements of §418.110 as a Medicare/Medicaid certified hospital or SNF/NF.</i>

A hospice freestanding inpatient facility is defined in this context as a facility that is not a part of another Medicare/Medicaid certified facility (e.g., hospital or SNF/NF).

2085 - Operation of Hospice Across State Lines

(Rev.)

When a hospice provides services across **State** lines each respective **SA** must be aware of and approve the action. Each SA must verify that applicable state licensure, personnel licensure, and other State requirements are met in its respective State.

The provision of services across **State** lines is appropriate in most circumstances. Areas in which community services, such as hospitals, public transportation, and personnel services are shared on both sides of **State** boundaries are most likely to generate an extension of hospice services.

When a hospice provides services across **State** lines, it must be certified by the **State** in which its CMS **certification** number (**CCN**) is based, and its personnel must be qualified in all States in which they provide services. *The appropriate SA completes the certification activities.* The involved **States must** have a written reciprocal agreement permitting the hospice to provide services in this manner. The reciprocal agreement must indicate that both States are aware of their respective responsibilities for assessing the hospice’s compliance with the CoP within their **State**. The agreement should assure that home visits are conducted to a sample of all patients, *in all States served by the hospice.*

The CMS **Regional Office (RO)** will review the required reciprocal agreement between the States to assure that the SA where the practice location resides is assuming responsibility for any necessary surveys of the location. If the SAs are unable to come to a reciprocal agreement on assuring the necessary surveys of the location, the location should not be approved as a part of the hospice. The provision of interstate service without a written reciprocal agreement could severely undermine the State’s ability to fulfill its statutory responsibilities under §1864 of the

Act to enforce Medicare's health and safety requirements. It is at the discretion of the States to decide whether entering into reciprocal agreements is in the best interest of their residents, provider markets, and quality assurance and oversight systems.

Exhibit 289 contains a model reciprocal agreement document for States to use to assist them in fulfilling their statutory responsibility to enforce Medicare's health and safety requirements when a hospice provides services across State lines.

In *States* that have a reciprocal agreement in place, providers are not required to be separately approved in each State; consequently, they would not have to obtain a separate Medicare provider agreement/*certification* number in each State. Providers residing in a State that does not have a reciprocal agreement with a contiguous State are precluded from providing services across State lines.

In the event that the hospice operates in two CMS ROs, the RO responsible for the State in which the hospice provider agreement/*certification number* is based should take the lead in assuring that the required survey and certification activities are met.

2086 – Hospice Change of Address

(Rev.)

It is inherent in the provider certification process that a provider notify CMS of its intent to change the location or site from which it provides services. Absent such notification, CMS has no way of carrying out its statutorily mandated obligation of determining whether the provider is complying with applicable participation requirements at the new site or location. It is longstanding CMS policy that there is no basis for a provider to bill Medicare for services provided from a site or location that has not been determined to meet applicable requirements of participation. This guidance is contained in §3224.

When an existing hospice intends to move from its surveyed, certified location to a new site or location, it notifies CMS either directly or through the SA, and, if deemed, it notifies its approved national accreditation organization (AO), in writing of the proposed change of location. The provider also notifies its MAC and submits all required documentation including an amended CMS Form-855A before CMS approval can be granted. The provider obtains CMS's approval of the new address before it provides Medicare services from the new address.

Upon receipt of a provider's notice and request for approval of the move to the new site or location, the RO will carefully evaluate the information, together with any supporting documentation from the provider and any other relevant information known to the RO in making its decision. If a decision can be made on the written application and supporting documentation, CMS will grant or deny an approval without requiring a survey. If, however, the RO concludes that circumstances warrant a survey to establish whether the new address complies with all applicable requirements, CMS will advise the provider and will make no further findings until a survey has been completed and submitted to CMS for its review. In either event, CMS will notify the provider of its decision in writing, as appropriate.

CMS generally will not approve a change of location of a primary hospice with one or more previously approved multiple locations if the new location increases the distance between the primary hospice location and its previously approved multiple location(s) to a point that prevents the hospice from exerting the supervision and control necessary at each multiple location to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings. In that event, the application for approval of the new location would usually be denied without a survey, and the provider would apply for a new certification number for the new location. Request for approval of a proposed change of location of an approved multiple location is handled as a request for approval of a new multiple location, in accordance with the regulations and guidelines at §418.100(f).

NOTE: CMS will not approve a change of location for a hospice's own inpatient facility without a survey to assure that the facility meets all requirements specified at §418.110.

2086.1 - Effective Date

(Rev.)

A hospice may not bill for services provided from the new site or location and should not bill Medicare until the new site or location has been approved by CMS. The effective date of coverage for services provided from the new location is the date CMS grants approval to the hospice's request to change locations. The fact that a national AO has approved a new site or location will not affect CMS' decision. CMS' determination will be based on its independent application of its regulations to the facts in the case. Services provided before the effective date of approval should not be billed to Medicare.

2086.2 – Administrative Review

(Rev.)

