

# Crosswalk

between

## Medicare Hospice CoPs and DPH State Hospice Licensure Regulations

April 2009

### Reference Websites

#### CoPs 2008

Medicare Conditions of Participation for Hospice Care 42 CFR418 (2008)

<http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf>

#### State Operations Manual

CMS State Operations Manual; Interpretive Guidelines, Hospice, Interim Version 1.1 (01/09)

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-19.pdf>

#### Mass DPH State Licensure Regulations

Mass. Department of Public Health, Chapter 141.000: Licensure of Hospice Programs (2003)

[http://www.mass.gov/Eeohh2/docs/dph/regs/hospice\\_reg\\_final\\_03.pdf](http://www.mass.gov/Eeohh2/docs/dph/regs/hospice_reg_final_03.pdf)

#### Mass Health

Mass Division of Medical Assistance, Hospice Provider Manual , 8/1/1998

[http://www.mas.gov/Eeohhs2/docs/mashealth/regs\\_provide/regs\\_hospice.pdf](http://www.mas.gov/Eeohhs2/docs/mashealth/regs_provide/regs_hospice.pdf)

#### NHPCO

National Hospice and Palliative Care Organization

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# Regulatory Crosswalk

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
<b>418.20</b>	<b>Eligibility requirements</b>		141.207		
	In order to be eligible to elect hospice care under Medicare, an individual must be				
	(a) Entitled to Part A of Medicare				
	(b) Certified as being terminally ill in accordance with Sec. 418.22				
<b>418.21</b>	<b>Duration of hospice care coverage—Election periods</b>				
	(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods				
	(1) An initial 90-day period;				
	(2) A subsequent 90-day period; or				
	(3) An unlimited number of subsequent 60-day periods.				
<b>418.22</b>	<b>Certification of terminal illness</b>		141.208 (A) (3)	437.411	
	a) Timing of certification				
	<b>(1) General rule.</b> The hospice must obtain written certification of terminal illness for each of the periods listed in 418.21, even if a single election continues in effect for an unlimited number of periods, as provided in 418.24 C.				
	<b>(2) Basic requirement.</b> Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification before it submits a claim for payment				
	<b>(3) Exception.</b> If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment				
	(b) Content of Certification. Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements:				
	(1) The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course				
	2) Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification as set forth in paragraph (d) (2) of this section. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.				
	(c) Sources of certification				
	(1) For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph (a)(3) of this section) from --				
	(i) The medical director of the hospice or the physician member of the hospice interdisciplinary group; and				
	(ii) The individual's attending physician if the individual has an attending physician				
	(2) For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph C)(1)(i) of this section				
	(d) Maintenance of records. Hospice staff must--		141.207 C(3)		
	1) Make an appropriate entry in the patient's medical record as soon as they receive an oral certification; and				
	2) File written certifications in the medical record.				

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418.24	<b>Election of hospice care</b>		141.205 (A) (B)		
	(a) Filing an election statement. An individual who meets the eligibility requirement of Sec. 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in sec. 418.30) may file the election statement			437.412 450.105	
	(b) Content of election statement. The election statement must include the following:	1) Identification of the particular hospice that will provide care to the individual.			
		2) The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness			
		3) Acknowledgement that certain Medicare services, as set forth in paragraph (d) of this section, are waived by the election			
		4) The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement			
		5) The signature of the individual or representative			
	(c) Duration of election. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual	1) Remains in the care of a hospice, and			
		(2) Does not revoke the election under the provisions of Sec.418.28			
	(d) Waiver of other benefits. For the duration of an election of hospice care, an individual waives all rights to Medicare payments for the following services:	(1) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice			
		(2) Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services -			
		(i) Provided by the designated hospice;			
		(ii) Provided by another hospice under arrangements made by the designated hospice; and Provided by another hospice under arrangements made by the designated hospice; and			
		(iii) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services			

