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FY 2014 Houston HSDA Ryan White State Services Service Definition

Local Service Category:	Hospice Services
Amount Available:	To be determined
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
Local Service Category Definition:	<p>Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.</p> <p>Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.</p>
Target Population (age, gender, geographic, race, ethnicity, etc.):	Individuals with AIDS residing in the Houston HIV Service Delivery (HSDA).
Services to be Provided:	<p>Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.</p> <p>Services NOT allowed under this category:</p> <ol style="list-style-type: none"> HIV medications under hospice care unless paid for by the client. Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.
Service Unit Definition(s):	A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	Individuals with an AIDS diagnosis and certified by a physician as having a life expectancy of 6 months or less.
Agency Requirements:	<p>Provider must be licensed by the Texas Department of State Health Services as a hospital, special hospital, special care facility or Home and Community Support Services Agency with Hospice Designation.</p> <p>Provider must inform Administrative Agency regarding issue of long term care facilities denying admission for HIV positive clients based on inability to provide appropriate level of skilled nursing care.</p>
Staff Requirements:	a) Services must be provided by a medically directed interdisciplinary team,

FY 2014 Houston HSDA Ryan White State Services Service Definition

	<p>qualified in treating individual requiring hospice services.</p> <p>b) Staff will document an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.</p> <p>c) Staff will refer Medicaid/Medicare eligible clients to a Hospice Provider for medical, support, and palliative care.</p>
Special Requirements:	<p>These services must be:</p> <p>a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement;</p> <p>b) Provided by a medically directed interdisciplinary team;</p> <p>c) Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client.</p> <p>d) Residents seeking care for hospice at Agency must first seek care from other facilities and denial must be documented in the resident's chart.</p> <p>Must comply with the <u>Houston EMA/HSDA</u> Standards of Care.</p>

FY 2014 RWPC "How to Best Meet the Need" Decision Process

Step in Process: Council		Date: 06/13/13
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Steering Committee		Date: 06/06/13
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Quality Assurance Committee		Date: 05/16/13
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: HTBMTN Workgroup		Date: 04/29/13
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

DSHS STATE SERVICES
 1314 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE
 HOSPICE SERVICES

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.1	<p><u>Scope of Service</u></p> <p>Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client’s family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.</p> <p>Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.</p> <p>Services NOT allowed under this category:</p> <p>a) HIV medications under hospice care unless paid for by the client.</p> <p>b) Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.</p>	<ul style="list-style-type: none"> • Program’s Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files.

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.2	<p><u>Client Eligibility</u> In addition to general eligibility criteria, , individuals must meet the following criteria in order to be eligible for services:</p> <ul style="list-style-type: none"> • Referred by a licensed physician • Deemed by his or her physician to be terminally ill as defined as having six (6) months or less to live • Must be reassessed by a physician every six (6) months • Must first seek care from other facilities and denial must be documented in the resident's chart. 	<ul style="list-style-type: none"> • Documentation of HIV+ status, residence, identification and income in the client record. • Documentation in client's chart that an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
9.3	<p><u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.</p>	<ul style="list-style-type: none"> • Documentation of referrals received. • Documentation of referrals out • Staff reports indicate compliance
9.4	<p><u>Ongoing Staff Training</u></p> <ul style="list-style-type: none"> • Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff (in addition to training required in General Standards). • One (1) hour of training in HIV/AIDS is required annually for all other staff (in addition to training required in General Standards). 	<ul style="list-style-type: none"> • Materials for staff training and continuing education are on file • Documentation of training in personnel file
9.5	<p><u>Staff Experience</u> A minimum of one year documented hospice and/or HIV/AIDS work experience is preferred.</p>	<ul style="list-style-type: none"> • Documentation of work experience in personnel file
9.6	<p><u>Staff Requirements</u> Hospice services must be provided under the delegation of an attending physician and/or registered nurse.</p>	<ul style="list-style-type: none"> • Review of personnel file indicates compliance • Staff interviews indicate compliance
9.7	<p><u>Volunteer Assistance</u> Volunteers cannot be used to substitute for required personnel. They may however provide companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will:</p> <ul style="list-style-type: none"> • Be provided with clearly defined roles and written job descriptions • Conform to policies and procedures 	<ul style="list-style-type: none"> • Review of agency's Policies & Procedures Manual indicates compliance • Documentation of all training in volunteer files • Signed compliance by volunteer

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.8	<p><u>Volunteer Training</u> Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care.</p> <p>Volunteer training must also address program-specific elements of hospice care and HIV/AIDS. For volunteers who are licensed practitioners, training addresses documentation practices.</p>	<ul style="list-style-type: none"> • Review of training curriculum indicates compliance • Documentation of all training in volunteer files
9.9	<p><u>Staff Supervision</u> Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years experience in hospice care of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.</p>	<ul style="list-style-type: none"> • Review of personnel files indicates compliance. • Review of agency's Policies & Procedures Manual indicates compliance
9.10	<p><u>Facility Licensure</u> Agency has and maintains a valid Texas licensure as either a Hospice or a Special Care Facility license with an AIDS Hospice designation.</p>	<ul style="list-style-type: none"> • Documentation of license and/or certification is available at the site where services are provided to clients
9.11	<p><u>Notification of Denial of Service</u> Agency must develop and maintain s system to inform Administrative Agency regarding issue of long term care facilities denying admission for HIV positive clients based on inability to provide appropriate level of skilled nursing care.</p>	<ul style="list-style-type: none"> • Review of agency's Policies & Procedures Manual indicates compliance • Documentation of notification is available for review.
9.12	<p><u>Multidisciplinary Team Care</u> Agency must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.</p>	<ul style="list-style-type: none"> • Review of agency's Policies & Procedures Manual indicates compliance • Documentation in client's records

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.13	<p><u>Comprehensive Health Assessment</u></p> <p>A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing.</p> <p>Medical history should include the following components:</p> <ul style="list-style-type: none"> • History of HIV infection and other co morbidities • Current symptoms • Systems review • Past history of other medical, surgical or psychiatric problems • Medication history • Family history • Social history • A review of current goals of care <p>Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.</p>	<ul style="list-style-type: none"> • Documentation in client record
9.14	<p><u>Plan of Care</u></p> <p>Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient's priorities.</p> <p>A written Plan of Care is completed for each patient within 48 hours of admission and once every six months thereafter or more frequently as clinically indicated. Hospice care should be based on the USPHS guidelines for supportive and palliative care for people living with HIV/AIDS (http://hab.hrsa.gov/tools/palliative/contents.html) and professional guidelines</p>	<ul style="list-style-type: none"> • Documentation in patient record

#	STANDARD	MEASURE
9.0 Service-Specific Requirements		
9.15	<u>Medication Administration Record</u> Agency documents each patient's scheduled medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff.	<ul style="list-style-type: none"> • Documentation in patient record
9.16	<u>PRN Medication Record</u> Agency documents each patient's PRN medications. Documentation includes patient's name, date, time, medication name, dose, route, reason, result, and signature and title of staff.	<ul style="list-style-type: none"> • Documentation in patient record
9.17	<u>Physician Orders</u> Patient's physician orders are documented.	<ul style="list-style-type: none"> • Documentation in patient record
9.18	<u>Bereavement and Counseling Services</u> The need for bereavement and counseling services for family members must be assessed and a referral made if requested.	<ul style="list-style-type: none"> • Documentation in patient record

DSHS STATE SERVICES
1314 HOUSTON HSDA OUTCOME MEASURES
HOSPICE SERVICES

Purpose: The purpose of the DSHS State Services Outcome Measures is to provide a measurement of the effectiveness of services in terms of health, quality of life, cost-effectiveness, and knowledge, attitudes, and practices (KAP), where applicable.