CMS's decision on a request for approval of a change of address does not qualify as an initial determination subject to administrative review under §498.3. Such a determination does not affect the existing provider agreement, which continues in effect at the surveyed, certified location until voluntarily terminated by the provider pursuant to §489.52 or involuntarily terminated by CMS pursuant to §489.53. In the event approval of the new change of address is denied, the provider has the option of formally applying for initial certification of the new site or location as a separate Medicare provider of hospice services. In that event, an initial certification survey by CMS or the SA (or accreditation based on survey by a national AO with deeming authority) would be required.

2086.3 – Move after Certification Survey

(Rev.)

Requests for initial certification cannot be processed to completion if a prospective provider moves to a new location after it is surveyed and/or deemed to meet the CoPs by a national AO with deeming authority. If a prospective provider moves after its location has been surveyed and/or accredited but prior to a certification determination by CMS, the prospective provider's application for certification becomes incomplete. Absent a survey of the new location to which the prospective provider has moved, CMS is unable to determine whether applicable program

requirements are met at the new location, and therefore is prevented from completing its review of the pending application. In these circumstances, CMS advises the prospective provider that its application is incomplete. Such an incomplete application is held in abeyance pending receipt of a report of survey of the current location from the SA or a national AO with deeming authority meeting the requirements of and approved by CMS. The decision to hold an incomplete application in abeyance does not qualify as an initial determination as defined in §498.3.

2087 – Simultaneous Surveys

(Rev.)

If a hospice is established by an entity which participates in the Medicare program as another type of provider (hospital, SNF, HHA), the SA should attempt to coordinate simultaneous certification surveys of these entities, i.e., for compliance with hospice CoPs and for compliance with the other appropriate CoPs/requirements.

NOTE: Section 1861(dd)(4)(A) of the Act states that if a hospice is approved as being part of another type of provider, with a separate certification number, it shall be considered to meet those CoPs that are common to both the hospice and the other type of provider.

2088 – Multiple Locations

(Rev.)

When an existing hospice intends to add a multiple location, it must notify CMS, the SA, and, if deemed, it should notify its approved national AO, in writing, of the proposed location if it expects this location to participate in Medicare or Medicaid. The hospice must also submit a CMS Form-855A change of information request (including all supporting documentation) to its MAC before CMS approval can be granted. The provider must obtain CMS approval of the new location before it is permitted to bill Medicare for services provided from the new location.

Upon receipt of a hospice's notice and request for approval of a multiple location, the CMS RO will carefully evaluate the information, together with any supporting documentation from the hospice and any other relevant information known to the RO in making its decision. If a decision can be made based on the written application and supporting documentation, CMS will grant or deny an approval without requiring a survey. If, however, the RO concludes that circumstances warrant a survey to establish whether the new location complies with all applicable requirements, CMS will advise the provider and will make no further findings until a Medicare certification survey has been completed and submitted to CMS for its review. In either event, CMS will notify the provider of its decision in writing, as appropriate.

In evaluating a hospice's request for approval of a multiple location, the SA and RO should consider the following in determining whether the new location meets all applicable Medicare requirements:

- *Ability of the governing body to manage the location;*
- *Any changes made to the lines of authority, and professional and administrative control;*

- *Ability of the Medical Director to assume responsibility for the medical component of the hospice's patient care at all locations;*
- *Ability of the hospice to monitor and exercise control over services provided by personnel under arrangements or contracts at the multiple location;*
- *Changes in the IDG(s) providing hospice services;*
- *Changes in staffing or the client population, or both;*
- *Changes in the way clinical records are maintained, protected and safeguarded against loss, destruction or unauthorized use;*
- *Ability of the hospice to provide all hospice services at the multiple location.*

A hospice may not bill Medicare for services provided from a multiple location until the new site or location has been approved by CMS. The fact that a national AO with deeming authority has approved a new site or location will not affect CMS' decision. CMS' determination will be based on its independent application of its regulations to the facts in the case. Services provided before the effective date of approval should not be billed to Medicare.

If the hospice does operate at multiple locations, a deficiency found at any location will result in a compliance issue for the entire hospice.

For further information on hospice multiple locations, see 42 CFR 418.100(f) and 418.116.

2089 – Survey Requirements When the Hospice Provides Care to Residents of a SNF/NF or ICF/MR

(Rev.)

When an SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the SNF or NF must comply with the requirements for participation in Medicare or Medicaid. The Medicare/Medicaid regulations for long term care facilities regarding the completion and submission of the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) data do not change when the resident elects the Medicare Hospice Benefit. This means the SNF or NF must assess the hospice resident using the RAI, and have a care plan and provide the services required under the plan of care. This can be achieved through cooperation between the hospice and facility staff with the consent of the resident. In these situations, the hospice IDG should participate with the facility in completing the RAI.

Similarly, the SNF/NF must complete the RAI for any hospice patient who receives short term inpatient care in a Medicare/Medicaid participating SNF/NF if the hospice patient resides in the facility for more than 14 days.

For further information on the hospice requirements when it provides care in these settings, see 42 CFR Part 418.112.