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	(e) Re-election of hospice benefits. If an election has been revoked in accordance with Sec. 418.28, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual				
<b>418.25</b>	<b>Admission to hospice care</b>				
	a) The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).		141.208	437.411 437.112	DPH has specific language regarding admission policies and procedures
	b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:	1) Diagnosis of the terminal condition of the patient			
		2) Other health conditions, whether related or unrelated to the terminal condition			
		3) Current clinically relevant information supporting all diagnoses			
<b>418.26</b>	<b>Discharge from hospice care</b>	L 682	141.207 141.209		Code of Federal Regulations 624 (b) (2)
	a) Reasons for discharge. A hospice may discharge a patient if	1) The patient moves out of the hospice's service area or transfers to another hospice:			
		2) The hospice determines that the patient is no longer terminally ill; or			
		3) the hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a) (3) (i) through (a) (3)(iv) of this section, 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:			
		(i) Advise the patient that a discharge for cause is being considered;			
		(ii) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;			
		(iii) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and			

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	<p>(iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records</p> <p>b) Discharge order. Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice 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 or her review and decision included in the discharge note.</p> <p>c) Effect of discharge. An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice -</p> <p>d) Discharge planning</p>				
	<p>(1) Is no longer covered under Medicare for hospice care;</p> <p>(2) Resumes Medicare coverage of the benefits waived under 418.24(d); and</p> <p>(3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit</p>				
	<p>(1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill</p> <p>(2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill</p>				
418.28	<p><b>Revoking the election of hospice care</b></p> <p>a) An individual or representative may revoke the individual's election of hospice care at any time during an election period</p> <p>b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:</p> <p>c) An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period --</p>	L 683	141.209	437.412 (C) (2)	
	<p>1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period</p> <p>2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made)</p> <p>1) Is no longer covered under Medicare for hospice care;</p> <p>2) Resumes Medicare coverage of the benefits waived under Sec. 41824(e)(2); and</p> <p>3) May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive</p>				

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<b>418.30</b>	<b>Change of the designated hospice</b>	L682	141.207 C(3)	437.412 (C) (3)	
a) An individual of representative my change, once in each election period, the designation of the particular hospice from which hospice will be received			141.209		
b) The change of the designated hospice is not a revocation of the election for the period in which it is made					
c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:	1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care 2) The date the change is to be effective				
<b>418.52</b>	<b>Patient's rights</b>	L500-L519	141.205		Omnibus Budget Reconciliation Act (OBRA) 1990 - PL 101 - 508
	The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.	L 501	141.205 141.207 (C)(10)		
	a) Notice of rights and responsibilities	L 502	141.205; 141.206		<b>Civil Rights Act, Title VI, Section 601, 1964</b> - 45 CFR 80.3 (b) (2) <b>HHS Title VI Guidance of Limited English Proficiency</b> - 68 FR 48311 (8/2003) <b>Medicare Claims Processing Manual</b> , Chapter 30- Financial Liability Protections (Rev) <b>CMS Transmittal R1587CP</b> , Change Request 6135, 09/05/09, Revised Form CMS-R-131 Advance Beneficiary Notice of Non-coverage, Effective date 03/03/08, Implementation date 03/01/09 <b>Social Security Act</b> - Section 1879 Limitation on Liability Provisions <b>NHPCO Advance Beneficiary Notice Form (CMS-R-131) Tip Sheet</b>

Medicare CoP's 2008		State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
		L503			<b>Clarification from CMS IG</b> - If the hospice has a policy not to certify staff for CPR and the patient does not have a DNR order, the patient must be informed of what procedure will be occur should resuscitation be needed <b>Patient Self Determination Act</b> 1995 - 489.102 <b>Mass Health Care Proxy/Care and Comfort Legislation</b> - 201 B, D <b>Mass Health Legislation for Health Care Proxy</b> - 130 CMR 501
		L504			
b) Exercise of rights and respect for property and person	2) The hospice must comply with the requirements of subpart 1 of part 489 of this chapter regarding <b>advance directives</b> . The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law	L505	141.205		
	3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities	L505			
	1) The patient has the right:				
	i) To exercise his or her rights as a patient of the hospice				
	ii) To have his or her property and person treated with respect		141.201 F		
	iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and		141.201 (G)		
	iv) To not be subjected to discrimination or reprisal for exercising his or her rights				
	2) If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf	L506			
	3) If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law	L507			
	4) The hospice must:	L508	141.201 F, G		
i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator;		141.204 (F) 155.000			
ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures;	L509				
iii) take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and	L510				
					<b>Clarification of CMS IG</b> - Violations of patients rights must immediately be