Outcome Measure	Indicator	Data Collection Method
1.0 Knowledge, Attitudes, and Practices		
1.1. Increased client understanding of the terminal process	85% of clients will report an increased or maintained understanding of the terminal process over time	<ul style="list-style-type: none"> • Self-Administered Client/Caregiver Survey
1.2 Increased family understanding of HIV/AIDS and the terminal process	85% of family members will report an increased or maintained understanding of HIV/AIDS and the terminal process over time	<ul style="list-style-type: none"> • Self-Administered Caregiver/Family Survey
2.0 Health		
2.1 Improved management of pain	85% of clients will increase or maintain pain management over time	<ul style="list-style-type: none"> • Provider Assessment/Client Record Abstraction
2.2 Improved management of symptoms that present with disease progression	85% of clients will increase or maintain symptom control over time	<ul style="list-style-type: none"> • Provider Assessment/Client Record Abstraction
3.0 Quality of Life		
3.1 Decreased levels of depression/anxiety	85% of clients will report decreased or maintained levels of depression/anxiety over time	<ul style="list-style-type: none"> • Self-Administered Client/Caregiver Survey
3.2 Maintenance of preferred levels of participation in life/social interaction	85% of clients will report a maintenance or improvement in their preferred levels of participation in life/social interaction	<ul style="list-style-type: none"> • Self-Administered Client/Caregiver Survey

Outcome Measure	Indicator	Data Collection Method
4.0 Cost-Effectiveness		
4.1 Cost savings due to decreased number of days of HIV/AIDS-related hospitalization	Difference between the total cost of Part A hospice care per client compared with the cost of continued hospitalization (based on HCHD costs).	<ul style="list-style-type: none"> • Client Record Review



HOSPICE SERVICES
2012 CHART REVIEW

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HSDA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts one Subgrantee to provide hospice services in the Houston HSDA.

INTRODUCTION

Description of Service

Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.

Tool Development

The TRG Hospice Review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a provider population of 48 who accessed case management services between 1/1/1512 – 12/31/1512. The records of 15 clients were reviewed, representing 31% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Report Structure

A categorical reporting structure was used. The report is as follows:

- Consents
- Admission Orders
- Standing Orders
- Medication Administration
- Care Plan
- Multidisciplinary Team Meetings
- Homelessness
- Substance Abuse assessment
- Psychiatric Assessment
- Pain Assessment and treatment
- Support Systems

FINDINGS**CONSENTS**Consent for Service

Percentage of clients that have a signed and completed consent for service document in the record

	Yes	No	N/A
Number of HIV- positive clients served who have a documented consent for service in the record.	15	0	0
Number of HIV- positive clients who were served during the measurement year.	15	15	15
Rate	100.0%	-	-

Consents – Exchange/Release of Information

Percentage of clients that have a signed exchange/release of information document in the record

	Yes	No	N/A
Number of HIV- positive clients served who have a documented Consent for exchange/release of information in the record.	15	0	0
Number of HIV- positive clients who were served during the measurement year.	15	15	15
Rate	100.0 %	-	-

Consents Proof of Receipt by Client of Client Confidentiality Policy

Percentage of charts reviewed that have evidence that the client received the agency confidentiality policy

	Yes	No	N/A
Number of HIV- positive clients served who have a documented Proof of Receipt by Client of Confidentiality Policy in the record.	15	0	0
Number of HIV- positive clients who were served during the measurement year.	15	15	15
Rate	100.0%	-	-

ADMISSION ORDERS

Percentage of HIV-positive client records that have admission orders

	Yes	No	N/A
Number of client records that showed evidence of an admission order document.	15	0	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	100%	-	-

SYMPTOM MANAGEMENT ORDERS

Percentage of HIV-positive client records that have symptom management orders

	Yes	No	N/A
Number of client records that showed evidence of symptom management orders.	15	0	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	100%	-	-

MEDICATION ADMINISTRATION

Percentage of HIV-positive client records that have medication administration record

	Yes	No	N/A
Number of client records that showed evidence of medication administration.	15	0	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	100%	-	-

CARE PLAN

Percentage of HIV-positive client records that have a completed initial plan of care

	Yes	No	N/A
Number of client records that showed evidence of completed initial plan of care.	15	0	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	100%	-	-

WEEKLY IDT MEETING

Percentage of HIV-positive client records that showed weekly updates to the Interdisciplinary Team (IDT) care plan

	Yes	No	N/A
Number of client records that showed evidence of weekly updates to the IDT.	15	0	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	100%	-	-

HOMELESSNESS

Percentage of HIV-positive client records that show the client was homeless on admission

	Yes	No	N/A
Number of client records that showed evidence of documentation that the client was homeless on admission.	4	11	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	27%	73%	-

SUBSTANCE ABUSE

Percentage of HIV-positive client records that showed the client had active substance abuse on admission.

	Yes	No	N/A
Number of client records that showed evidence of active substance abuse on admission.	4	16	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	27%	73%	-

PSYCHIATRIC ILLNESS

Percentage of HIV-positive client records that showed the client had active psychiatric illness on admission (excluding depression).

	Yes	No	N/A
Number of client records that showed evidence of active psychiatric illness (excluding depression).	6	9	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	40%	60%	-

PAIN ASSESSMENT

Percentage of HIV-positive client records that showed assessment for pain at each shift

	Yes	No	N/A
Number of client records that showed evidence of a pain assessment at each shift.	15	0	-
Number of HIV-infected clients in hospice services that were reviewed.	15	15	-
Rate	100.0%	80.0%	-

FAMILY SUPPORT

Percentage of HIV-positive client records that showed support services were given to the family.

	Yes	No	N/A
Number of client records that showed evidence of support services being offered to the family.	10	0	11
Number of HIV-infected clients in hospice services that were reviewed.	15	15	15
Rate	67%	-	33%

Conclusion

2012 shows Hospice Care remains at a very high standard. Nine out of the nine data elements were scored at 100%. Twenty-seven percent (4) of records reviewed indicated that the client was homeless. Twenty-seven percent (4) of records reviewed showed evidence that the client had active substance abuse. Forty percent (6) of records reviewed showed evidence of active psychiatric illness.



DAVID L. LAKEY, M.D.
COMMISSIONER

June 25, 2010

BRIEFING

MEMORANDUM FOR THE PREVENTION AND PREPAREDNESS DIVISION ASSISTANT
COMMISSIONER

THROUGH: Jana Zumbrun
Director, Infectious Disease Prevention Section

THROUGH: Felipe Roche
Manager, TB/HIB/STD/Viral Hepatitis Unit

FROM: Ann Robbins,
Manager, HIV/STD Prevention and Care Branch

SUBJECT: Use of Ryan White and State Services funds for care provided within Special Care
Facilities

Purpose

To establish a DSHS policy to address the following issues relating to Special Care Facilities.

