

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Health Care Financing Administration

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Region VI  
1301 Young Street, Room 833  
Dallas, Texas 75202

March 24, 1998

REGIONAL SURVEY AND CERTIFICATION LETTER NO: 98-04

To: All State Survey Agencies (Action)  
All Title XVIII Single State Agencies (Action)

Subject: Questions and Answers About Surveying Hospices

This letter discusses several inquiries concerning hospices.

**Question # 1: If a hospice agency has both Medicare and non-Medicare (Medicaid and/or private pay patients) do the Conditions of Participation apply to all of the patients including the private pay and Medicaid patients?**

Answer: Yes, according to Section 2083 of the *State Operations Manual, Transmittal Number 265*, with the exception of 42 CFR 418.60 -The Condition of Care Requirement and 42 CFR 418.98(c) -The 80-20 Inpatient Care Limit, the Medicare Conditions of Participation apply to any patient being seen by the hospice facility regardless of the payment source.

**Question 2: Is it just a change of address if a hospice discharges all of its patients and moves to a new city in a different geographic area - not an adjacent city? Is the hospice agency able to move ( to a totally different city in a different geographic arcs) and keep its same provider number?**

Answer: No, if a hospice discharges all of its patients it has voluntarily ceased business. According to 42 CFR 489.52 when a provider voluntarily ceases business, it must be terminated from the Medicare program.

**Question # 3: May a hospice have a sub-location in a geographic location which does not meet the requirements for a provider-based site? For example, may a hospice whose main site (the location for which the provider number was issued) is in Dallas, Texas have a sub-location in Waco, Texas which is more than one hundred and twenty miles away and in a different catchment area?**

Answer: No. The sub-location would not meet several of the criteria outlined in HCFA's Program Memorandum, HCFA Pub. 60A, Rev. A-96-7, 08-96 which discusses the requirements which apply before an entity is designated as part of a provider for payment purposes. For example the proposed sub-location in Waco, Texas:

- (1) is not close proximity and does not serve the same population or catchment area.
- (2) does not function as a department of the provider where it is based: there is no significant common resource usage of buildings, equipment and/or service personnel on a daily basis.

(3) the patient services furnished by the sub-location are not integrated into the corresponding inpatient and/or outpatient services, as appropriate, of the main site.

(4) the medical staff or other professional committees for the main site (location for which the provider number was issued) are not responsible for the medical activities in the sub-location. They do not monitor the clinical and quality assurance activities on a uniform basis and attend the professional committee meetings regularly.

**Question 4. How will the Balanced Budget Act impact the Medicare Conditions of Participation for Hospice?**

Answer: The changes are as follows:

- The BBA amended section 1861 (dd)(2)(B)(I) of the Social Security Act (the Act) to allow a hospice to contract for a physician To be a member of the hospice's interdisciplinary group (IDG) effective August 5, 1997. Also, effective August 5, 1997, the hospice's medical director no longer has to be an employee of the hospice. Although the hospice Conditions of Participations have not been revised to reflect the changes, a hospice should not be cited for a deficiency at 42 CFR 418.68(a) or 42 CFR 418.54 for surveys performed August 5, 1997, or later, solely because the physician member of the IDG or the hospice's medical director is under contract to the hospice rather than an employee of the hospice (interpretive guidelines tag numbers L148 - L149 and L111-L112). In addition, no deficiency should be cited at 42 CFR 418-80 (tag numbers L187-L188) solely because physician services are provided through a contracted employee.
- Section 1861 (dd)(5) of the Act was amended by the BBA to allow HCFA to permit certain waivers of the requirements that the hospice make physical therapy, occupational therapy, speech language pathology services (42 CFR 418.92) and dietary counseling (42 CFR 418.88 (b)) available (as needed) on a 24-hour basis. The Health Care Financing Administration (HCFA) is also now allowed to waive the requirement that hospices provide dietary counseling directly. The Act stipulates that these waivers are only available to an agency or organization that " ... (1) is located in an area which is not in an urbanized area (as defined by the Bureau of the Census), and demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel." HCFA will apply the requirements for the nursing services waiver at 42 CFR 418.83(a)(3) in determining whether a hospice has made diligent efforts. This includes the requirement that a waiver request will be deemed to be granted unless it is denied by HCFA within 60 days after it is received. This change became effective August 5, 1997. Waiver applications should be sent to:

Health Care Financing Administration  
Office of Clinical Standards and Quality  
Clinical Standards Group  
7500 Security Boulevard  
Baltimore, Maryland 21244

If you have any questions concerning this letter, please contact Karen Herbelin, a member of the staff, at (214) 767-4422.

Sincerely,

(Signature)

Calvin Cline, Branch Chief  
Survey and Certification Operations Branch