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					patients rights must immediately be investigated and reported to the hospice administrator and if verified, be reported to state and local authorities with five (5) days
	iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within five (5) working days of becoming aware of the violation	L511			
	c) Rights of the patient	L512	141.205		
	The patient has a right to the following :				
	1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;				
	2) Be involved in developing his or her hospice plan of care;	L513	141.203 141.205 (A)(4) 141.206 (C)(6)		
	3) Refuse care or treatment;	L514	141.205 (A)(3)		<b>Clarification of CMS IG</b> - If one discipline, e.g. chaplain or volunteer, is consistently refused, the surveyor may look at how the services are presented to the patient and family.
	4) Choose his or her attending physician;	L515			
	5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164	L516	141.205 (A)(2) 141.209 (F)		
	6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;	L517	141.201(F)		
	7) Receive information about the services covered under the hospice benefit	L518	141.205(A)(1)		
	8) Receive information about the scope of services that the hospice will provide and specific limitations on those services	L519	141.205 (A)(1),(B), (D)		
418.54	<b>Initial &amp; Comprehensive Assessment of the Patient</b>	L520	141.202		
	The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.	L521			

Medicare CoP's 2008		State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
a) Initial Assessment	The RN must complete an initial assessment within 48 hours after the election of hospice care in accordance with 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours	L522	141.202 141.204 D) (4)		CoPs require Initial Assessment to be developed within forty-eight (48) hours of the election of the hospice benefit which a stricter time frame than Mass DPH. Additionally, Mass DPH requires that 1) the initial POC shall be developed ...by at least three (3) members of the IDT, including a RN and the medical director, and 2) the Initial POC shall be reviewed and ratified by the full IDT at their next scheduled meeting. <b>Clarification of CMS IG - 1)</b> The Initial Assessment must be completed within forty-eight (48) hours from the <u>effective date</u> of the Notice of Election; 2) This is not including a "meet and greet" visit and; 3) <u>The Initial Assessment must be completed in the location where the hospice services are to be delivered.</u>
b) Timeframe for completion of the comprehensive assessment	Hospice interdisciplinary group, in consultation with the individual's attending physician (if any) must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with 418.24	L523	141.202 141.203		<b>Clarification of CMS IG - 1)</b> The Comprehensive Assessment must be completed in <u>five (5) calendar days</u> from the effective date of the Notice of Election; 2) the Comprehensive Assessment should be an <u>interdisciplinary process</u> ; 3) The RN is the coordinator but should not be completing the assessment in a vacuum; 4) There should be evidence that the IDT is actively involved in evaluating patient care; 5) The hospice must show that the patient and family have been assessed to update the Plan of Care. If no changes were noted, then that should be documented and; 6) The hospice must include data elements that allow for outcome measurements, e.g. pain, dyspnea, nausea, spiritual needs, and emotional distress.
c) Content of the comprehensive assessment	Comprehensive assessment must identify the physical, psychosocial, emotion, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:	L524			<b>Change from previous draft of CMS State Ops Manual -</b> Addition of "the assessment and screening, the hospice would then gather additional information to be able to meet patient/family needs. They suggest using Clinical Standards of Practice to guide data collection.
	(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints.	L525			
	2) Complications and risk factors that affect care planning.	L526			