1. HRSA does not allow use of Ryan White Part A or B funds to providers who are not billing third payer parties for clients with commercial or public insurance or some other payer. It is unclear if DSHS existing waiver policy (which allows DSHS to waive certification and billing for third party payment is allowable or is in conflict with Ryan White Legislation (Title XXVI – HIV Health Care Services Program).
2. It is not clear whether all of the services offered and currently paid for by Ryan White and State Service funds fall under the category of Hospice, or are reimbursable by Medicaid or other third party payers.
3. It is not clear whether HIV clients deemed as needing hospice care are staying within the facility as a resident thus precluding the facility from using Ryan White funds as a payer source.
4. Currently, facilities with Special Care Facility licenses do not bill Medicaid for Medicaid beneficiaries because this services provided under this licenses are not Medicaid eligible. While they have to option of applying for license, these Special Care Facilities feel applying and holding the appropriate licensure would be an unnecessary burden. Therefore, it is not clear whether Special Care Facilities can apply for license as hospice facilities or clinics (for example dental) and then bill for services to eligible clients.

Background/Summary

The Texas Department of State Health Services (DSHS) contracts with Administrative Agencies (AA) to provide Ryan White Part B and State Services funds. Some AAs subcontract with Special Care Facilities, who are licensed under Title 4, Subtitle B; Chapter 248 of the Texas Health and Safety Code, to “provide medical care for improving life span and quality of life, for comfort, for prevention and treatment of illness, and for maintenance of bodily and mental function.” In addition, this Statute allows a Special Care Facility licensed under this chapter to be designated as a residential AIDS hospice to provide exclusively palliative care, bereavement services, and support services to the family. Title 25, Chapter 125 of the Texas Administrative Code establishes the rules implementing the Texas Special Care Facility Licensing Act and to provide minimum standards for the licensing of these facilities. The rules were reviewed and updated on March 20, 2011.

Currently there are 12 licensed Special Care Facilities within Texas. Each facility offers differing levels of care ranging from supportive housing services with limited supportive care provided by a home health aide/nursing assistant to skilled nursing care provided by physicians and registered nurses (see attached chart). These facilities are not licensed to accept and bill Medicaid.

To reiterate that Health Resources and Services Administration (HRSA) Ryan White federal funding is the payor of last resort, a HRSA policy letter was released in August 2000 stating the Ryan White Comprehensive AIDS Resources Emergency Act (CARE) funded services may not be used to pay for Medicaid covered services for Medicaid beneficiaries. Therefore, grantees and their contractors who provide Medicaid covered services must be Medicaid certified. It is assumed that this policy remains in effect through 2012.

Discussion

Special Care Facility Licensure. All Special Care Facilities are currently operating within the requirements for this type of license. No changes are recommended at this time to either the Statute (Health and Safety Code Title 4; Subtitle B; Chapter 248) or Rules (Texas Administrative Code Title 25; Part 1; Chapter 125).

Medicaid Eligible Clients. DSHS has determined that only a small fraction of clients admitted to Special Care Facilities would be eligible for Medicaid/Medicare Hospice. Most clients/patients are homeless and undocumented residents. The facilities that offer hospice services to potential Medicaid/Medicare clients require that other long term nursing facilities/skilled nursing facilities be contacted prior to admission. Most long term nursing facilities generally will not admit HIV positive clients because they do not have the expertise required for specialized end-of-life care for this medical condition. For providers holding a Special Care Facility license to be able to bill for Medicaid services, Medicaid program rules would need to be revised. Similarly, the impact of the Affordable Care Act and resultant Medicaid expansion impact on these facilities is not known.

Contractors who provide Medicaid covered services must be Medicaid certified. Medicaid will only reimburse for acute episodes. Upon prior authorization, Medicaid limits care to eligible recipients for acute conditions or acute exacerbations of chronic conditions to 60 days if resident is receiving home health services (Texas Administrative Code; Title 1; Part 15; Chapter 354; Subchapter A; Division 3; Rule §354.1039 - Home Health Services Benefits and Limitations). Therefore, even if a Special Care Facility is licensed as a Home Health Care Agency, a HIV client who, for example, had pneumonia and

needed to be admitted to receive supportive services to encourage proper consumption of medication and food, Medicaid would only reimburse for services rendered for the acute medical care.

Other services provided to HIV/AIDS patients through Special Care Facilities, such as personal care services, transportation, and food is not covered by Medicaid (State Plan Attachments (SPA) to the State of Texas Medicaid Plan). The Centers for Medicare and Medicaid Services (CMS) do not reimburse for inpatient respite care (longer than 5 days) and as stated above, general inpatient care is for acute management of a disease. Within the category of case management, Medicaid reimburses for case management services. However, Medicaid does not reimburse for Medical Case Management services as directed in the Ryan White Standards of Care. Medicaid does not reimburse for non-medical case management as directed in the Ryan White Standards.

As such, there is no apparent conflict between services being currently provided by Special Care Facilities and the HRSA policy letter dated August 2000 as none of the services provided under the requirements of the Special Care Facility (25 TAC 125) and funded by Ryan White Part A & B/State Services Funds are Medicaid covered services. Therefore, Medicaid certification will not be of benefit.

Recommendations

1. Continue to support activities currently in place provided by Special Care Facilities with Ryan White Part B/State Services funds. Future use of funds depends on this category continuing to be a priority and receive allocation. Special Care Facilities will need to successfully compete for funding on a periodic basis.
2. Encourage Ryan White Part A administrators to reexamine their policy to contract for these services based on information provided in this briefing.
3. Require that Special Care Facilities document that Medicaid/Medicare clients have actively sought other placement prior to admitting into Special Care Facility Hospice Program and that other sources of funds be used for their medical care.
4. Require that Special Care Facilities refer Medicaid/Medicare eligible residents to hospice providers for palliative care.
5. Inform HHSC leadership regarding issue of long term care facilities denying admission for HIV positive clients based on inability to provide appropriate level of skilled nursing care.
6. Analyze situation after decision regarding Health Care Reform if Medicaid expansion is implemented as to effect on services provided and eligibility requirements of facilities and clients to bill Medicaid.

Assistant Commissioner's Decision

Approve	_____	Disapprove	_____
Modify	_____	Needs More Discussion	_____
Pend for Future Consideration	_____		

Attachments
 Matrix of Special Care Facilities licensed in Texas

 <p>TEXAS Department of State Health Services</p> <p>Ryan White Part B/state services Funded Services within Special Care Facilities</p>	Tracking Number	HIV/STD
	Effective Date (<i>original issue</i>)	September 1, 2012
	Revision Date (<i>most recent</i>)	
	Subject Matter Expert (<i>title</i>)	HIV Care Group Service Consultants
	Approval Authority (<i>title</i>)	HIV/STD
	Signed by (<i>signature for hard copy; name for online</i>)	

1.0 Purpose

The purpose is to define services that are allowable under Ryan White Part B and state services funds when a client is admitted to a Special Care Facility.

2.0 Policy

Ryan White Part B and state services funds may be used to support non-Medicaid/Medicare eligible services for HIV positive clients when admitted to a Special Care Facility for care as outlined in Texas Administrative Code Title 25 §125.

3.0 Definitions

Contractor – The entity the Department of State Health Services has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who actually provides the services.

Department of State Health Services (DSHS) – The agency responsible for administering physical and mental health-related prevention, treatment, and regulatory programs for the State of Texas.

Human Immunodeficiency Virus (HIV) – a virus that damages immune system by interfering with the body's ability to fight the organisms that cause disease. HIV is a disease of the immune system caused by infection with the retrovirus HIV, which destroys some types of white blood cells and is transmitted through blood or bodily secretions such as semen. HIV can cause AIDS; a chronic, potentially life-threatening condition.

HIV Services - Any of the social or medical assistance defined in the HIV Services Taxonomy (<http://www.dshs.state.tx.us/hivstd/taxonomy/default.shtm>) paid for with Ryan White Part B/ State Services funding streams disseminated through DSHS.

Hospice Services – Coordinated program which includes palliative care for terminally ill residents and support services for a resident and a resident's family.

Limited Care – Medical and nursing care, treatment, and other services to residents who require staff attendance and supervision

Medicaid – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Medicare - a federal government insurance program providing health insurance coverage to people who are aged 65 and over; to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria.

Palliative Care - services that focus primarily on the reduction or abatement of physical, psychosocial, and spiritual symptoms of a terminal illness.

Resident – a person who lives in a place.

Residential Board and Care – Medical and nursing care, treatment and other services for residents who do not require routine or continuous staff attendance and supervision.

4.0 Persons Affected

DSHS HIV Care Services Staff
 Administrative Agencies
 Contractors
 Resident with HIV living in a Special Care Facility

5.0 Responsibilities

- 5.1 DSHS HIV Care Services Consultants** – ensure that funds from Ryan White Part B and state services are the payers of last resort for services rendered through contracts with Administrative Agencies
- 5.2 Administrative Agency** – develop policy for monitoring of Special Care Facilities to ensure compliance.
- 5.3 Contractor** – develop policies/procedures to ensure that individuals seeking services meet eligibility criteria as outlined in HIV 220.001 and that services rendered are within facility's occupancy classification.
- 5.4 DSHS HIV/STD Prevention and Care Branch** - review processes for contractor compliance with these requirements.

6.0 Procedures

- 6.1** Special Care Facilities must adhere to all guidelines set forth in Texas Administrative Code Title 25 §125.
- 6.2** Directors of Special Care Facilities must determine eligibility for use of Ryan White Part B and state services funds according to DSHS Policy 220.001 – Eligibility Determination
- 6.3** Ryan White Part B/state services funds may not be used to support care for residents who are eligible for Medicaid/Medicare covered services.
- 6.4** Ryan White Part B and state services funds may only be used for services not covered by Medicaid/Medicare.
1. Special Care Facilities will document in resident's chart that an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission

2. Special Care Facilities will refer Medicaid/Medicare eligible clients to a Hospice Provider for medical, support, and palliative care.
- 6.5** Allowable services include, but are not limited to:
1. Assistance with activities of daily living
 2. Symptom management
 3. Transportation/coordination to medical appointments
 4. Patient navigation
 5. Medical Case Management as outlined in the Ryan White Standards of Care
 6. Medication Supervision/direct administration of medications
 7. Medical management for pain and symptoms
 8. Nutrition services

Additional services are allowable when admitted to a Special Care Facility with a residential AIDS Hospice designation with physician certification of need.

1. Palliative care
2. Counseling services
3. Bereavement services
4. Support services to include social, spiritual, and emotional care provided to a resident and the family

Residents seeking care for hospice within a Special Care Facility must first seek care from other facilities and denial must be documented in the resident's chart.

The following are not allowable services

1. HIV medications under hospice care unless paid for by the client.
2. Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.

- 6.6** Administrative Agency will monitor for compliance on a quarterly basis.

7.0 Revision History

Date	Action	Section

SPECIAL CARE FACILITIES
As of June 2012

Name of Facility	Location	Primary Services Offered	Designated as Hospice	Funding Sources
Bering Omega – licensed for 8 beds	Houston	<p><u>"Skilled" Care Facility with Residential AIDS Hospice Designation</u></p> <ul style="list-style-type: none"> • 24 hour nursing and medical care - - Registered nurses are always on call - House nurse on site 24/7 - Volunteer medical director - Volunteers • HIV medications are not provided under hospice care, unless paid for by the client • Symptom and pain management • Wound care • Weekly care plans 	<p>Yes</p> <ul style="list-style-type: none"> • Medication management – but not HIV medications, on call staff, and nursing aides • Chaplaincy service • Focus is on the end of life residential care with the vast majority of clients passing away at this facility 	<p>RW Part A State Services Private donations</p>
San Antonio AIDS Foundation – licensed for 61 beds	San Antonio	<p><u>"Skilled" Care Facility with Residential AIDS Hospice Designation Staffing</u></p> <ul style="list-style-type: none"> - Registered nurses - LVNs - CNAs - Medical Director 	<p>Yes.</p> <p>Using RW funds SAAF provides 24 hour residential nursing care to hospice patients only, which is not a Medicaid reimbursable service.</p>	<p>1- RW A & B, RW B State Services (24 hour residential nursing care for hospice patients) (RW makes up 11% of entire nursing program budget. Hospice patients on average</p>

Name of Facility	Location	Primary Services Offered	Designated as Hospice	Funding Sources
		<p>Hospice Care</p> <p><u>Other Services:</u></p> <ul style="list-style-type: none"> • Skilled nursing care • Medical and Non-Medical Case Management • Medical Transportation • Emergency Financial Assistance • Transitional Housing Program • Long-term Tenant-based Rental Assistance • HIV/STD Prevention education • HIV testing 		<p>make up 10-20% of SAAF's inpatients.)</p> <p>2- RWA&B Medical Case Mgmt</p> <p>3- RWA&B –pays a portion of medical transportation</p> <p>4- RW A&B – pays for a portion of our hot meal program, but almost all are meals for community based clients. Only 200 out of 52,000 meals were for inpatients. Virtually all the meals of our inpatients are funded by the City of San Antonio and by HOPWA.</p>
Sunshine Haven – licensed for 3 beds	Olmito	<p><u>Limited care</u></p> <ul style="list-style-type: none"> • Palliative care for terminally ill patients (1.5% are HIV/AIDS clients) 	Yes	City Block Private Foundation
Aurora House – licensed for 4 beds	Weslaco	<p><u>Limited care</u></p> <p>24-hour care by caregivers</p> <ul style="list-style-type: none"> • Supportive care for end of life (policy states length of stay must be 90 days or less • Medications, nourishment, linen 	Yes	Grants (not RW) Fund raisers Local community

Name of Facility	Location	Primary Services Offered	Designated as Hospice	Funding Sources
Project Transition (Doug's House) – licensed for 5 beds	Austin	<p>changes</p> <p>Limited care</p> <ul style="list-style-type: none"> • Medical, pain, and symptom management • Assistance with client medication • Client care to include nursing, medical, social work, and volunteer coordination • Each client has a primary care physician that manages care 	<p>Yes</p> <ul style="list-style-type: none"> • When hospice care is needed, a care plan is established in conjunction with hospice • Patients private physician remains involved with care when the hospice organization is brought in • For patients that improve upon being admitted to hospice (e.g., because of access to care), terminated from hospice • If discharged from hospice, staff work to identify access to follow-up treatment 	
Blessed Trinity Home – licensed for 8 beds	Corpus Christi	<p>Limited Care</p> <p>24-hour care</p> <p>Residential room and board for terminally ill patients – <u>No HIV/AIDS</u> clients are admitted.</p>		Self-pay
Comfort House – licensed for 10 beds	McAllen	<p>Limited Care</p> <p>24-hour care</p> <ul style="list-style-type: none"> • All of the medical management is performed by the hospice team. • direct care services that include suctioning, 	Yes	Individual and business contributions, Grants (not RW) Funds from fundraisers.