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		L527			
	3) Functional status, including the patient's ability to understand and participate in his or her own care.	L528			
	4) Imminence of death.	L529			
	5) Severity of symptoms.	L530			
	6) Drug Profile. A review of all the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:				
	(i) Effectiveness of drug therapy.				
	(ii) Drug side effects.				
	(iii) Actual or potential drug interactions.				
	(iv) Duplicate drug therapy.				
	(v) Drug therapy currently associated with laboratory monitoring.				
	7) Bereavement. An Initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Must be incorporated into the plan of care and considered in the bereavement plan of care.	L531	141.204 (G) (3)	437.423 (D) (1)	
	8) Need for referrals and further evaluation by appropriate health professionals.	L532			
(d) Update of the comprehensive assessment	The RN must complete an initial assessment within 48 hours after the election of hospice care update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less than every 15 days.	L533	141.202		CoP's contain more specific language regarding the Comprehensive Assessment - should be updated no less frequently than every fifteen (15) days.
(e) Patient Outcome Measures	(1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.	L534			
	(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.	L535			
<b>418.56</b>	<b>Interdisciplinary group, care planning, and coordination of services</b>	L536	141.203 B) (5)(6)		<b>Clarification of CMS IG - 1)</b> Documentation must verify IDT participation including

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<p>The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.</p>		L537, L538	141.203		<p>Attending MD; 2) CMS views the Plan of Care as the most important document in hospice, Signatures of all IDT members are not required but there must be documentation of collaboration, i.e. each IDT members signs the forms; 3) Narrow ranges for services are appropriate but should never use zero (0) as a range unless accompanied by a visit range. PRN is permitted but only when there is also a range provided; 4) standing orders must be individualized and signed by the patient's attending MD; 5) Documentation of how (phone, email) the attending MD was communicated with is important, and; 6) One of the top ten (10) deficiencies was failing to have systems in place to facilitate exchange of information and coordination of services between hospice and non-hospice staff.</p>
a) Approach to service delivery	<p>1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:</p> <p>(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice)</p> <p>(ii) A registered nurse</p> <p>(iii) A social worker</p> <p>(iv) A pastoral or other counselor</p> <p>2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.</p>	L539, L540	141.203 A) (3)(6) 141.203 C		
		L541			
			141.204 e) (6)		
		L542			
b) Plan of Care	<p>All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.</p>	L543, L544	141,202 B 141.203 (B) (3) 141.207 (C) (8)	437.422	
c) Content of the plan of care	<p>The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:</p> <p>1) Interventions to manage pain and symptoms</p>	L545	141.202 C (1,2,3,6,7,8,9, 10) 141.203		
		L546			

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	2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs	L547			
	3) Measurable outcomes anticipated from implementing and coordinating the plan of care	L548			
	4) Drugs and treatment necessary to meet the needs of the patient	L549			
	5) Medical supplies and appliances necessary to meet the needs of the patient	L550			
	6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.	L551	141.206 C)(7)		
d) Review of the plan of care	The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care	L552, L553			CoP's contain more specific language regarding the Comprehensive Assessment - should be updated no less frequently than every fifteen (15) days.
e) Coordination of services	The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-	L554	141.204 (H) (3) (b)		
	1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided	L554			
	2) Ensure that the care and services are provided in accordance with the plan of care	L555			
	3) Ensure that the care and services provided are based on all assessments of the patient and family needs	L556			
	4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement	L557			
	5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions	L558			
<b>418.58</b>	<b>Quality assessment and performance improvement</b>	L559	141.207 C(11)		CoP's contain greater detail for QAPI.
	The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS	L560	141.210		<b>Changes from previous version of CMS State Ops Manual -</b> _1) The requirement for minutes or notes of the meeting about the development/implementation of the QAPI Plan is eliminated; 2) Evidence that the QAPI system is in place and operating effectively is required. Several methods to demonstrate the functioning QAPI program are listed; 3)
a) Program scope	1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.	L561	141.210 (A), (C)		