Name of Facility	Location	Primary Services Offered	Designated as Hospice	Funding Sources
<p>AIDS Services of Dallas Ewing Center – licensed for 27 bed Hillcrest House – licensed for 64 beds Revlon Apartments – licensed for 66 beds Spencer Gardens – licensed for 68 beds</p>	<p>Dallas</p>	<p>oxygen administration, and catheter/Foley care, positional changes, feeding, and administering palliative care medications.</p> <p><u>Residential Board and Care</u> Apartment Units - Home Health Aids</p> <ul style="list-style-type: none"> • Symptom management • HOPWA (City of Dallas) requires special care facility licensure • Residents are managed by their primary care physician • Medical case management • Medication supervision • Patient navigation • Transportation coordination to medical appointments. 	<p>No</p>	<p>HOPWA (City of Dallas) RW Part A and B</p>
<p>Samaritan House - licensed for 60 beds</p>	<p>Fort Worth</p>	<p><u>Residential Board and Care</u></p> <ul style="list-style-type: none"> • 60 apartment units - Full-time RN and - Six (6) Para-professional care attendants • Medical case management • Medication supervision • Patient navigation 	<p>Yes Residents contract with outside hospice providers for skilled nursing service in their "home", as needed.</p>	<p>Ryan White State Services HOPWA Private donations</p>

Name of Facility	Location	Primary Services Offered	Designated as Hospice	Funding Sources
Legacy Founders Cottage – licensed for 7 beds	Dallas	<ul style="list-style-type: none"> • Transportation coordination to medical appointments. <u>Residential Board and Care</u> Residential facility - Nursing Assistants <ul style="list-style-type: none"> • Assistance with activities of daily living • Most clients self administer medications, but staff can assist with medications under a direct delegation order from a physician • Housing 	No HIV medications are not provided under hospice care, unless paid for by the client or used prophylactic in rare cases. Obtain hospice services from outside hospice service provider	HOPWA RW Part A and B State Services funding for housing and housing based case management

2011 Home Health and Hospice Care Nurse Staffing Survey



Highlights and Recommendations

Background Information

Home Health Agencies

The American Nurses Association, in its 2008 Scope and Standards of Home Health Nursing Practice, defines home health nursing as “the provision of nursing care to acutely ill, chronically ill, terminally ill, and well patients of all ages in their residences. Home health nursing focuses on health promotion and care of the sick while integrating environmental, psychosocial, economic, cultural, and personal health factors affecting an individual’s and family’s health status.”¹

In 2009, the sources and percentage of expenditures for services provided by licensed and certified home health agencies were Medicare (41%), Medicaid (24%), state/local governments (15%), private insurance (8%), out-of-pocket (10%), and other (2%).² According to Deckman (2010), “changing reimbursement patterns have had such a profound effect on the outline of home health services provided that reimbursement is said to set the direction for home health.”³ Thus, it remains to be seen what future impact the political and economic environment; reimbursement changes in Medicare, Medicaid and other third party payers; increase in management of chronic illnesses; and a growing population with a larger cohort of people 65 and older who want home-based care, will have on expansion of home health services.

Home health care is the second largest employer of nurses in Texas with approximately 12,855, or 7.0% of RNs and 13,274, or 18.2% of LVNs working in the home health care employment setting in 2011.⁴ According to the Bureau of Labor Statistics (BLS), employment of nurses in home health care is expected to increase by 33% from 2008 to 2018 in response to the aging population, increasing prevalence of chronic disease, longer life span, patient preference for in-home care, and technological advances that make it possible to bring increasingly complex treatments into the home. Employment of home health aides is also projected to grow by 50% between 2008 and 2018, which is much faster than the average for any other occupation.⁵

Hospice Agencies

Hospice is a type of care and philosophy of care that focuses on relieving and preventing the suffering of an incurably or terminally ill patient’s symptoms. These symptoms can be physical, emotional, spiritual or social in nature. In 2008, 1.45 million individuals and their families received hospice care. Hospice is the only Medicare benefit that includes pharmaceuticals, medical equipment, twenty-four hour/seven day a week access to care, and support for loved ones following a death. Most hospice care is delivered at home but is also available to people in home-like hospice residences, nursing homes, assisted living facilities, veterans’ facilities, hospitals, and prisons.⁶

In 2009, an estimated 1.56 million patients received services from hospice as reported by the National Hospice and Palliative Care Organization. The percentage of hospice patients covered by the Medicare hospice benefit was 83.4% in 2009.⁶

Highlights of Results of the 2011 Home Health and Hospice Care Nurse Staffing Survey

Home Health and Hospice Characteristics

- 572 out of 2,597 licensed and certified home health and hospice agencies in Texas responded to the nurse staffing survey for a 22% response rate. All 8 regions in Texas had at least a 20% response rate. Analysis showed that respondents were representative of all agencies in terms of geographic location and patient census.
- More than three-quarters (76%) of the responding agencies are located in Metropolitan Non-Border counties. Only 13% and 10% of the responding agencies are located in the Non-Metropolitan Border and Metropolitan Border counties, respectively.
- 92% of home health only agencies are proprietary as compared to 56% of the hospice only and 60% of the mixed agencies.
- Patient census among responding agencies ranged from 1 to 3,581. More than half of the responding agencies reported a patient census of 150 or less. This is consistent with the patient census among all agencies (as reported by the Department of Aging and Disabilities Services) where more than half of all home health and hospice agencies reported a patient census of 150 or less.

Staffing

- RNs make up 38.6% of the direct patient care staff employed in licensed and certified home health and hospice agencies in Texas. LVNs and home health and hospice aides make up 35.3% and 25.6% of the direct patient care staff, respectively.
- The statewide median turnover rate among nursing staff was: 21.4% among RNs, 21.2% among LVNs, and 8.7% among home health or nursing aides (HHAs/NA/CNAs).
- 146 vacant FTE RN positions were on hold or frozen as reported by 95 (16.8%) of the agencies.
- 123 vacant FTE LVN positions were on hold or frozen as reported by 61 (12.8%) of the agencies.
- 99.5 vacant FTE home HHA/NA/CNA positions were on hold or frozen as reported by 50 (11%) of the agencies.
- The statewide vacancy rate for RNs was 15.9%, LVNs was 16.8% and HHAs/NA/CNAs was 13.9%.
- It is important to note that many home health and hospice agencies hire non-regularly scheduled staff on an “as needed” basis when patient census increases or use contract/temporary nurses which are not counted as permanent staff. Thus, the vacancy rate calculated by the number of occupied and vacant FTEs at a given point in time may not be as good a measure of need. Thus, the use of non-regularly scheduled nursing staff, the extent that agencies had to turn away any patients, and additional positions needed were also reported.
- Home health and hospice agencies reported that 27% of their RNs, 32% of their LVNs, and 22% of HHAs/NA/CNAs were non-regularly scheduled nursing staff.
- More than 75% of the agencies indicated that they did not decline any patients due to lack of staff to provide the necessary care during the one-year reporting period. 139 of 572 agencies (24.3%) reported that they had to turn away a total of 3,940 patients.
- 422 (75%) of the agencies would hire an additional 1,191 RN FTEs, and 368 (65%) of the agencies would hire 1,155 more LVN FTEs if they could hire as many direct patient care nursing staff as needed.