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	2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.	L562			Although minutes can be used to demonstrate effective implementation, surveyors can not require minutes unless they are essential to analyze adverse events. <b>CMS clarification:</b> 1) The hospice must self assess for PI through methods such as clinical record review, incident reports, complaints, patient and family satisfaction surveys, direct observation, patient/family interviews; 2) Surveyors will look for evidence of effectiveness of PI plan; 3) the hospice must define adverse event in a policy; and 4) the clinical record should show evidence that spiritual counseling has been offered or that visits have been facilitated to local clergy.
b) Program data	1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.	L563	141.210 (C)(2)		
	2) The hospice must use the data collected to do the following:	L564	141.211		
	(i) Monitor the effectiveness and safety of services and quality of care.				
	(ii) Identify opportunities and priorities for improvement.				
	3) The frequency and detail of the data collection must be approved by the hospice's governing body.	L565	141.210 (C)(3)		
c) Program activities	1) The hospice's performance improvement activities must:	L566	141.210 (B)		
	(i) Focus on high risk, high volume, or problem-prone areas.				
	(ii) Consider incidence, prevalence, and severity of problems in those areas.	L567			
	(iii) Affect palliative outcomes, patient safety, and quality of care.	L568			
	2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.	L569			
	3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.	L570			
d) Performance improvement projects	Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects	L571	418.58 (d)		
	1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operation	L572			
	2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.	L573			
e) Executive responsibilities	The hospice's governing body is responsible for ensuring the following:	L574	141.210 (b)(3), (e)		
	1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.				
	2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.	L575			

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	3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.	L576			
418.60	<b>Infection Control</b>	L577	141.206 C)(13)		
	The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.	L578			
	a) Prevention The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.	L579			CoP's contain very specific language
	b) Control The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that -  1) Is an integral part of the hospice's quality assessment and performance improvement program; and 2) Includes the following: i) A method of identifying infectious and communicable disease problems; and ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.	L580			<b>Changes from previous version of CMS state Ops Manual</b> - This version includes a description of the program elements.
		L581			
	c) Education The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.	L582	141.206 (B) (13)		Occupational Safety and Health Administration - 1910.1030 (g) (2) (i)
418.62	<b>Licensed professional services</b>	L583			
	a) Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under 418.114 and who practice under the hospice's policies and procedures.	L584			
	b) Licensed professionals must actively participate in the coordination of all aspects of the patient's hospice care, in accordance with current professional standards and practice, including participating in on going interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education; and	L585			

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	c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training.	L586			
<b>418.64</b>	<b>Core Services</b> A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. 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. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.	L587	141.204	437.423	<b>Clarification of CMS IG - 1) Continuous Care can not be contracted out; 2) Dietary Counseling can not be contracted out (must be a W-2 employee); and 3) The Bereavement Assessment should be incorporated within the Comprehensive Assessment and show how the bereavement outcomes are evaluated and are effective; and 4) The clinical record should show evidence that Spiritual Counseling has been offered or that local clergy visits have been facilitated.</b>
	a) Physician services The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness. 1) All physician employees and those under contract, must function under the supervision of the hospice medical director. 2) All physician employees and those under contract shall meet this patient care with the attending physician 3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.	L588, L589	141.204 A, G	437.423	
	b) Nursing services 1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. 2) If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to beneficiaries receiving hospice care. 3) High specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.	L590		437.423 C	
	c) Medical Social Services Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.	L591	141.204 D 2-5	437.423 (A)	
	d) Counseling services Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process. Counseling services must include, but are not limited to, the following: 1) Bereavement counseling. The hospice must:	L592			
		L593			
		L594	141.204 (E)	437.423 (B)	DPH more specific regarding: 1) supervision of social workers; 2) The educational preparation and licensure of a social worker and ; 3)the responsibilities of the administrator/supervisor of social work.
		L595	141.204 (G)	437.432 (D)	
		L596	141.204 (G) (3)	437.423 (D) (1)	