Highlights and Recommendations

Highlights of Results of the 2011 Home Health and Hospice Care Nurse Staffing Survey

Recruitment and Retention of Nurses

- Responding home health and hospice agencies reported that experienced RNs were the most difficult to recruit than newly licensed RNs, LVNs, and HHAs/NAs/CNAs. It takes an average of 7.8 weeks to recruit and hire an experienced RN as compared to 3.4 weeks for HHAs/NAs/CNAs.
- The five most frequently selected recruitment and retention strategies that responding home health and hospice agencies reported using were flexible scheduling/job sharing, benefits package, reimbursement for workshops or conferences, employee recognition programs, and bonus/paid time off.
- Responding agencies reported that increased workloads was the most frequently cited consequence of having an inadequate supply of nursing personnel. Inability to expand services, low staff morale, increased staff turnover, and declined referrals were the next most frequently cited consequences of inadequate supply of nursing staff.

Open-Ended Comments

In the 2011 HHCNSS, agencies had the opportunity to make comments about any of the sections of the survey. Appendix B contains comments made by responding agencies on staffing and recruitment /retention issues.

Conclusion

The majority of the home health and hospice agencies are located in the Metropolitan Non-Border regions of Texas. With the implementation of the Affordable Care Act and the anticipated increased need for home-based care, strategies will need to be developed to provide home health and hospice nursing care to Texas citizens in the Non-metropolitan and Border regions of the state. As demand for home-based care increases, it is logical to expect patient census to increase and the demand for more nurses, especially RNs and LVNs, to increase.

The statewide median turnover rates for RNs and LVNs are very high. It is considered critical when nurse staffing turnover rates exceed 8% and can adversely affect workload, overtime, and stress levels of the remaining staff. It can also negatively impact agency performance in areas such as costs, job satisfaction of staff, and quality and continuity of nursing care. In this study, these factors were identified as consequences of having inadequate supply of nursing personnel. Inability to expand services, declined referrals, and continuing increase in staff turnover were also major consequences when there is an inadequate supply of nurses. With the cost of turnover higher than the annual salary of the departing nurse, the increase in turnover becomes an economic issue. Jones and Gates (September 2007) identified the following as the cost of nurse turn-over: 1) advertising and recruitment; 2) vacancy costs (e.g., paying for interim, non-regularly scheduled nurses, overtime, declining referrals, etc.); 3) hiring; 4) orientation and training; 5) decreased productivity; 6) termination; 7) potential patient errors, compromised quality of care; 8) poor work environment and culture, dissatisfaction, distrust; 9) loss of organizational knowledge; and 10) additional turnover.⁷

Seventy-five (75%) percent of the responding home health and hospice agencies reported that they would hire an additional 1,191 RN FTEs and 66% of the agencies would hire 1,155 more LVN FTEs if they could hire as many direct patient care nursing staff as needed. Issues, such as funding; reimbursement by third party payers including Medicare and Medicaid; and having a larger RN and LVN workforce that is educationally and experientially prepared to provide home-based nursing care to a population of patients that are more acutely and chronically ill and require more complex nursing care, need to be addressed in order that home health and hospice agencies can meet future demands.

Highlights and Recommendations

Recommendations

1. To promote better understanding of home health and hospice nursing services, local and regional home health and hospice agencies should collaborate with each other as well as with nursing programs to provide educational and clinical experiences for nursing faculty and students (such as in the RN to BSN and graduate nursing programs).
2. In partnership with home health and hospice agencies, develop a transition to practice program for experienced RNs and LVNs who have worked in other settings in order to prepare them to function as a home health and hospice nurse in a home-based setting.
3. Administrators and nurses from home health and hospice agencies should serve as resources to nurse educators in providing guidance in the development of curriculum and teaching-learning strategies for classroom, web based and simulated learning and clinical practice experiences for nursing students based upon the knowledge, competencies and skills needed for home health and hospice nurses.
4. Home care administrators and managers should identify and evaluate specific factors influencing their workforce recruitment and retention and implement strategies that would improve recruitment and retention of their nursing staff (See Recruitment and Retention report).
5. To promote job satisfaction and enhance the efficiency and effectiveness of patient care and operation of the agency, home health and hospice agencies should continue to implement strategies to decrease the documentation time required, develop new documentation models that reduce the real or perceived paperwork burden, and increase the use of technology to decrease paperwork.

References

1. Dieckmann, J.L. (2010). Home health care: An historical perspective and overview. In Harris, M.D., *Handbook of home health care administration* (p. 4). Sudbury, MA: Jones and Bartlett Publishers.
2. Centers for Medicare & Medicaid Services, Office of the Actuary. (March 2010). *National Health Care Expenditures*. Available online at <http://www.cms.gov>
3. Dieckmann, J.L. (2010). Home health care: An historical perspective and overview. In Harris, M.D., *Handbook of home health care administration* (p. 17). Sudbury, MA: Jones and Bartlett Publishers.
4. Health Professions Resource Center. 2011 Texas Board of Nursing's RN/LVN Licensure Database.
5. Bureau of Labor Statistics, U.S. Department of Labor, Career Guide to Industries, 2010-11 Edition, Healthcare Available online at <http://www.bls.gov/oco/cg/cgs035.htm> (visited March 20, 2012).
6. National Hospice and Palliative Care Organization. (2010). *NHPCO facts and figures: Hospice care in America*. Alexandria, VA: National Hospice and Palliative Care Organization.
7. Jones, C.B. and Gates, M. (September 2007). The costs and benefits of nurse turnover: A business case for nurse retention. *The Online Journal of Issues in Nursing*, 12(3), manuscript 4, 1-12.
8. Smith-Stoner, M. and Markley, J. (March 2007). Home healthcare nurse recruitment and retention: Tips for retaining nurses—one state's experience. *Home Healthcare Nurse*, 25(3), 198-205.



Hospices, Wary Of Costs, May Be Discouraging Patients With High Expenses

TOPICS: [HEALTH COSTS](#), [MARKETPLACE](#), [MEDICARE](#), [INSURANCE](#), [DELIVERY OF CARE](#), [INSURING YOUR HEALTH](#)

By **MICHELLE ANDREWS**

JAN 21, 2013

Many people who are terminally ill delay entering hospice care until just a few days or weeks before they die, in part because they or their families don't want to admit that there's no hope for a cure.

"It's a hard decision to say yes to," says Jeanne Dennis, senior vice president at the [Visiting Nurse Service](#) of New York, which provides hospice care to 900 patients daily, among other services. "Everybody knows it means you're not going to get better."

A [recent study](#) published in the journal Health Affairs found that there may be another reason that patients don't take advantage of the comprehensive services that hospice provides: restrictive enrollment policies that may discourage patients from signing up.

The survey of nearly 600 hospices nationwide found that 78 percent had enrollment policies that might restrict patient access to care, especially for those with high-cost medical needs. The policies included prohibitions on enrolling patients who are receiving palliative radiation or blood transfusions or who are being fed intravenously.

Medicare pays the majority of hospice bills, and officials have [raised concerns](#) in recent years about possible misuse of federal funds. Eighty-three percent of hospice patients are 65 or older, according to the [National Hospice and Palliative Care Organization](#).

To [qualify for hospice care](#) under Medicare, a patient's doctor and a hospice medical director must certify that the patient has six months or less to live. Patients must also agree not to seek curative care.

Once a patient chooses to enter hospice, the benefits include medical treatment for non-curative purposes such as pain and symptom management as well as emotional and spiritual support for patients and their families. Most patients receive hospice care at home.

The Health Affairs study points out that some treatments typically considered curative also may be used to manage the symptoms of a dying patient. For example, someone might receive radiation treatments to shrink a tumor to make breathing easier or be given a blood transfusion to reduce fatigue.

But such care can be expensive, costing upward of \$10,000 a month, according to the Health Affairs study. That puts hospices in a financial bind. Last year, the [Medicare program paid](#) a base rate of \$151 per day to cover all routine hospice services, adjusted for geographic differences.

"It's a fixed, per-day cost that doesn't relate to the complexity of care provided," says the lead author of the study, Melissa Aldridge Carlson, an assistant professor of geriatrics and palliative medicine at New York's Mount Sinai School of Medicine.

Large hospices that care for more than 100 patients are better positioned to absorb the cost of such treatments, experts say.

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"They've got the economy of scale to be able to manage high-need patients," says Diane Meier, director of the [Center to Advance Palliative Care](#) in New York and a professor of geriatrics and palliative medicine at Mount Sinai. "Smaller hospices don't have that luxury."

Nearly two-thirds of hospices care for 100 or fewer patients per day, according to the National Hospice and Palliative Care Organization.

[Hospice of the Bluegrass](#) in Lexington, Ky., cares for more than 900 patients daily.

"It gives us the capacity to not be completely money-driven, so we can afford expensive treatments," says Gretchen Brown, the chief executive.

Still, hospice operators walk a fine line sometimes in distinguishing between palliative and curative care. Medicare reviews their work closely, Brown says, and sometimes [raises questions](#) when patients are in hospice care longer than six months.

"We really can't pay for something that's going to cause someone to live longer than six months," she says.

Worries that Medicare might deny coverage for a certain treatment is truly palliative rather than curative may contribute to smaller hospices' more restrictive enrollment policies, as the study found, Carlson says.

"The risk is that . . . they'd have to return the money," says study author Carlson. "So for a small hospice, it's very risky to enroll a patient who has these needs."

Some experts question whether smaller hospices actually do turn away patients with expensive needs, even if their enrollment policies suggest they would deny enrollment to those patients.

"Yes, the hospice may have [such] policies, but the study wasn't clear to what extent those policies impact admissions," says Jon Keyserling, senior vice president for health policy at the National Hospice and Palliative Care Organization.

As a patient or concerned family member, the important message is that all hospices are not alike, Meier says. If you encounter a hospice that won't provide the care you need, "it's worth your time to explore others, particularly those that have more than 200 patients a day," she says.

Please send comments or ideas for future topics for the [Insuring Your Health](#) column to questions@kaiserhealthnews.org.



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CENTERS FOR MEDICARE & MEDICAID SERVICES



Medicare Hospice Benefits

This [official government](#) booklet includes information about Medicare hospice benefits:

- ★ Who is eligible for hospice care
- ★ What services are included
- ★ How to find a hospice program
- ★ Where to get more information



Welcome

Choosing hospice care is a difficult decision. The information in this booklet and the support given by a doctor and trained hospice care team can help you choose the most appropriate health care options for someone who is terminally ill.

Whenever possible, include the person who may need hospice care in all health care decisions.



“Medicare Hospice Benefits” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

The information in this booklet was correct when it was printed. Changes may occur after printing. Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

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Hospice care

Hospice is a program of care and support for people who are terminally ill. Here are some important facts about hospice:

- Hospice helps people who are terminally ill live comfortably.
- The focus is on comfort, not on curing an illness.
- A specially trained team of professionals and caregivers provide care for the “whole person,” including his or her physical, emotional, social, and spiritual needs.
- Services may include physical care, counseling, drugs, equipment, and supplies for the terminal illness and related condition(s).
- Care is generally provided in the home.
- Hospice isn’t only for people with cancer.
- Family caregivers can get support.

Medicare hospice benefits

You can get Medicare hospice benefits when you meet **all** of the following conditions:

- You’re eligible for Medicare Part A (Hospital Insurance).
- Your doctor and the hospice medical director certify that you’re terminally ill and have 6 months or less to live if your illness runs its normal course.
- You sign a statement choosing hospice care instead of other Medicare-covered benefits to treat your terminal illness. (Medicare will still pay for covered benefits for any health problems that aren’t related to your terminal illness.)
- You get care from a Medicare-approved hospice program.

How hospice works

Your doctor and the hospice team will work with you and your family to set up a plan of care that meets your needs. Your plan of care includes hospice services that Medicare covers. For more specific information on a hospice plan of care, call your state or national hospice organization (see pages 12 and 14–15).

If you qualify for hospice care, you will have a specially trained team and support staff available to help you and your family cope with your illness.

You and your family members are the most important part of the team. Your team may also include some or all of the following people:

- Doctors
- Nurses
- Counselors
- Social workers
- Physical and occupational therapists
- Speech-language pathologists
- Hospice aides
- Homemakers
- Volunteers

In addition, a hospice nurse and doctor are on-call 24 hours a day, 7 days a week to give you and your family support and care when you need it.

A hospice doctor is part of your medical team. Your regular doctor or a nurse practitioner can also be part of this team as the attending medical professional to supervise your care. However, only your regular doctor (**not a nurse practitioner that you've chosen to serve as your attending medical professional**) and the hospice medical director can certify that you're terminally ill and have 6 months or less to live.

The hospice benefit allows you and your family to stay together in the comfort of your home unless you need care in an inpatient facility. If the hospice team determines that you need inpatient care, the hospice team will make the arrangements for your stay.

What Medicare covers

You can get a one-time only hospice consultation with a hospice medical director or hospice doctor to discuss your care options and pain and symptoms management. You don't need to choose hospice care to take advantage of this consultation service.

Medicare will cover the hospice care you get for your terminal illness, but the care you get must be from a Medicare-approved hospice program.

Important: Medicare will still pay for covered benefits for any health problems that aren't related to your terminal illness, such as care for an injury.

Medicare covers the following hospice services when they're needed to care for your terminal illness and related condition(s):

- Doctor services
- Nursing care
- Medical equipment (such as wheelchairs or walkers)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control or pain relief (may need to pay a small [copayment](#))
- Hospice aide and homemaker services
- Physical and occupational therapy
- Speech-language pathology services
- Social worker services
- Dietary counseling
- Grief and loss counseling for you and your family
- Short-term inpatient care (for pain and symptom management)
- Short-term [respite care](#) (may need to pay a small copayment)
- Any other Medicare-covered services needed to manage your pain and other symptoms related to your terminal illness, as recommended by your hospice team

Respite care

You can get inpatient respite care in a Medicare-approved facility (such as a hospice inpatient facility, hospital, or nursing home) if your usual caregiver (such as a family member) needs a rest. You can stay up to 5 days each time you get respite care. You can get respite care more than once, but it can only be provided on an occasional basis.