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	<p>by counseling services</p> <ul style="list-style-type: none"> <li>i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.</li> <li>ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNR/NF or ICF/MR when appropriate and identified in the bereavement plan of care.</li> <li>iii) Ensure that bereavement services reflect the needs of the bereaved</li> <li>iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in 418.204©.</li> </ul> <p>2) Dietary counseling. Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.</p> <p>3) Spiritual counseling. The hospice must:</p> <ul style="list-style-type: none"> <li>i) Provide an assessment of the patient's and family's spiritual needs.</li> <li>ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.</li> <li>iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.</li> <li>iv) Advise the patient and family of this service.</li> </ul>	<p>L597</p> <p>L598</p>	<p>141.204 (G) 4</p> <p>141.201(G)(4)(b)</p> <p>141.204(G)(4)b3(d)</p>	<p>437.423 (D) (2)</p>	
<p>418.66</p>	<p><b>Nursing services - Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.</b></p> <p>a) CMS may waive the requirement in 418.64(b) that a hospice provide nursing services directly, if the hospice is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services. CMS may waive the requirement that nursing services be furnished by employees based on the following criteria:</p> <ul style="list-style-type: none"> <li>1) The location of the hospice's central office is in a non-urbanized area as determined by the Bureau of the Census.</li> <li>2) There is evidence that a hospice was operational on or before January 1, 1983 including the following: <ul style="list-style-type: none"> <li>i) Proof that the organization was established to provide hospice services on or before January 1, 1983.</li> <li>ii) Evidence that hospice-type services were furnished to patients on or before January 1, 1983.</li> <li>iii) Evidence that hospice care was discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983.</li> </ul> </li> <li>3) By virtue of the following evidence that a hospice made a good faith effort to hire nurses: <ul style="list-style-type: none"> <li>i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.</li> <li>ii) Job descriptions for nurse employees.</li> <li>iii) Evidence that salary and benefits are competitive for the area.</li> <li>iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contacts with nurses at other providers in the area).</li> </ul> </li> </ul>	<p>L599</p> <p>L600</p>			

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	<p>b) Any waiver request is deemed to be granted unless it is denied within 60days after it is received.</p> <p>c) Waivers will remain effective for 1 year at a time from the date of the request.</p> <p>d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period, and certify that the conditions under which it originally requested the initial waiver have not changed since the initial waiver was granted.</p>				
<b>Non-Core Services</b>					
<b>418.70</b>	<b>Furnishing of non-core services</b>	L601			
	A hospice must ensure that the services described in 418.72 through 418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in 418.100. These services must be provided in a manner consistent with current standards of practice.		141.204 B		
<b>418.72</b>	<b>Physical therapy, occupational therapy, and speech-language pathology.</b>	L603			
	Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided offered in a manner consistent with accepted standards of practice.	L604		437.423 (E)	
<b>418.74</b>	<b>Waiver of requirement-Physical therapy, occupational therapy, speech-language pathology, and dietary counseling</b>	L605			
	<p>a) A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. The hospice may seek a waiver of the requirement that it make it physical therapy, occupational therapy, speech-language pathology, and dietary counseling services (as needed) available on a 24-hour basis. The hospice may also seek a waiver of the requirement that it provide dietary counseling directly.</p>	L606			
	<p>1) The hospice is located in a non-urbanized area as determined by the Bureau of the Census.</p>				
	<p>2) The hospice provides evidence that it had made a good faith effort to make available physical therapy, occupational therapy, speech-language pathology, and dietary counseling services on a 24-hour basis and/or to hire a dietary counselor to furnish services directly. This evidence must include the following:</p>				
	<p>i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.</p>				
	<p>ii) Physical therapy, occupational therapy, speech-language pathology, and dietary counselor job descriptions.</p>				