What Medicare won't cover

When you choose hospice care, you've decided that you no longer want care to cure your terminal illness and/or your doctor has determined that efforts to cure your illness aren't working. Medicare won't cover any of the following once you choose hospice care:

- **Treatment intended to cure your terminal illness**

Talk with your doctor if you're thinking about getting treatment to cure your illness. As a hospice patient, you always have the right to stop hospice care at any time.

- **Prescription drugs to cure your illness (rather than for symptom control or pain relief)**

- **Care from any hospice provider that wasn't set up by the hospice medical team**

You must get hospice care from the hospice provider you chose. All care that you get for your terminal illness must be given by or arranged by the hospice team. You can't get the same type of hospice care from a different provider, unless you change your hospice provider. However, you can still see your regular doctor if you've chosen him or her to be the attending medical professional who helps supervise your hospice care.

- **Room and board**

Medicare doesn't cover room and board if you get hospice care in your home or if you live in a nursing home or a hospice inpatient facility. However, if the hospice team determines that you need short-term inpatient or [respite care](#) services that they arrange, Medicare will cover your stay in the facility. You may have to pay a small [copayment](#) for the respite stay.

- **Care in an emergency room, inpatient facility care, or ambulance transportation, unless it's either arranged by your hospice team or is unrelated to your terminal illness**

Note: Contact your hospice team **before** you get any of these services or you might have to pay the entire cost.

What you pay for hospice care

Medicare pays the hospice provider for your hospice care. There is no [deductible](#). You will have to pay the following:

- **No more than \$5 for each prescription drug and other similar products for pain relief and symptom control.**
- **5% of the [Medicare-approved amount](#) for inpatient [respite care](#).** For example, if Medicare pays \$100 per day for inpatient respite care, you will pay \$5 per day. The amount you pay for respite care can change each year.

Hospice care if you're in a Medicare Advantage Plan or other Medicare health plan

All Medicare-covered services you get while in hospice care are covered under [Original Medicare](#), even if you're in a Medicare Advantage Plan (like an HMO or PPO) or other [Medicare health plan](#). That includes any Medicare-covered services for conditions unrelated to your terminal illness or provided by your attending doctor.

A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. However, if your plan covers extra services not covered by Original Medicare (like dental and vision benefits), your plan will continue to cover these extra services.



Care for a condition other than your terminal illness

You should continue to use **Original Medicare** to get care for any health care needs that aren't related to your terminal illness. You may be able to get this care from the hospice team doctor or your own doctor. The hospice team determines whether any other medical care you need is or isn't related to your terminal illness so it won't affect your care under the hospice benefit.

You must pay the **deductible** and **coinsurance** amounts for all Medicare-covered services. You must also continue to pay Medicare premiums, if necessary.

For more information about Original Medicare, Medicare Advantage Plans, and other **Medicare health plans**, look in your copy of the "Medicare & You" handbook, which is mailed to every Medicare household in the fall. If you don't have the "Medicare & You" handbook, you can view or print it by visiting www.medicare.gov/publications.

Information about Medicare Supplement Insurance (Medigap) policies

If you have Original Medicare, you might have a **Medigap policy**. Your Medigap policy covers your hospice costs for drugs and respite care, and still helps cover health care costs for problems that aren't related to your terminal illness. Call your Medigap insurance company for more information.

To get more information about Medigap policies, visit www.medicare.gov/publications to view or print the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How long you can get hospice care

Hospice care is intended for people with 6 months or less to live if the disease runs its normal course. If you live longer than 6 months, you can still get hospice care, as long as the hospice medical director or other hospice doctor recertifies that you're terminally ill.

Important: Hospice care is given in benefit periods. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period, the hospice medical director or other hospice doctor must recertify that you're terminally ill, so you can continue to get hospice care. A benefit period starts the day you begin to get hospice care and it ends when your 90-day or 60-day period ends.

Stopping hospice care

If your health improves or your illness goes into remission, you no longer need hospice care. Also, you always have the right to stop hospice care at any time for any reason. If you stop your hospice care, you will get the type of Medicare coverage you had before you chose a hospice program (such as treatment to cure the terminal illness). If you're eligible, you can go back to hospice care at any time.

Example: Mrs. Jones has terminal cancer and got hospice care for two 90-day benefit periods. Her cancer went into remission. At the start of her 60-day period, Mrs. Jones and her doctor decided that, due to her remission, she wouldn't need to return to hospice care at that time. Mrs. Jones' doctor told her that if she becomes eligible for hospice services in the future, she may be recertified and can return to hospice care.

Your Medicare rights

As a person with Medicare, you have certain guaranteed rights. If your hospice program or doctor believes that you're no longer eligible for hospice care because your condition has improved and you don't agree, you have the right to ask for a review of your case. Your hospice should give you a notice that explains your right to an expedited (fast) review by an independent reviewer hired by Medicare, called a **Quality Improvement Organization (QIO)**. If you don't get this notice, ask for one.

Note: If you pay out-of-pocket for an item or service your doctor ordered, but the hospice refuses to give you, you can file a claim with Medicare. If your claim is denied, you can file an appeal.

For more information about your Medicare rights, visit www.medicare.gov/publications to view or print the booklet "Medicare Appeals." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have a complaint about the hospice that is providing your care, contact your State Survey Agency. Visit www.medicare.gov/ombudsman/resources.asp and select "Filing a Complaint or Grievance" to find the number of your State Survey Agency. You can also call 1-800-MEDICARE.

Changing your hospice provider

You have the right to change providers only once during each benefit period. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods.

Finding a hospice program

To find a hospice program, talk to your doctor, or call your state hospice organization. See pages 14–15 for the phone number in your area. The hospice program you choose must be Medicare-approved to get Medicare payment. To find out if a certain hospice program is Medicare-approved, ask your doctor, the hospice program, your state hospice organization, or your state health department.

Words in blue are defined on page 13.

For more information



1. Call National Hospice Associations, or visit their websites.

Hospice Foundation of America (HFA)

1710 Rhode Island Ave. NW

Suite 400

Washington, DC 20036

1-800-854-3402

www.hospicefoundation.org

National Hospice & Palliative Care Organization (NHPCO)

1731 King Street

Suite 100

Alexandria, Virginia 22314

1-800-658-8898

www.nhpco.org

Hospice Association of America

228 7th Street, SE

Washington, DC 20003

1-202-546-4759

www.nahc.org/haa

2. Visit www.medicare.gov.
3. Call 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048.

Note: At the time of printing, these phone numbers and websites were correct. This information sometimes changes. To get the most updated phone numbers and websites, visit www.medicare.gov/contacts, or call 1-800-MEDICARE.

Definitions

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Medicare-approved amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan—A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, Programs of All-inclusive Care for the Elderly (PACE) and in some cases, plans available under Demonstration/Pilot Programs.

Medigap policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare—Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Quality Improvement Organization (QIO)—A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to people with Medicare.

Respite care—Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.

State Hospice Organizations

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit www.medicare.gov/contacts/home.asp. Thank you.

State Hospice Organizations (continued)

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit www.medicare.gov/contacts/home.asp. Thank you.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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This booklet is available in Spanish. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

¿Necesita usted una copia en español?
Para obtener su copia GRATIS, llame al
1-800-MEDICARE (1-800-633-4227).