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<p>The hospice must provide evidence that it has made a good faith effort to meet the requirements for these services before it seeks a waiver. CMS may approve a waiver application on the basis of the following criteria:</p> <p>b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.</p> <p>c) An initial waiver will remain effective for 1 year at a time from the date of the request.</p> <p>d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period and certify that conditions under which it originally requested the waiver have not changed since the initial waiver was granted.</p>		<p>iii) Evidence that salary and benefits are competitive for the area.</p> <p>iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contact discussions with physical therapy, occupational therapy, speech-language pathology, and dietary counseling service providers in the area).</p>			
<b>418.76</b>	<b>Condition of participation: Hospice aide and homemaker services.</b>	L607			
	All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.	L608	101.204 (1), (2)	437.423 (F)	CoPs contain very specific requirements for hospice aide training and ongoing education.
a) Hospice aide qualifications.	1) A qualified hospice aide is a person who has successfully completed one of the following:	L609			
	i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively.				
	ii) A competency evaluation program that meets the requirement of paragraph (c) of this section.				
	iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of 483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry.				
	iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section.				
	2) A hospice aide is not considered to have completed a program, as specified in paragraph (a)(1) of this section, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual as described in 409.40 of this chapter were for compensation. If there has been a 24-month lapse in furnishing services, the individual must complete another program, as specified in paragraph (a)(1) of this section, before providing services.	L610			
b) Content and duration of hospice aide classroom and supervised practical training.	1) Hospice aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse. Classroom and supervised practical training combined must total at least 75 hours.	611			

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	2) A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours.	L612			
	3) A hospice aide training program must address each of the following subject areas:	L613			
	i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff.				
	ii) Observation, reporting, and documentation of patient status and the care or service furnished.				
	iii) Reading and recording temperature, pulse, and respiration.				
	iv) Basic infection control procedures.				
	v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.				
	vi) Maintenance of a clean, safe, and healthy environment.				
	vii) Recognizing emergencies and the knowledge of emergency procedures and their application.				
	viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property.				
	ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:				
	(A) Bedbath.				
	(B) Sponge, tub, and shower bath.				
	( C ) Hair shampoo (sink, tub, and bed).				
	(D) Nail and skin care.				
	(E) Oral hygiene				
	(F) Toileting and elimination.				
	x) Safe transfer techniques and ambulation.				
	xi) Normal range of motion and positioning.				
	xii) Adequate nutrition and fluid intake.				
	xiii) Any other task that the hospice may choose to have an aide perform. The hospice is responsible for training hospice aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section.				
	4) The hospice must maintain documentation that demonstrates that the requirements of this standard are met.	L614			
c) Competency evaluation	An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section.	L615			
	1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)93)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.				
	2) A hospice aide competency evaluation program may be offered by any organization, except as described in paragraph (f) of this section.	L616			

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	3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.	L617			
	4) A hospice aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. An aide must not perform that task without direct supervision by a registered nurse until after he or she has received training in the task for which he or she was evaluated as "unsatisfactory," and successfully completes a subsequent evaluation. A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required areas.	L618			
	5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met.	L619			
d) In-Service training	A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-Service training may occur while an aide is furnishing care to a patient.	L620			
	1) In-service training may be offered by any organization, and must be supervised by a registered nurse.	L621			
	2) The hospice must maintain documentation that demonstrates the requirements of this standard are met.	L622			
e) Qualifications for instructors conducting classroom and supervised practical training.	Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of 2 years nursing experience, at least 1 year of which must be in home care, or by other individuals under the general supervision of a registered nurse.	L623			
f) Eligible competency evaluation organizations	A hospice aide competency evaluation program as specified in paragraph ( c ) of this section may be offered by any organization except by a home health agency that, within the previous 2 years:	L624			
	1) Had been of compliance with the requirements of 484.36 (a) and (b) of this chapter.				
	2) Permitted an individual that does not meet the definition of a "qualified home health aide" as specified in 484.36 (a) of this chapter to furnish home health aide services (with the exception of licensed health professionals and volunteers).				
	3) Had been subjected to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State).				
	4) Had been assessed a civil monetary penalty of \$5,000 or more as an intermediate sanction.				
	5) Had been found by CMS to have compliance deficiencies that endangered the health and safety of the home health agency's patients and had temporary management appointed to oversee the management of the home health agency.				
	6) Had all or part of its Medicare payments suspended.				
	7) Had been found by CMS or the State under any Federal or State law to have:				
	i) Had its participation in the Medicare program terminated.				
	ii) Been assessed a penalty of \$5,000 or more for deficiencies in Federal or State standards for home health agencies.				
	iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled.				
	iv) Operated under temporary management that was appointed by a governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency's patients.				
	v) Been closed by CMS or the State, or had its patients transferred by the State.				
g) Hospice aide assignments and duties.	1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.	L625			
	2) A hospice aide provides services that are:	L626			

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	<ul style="list-style-type: none"> <li>i) Ordered by the interdisciplinary group.</li> <li>ii) Included in the plan of care</li> <li>iii) Permitted to be performed under State law by such hospice aide.</li> <li>iv) Consistent with the hospice aide training.</li> </ul>				
	3) The duties of a hospice aide include the following:	L627			
	i) The provision of hands-on personal care.				
	ii) The performance of simple procedures as an extension of therapy or nursing services.				
	iii) Assistance in ambulation or exercises.				
	iv) Assistance in administering medications that are ordinarily self-administered.				
	4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.	L628			
	h) Supervision of hospice aides				
	1) A registered nurse must make an on-site visit to the patient's home:	L629			
	i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.				
	ii) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.	L630			
	iii) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete a competency evaluation in accordance with 418.76( c).	L631			
	2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.	L632			
	3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to -	L633			
	i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.				
	ii) Creating successful interpersonal relationships with the patient and family.				
	iii) Demonstrating competency with assigned tasks.				
	iv) Complying with infection control policies and procedures.				
	v) Reporting changes in the patient's condition.				
	i) Individuals furnish Medicaid personal care aide-only services under a Medicaid personal care benefit	L634			
	An Individual may furnish personal care services, as defined in 440.167 of this chapter, on behalf of a hospice agency.				
	1) Before the individual may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services. The individual only needs to demonstrate competency in the services the individual only needs to demonstrate competency in the services the individual is required to furnish.				
	2) Services under the Medicaid personal care benefit may be used to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care.	L635			
	3) The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services he or she needs.	L636			

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j) Homemaker qualifications	1) An individual who meets the standards in 418.202(g) and has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with terminal illness; or 2) A hospice aide as described in 418.76.	L637			
k) Homemaker supervision and duties	1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group.	L638			
	2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.	L639			
	3) Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services.	L640			
<b>418.78</b>	<b>Volunteers</b>	L641			
The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.		L642	141.204		
a) Training	The hospice must maintain, document, and provide volunteer orientation and training that is consistent with hospice industry standards.	L643	141.204 F3, 7		
b) Role	Volunteers must be used in day-to-day administrative and/or direct patient care roles.	L644	141.204 F1, 4 a-f,		
c) Recruiting and retaining	The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.	L645			
d) Cost saving	The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following:	L646			
	1)The identification of each position that is occupied by a volunteer.				
	2) The work time spent by volunteers occupying those positions.				
	3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.				
e) Level of activity	Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals five (5) percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.	L647			
<b>Subpart D-- Conditions of Participation: Organizational Environment</b>					
<b>418.100</b>	<b>Organization and administration of services</b>	L648			
The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.		L649	141.204	437.432	
a) Serving the hospice patient and family	The hospice must provide hospice care that -	L650			
	1) Optimizes comfort and dignity; and				
	2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.				

Medicare CoP's 2008		State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
b) Governing body and administrator	A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by a the hospice's governing body.	L651	Governing Body 141.200, Administration 141.201 141.204 D) (1)		<b>CMS State Ops Manual Updates from previous version</b> - 1) When the administrator is absent, a person must be identified to assume those duties; and 2) The Governing body must assume responsibility for ensuring that the hospice is managed by the administrator and any managers that the administrator appoints.
c) Services	1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:	L652	141.204	437.432	
	i) Nursing services		141.204 D	437.423 (A)	
	ii) Medical social services		141.204 E	437.423 (B)	
	iii) Physician services		141.204 C	437.423 C	
	iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling		141.204 B 141.204 G	437.423 (D)	
	(v) Hospice aide, volunteer, and homemaker services		141.204 B, 141.204 F	437.432 (F)	
	(vi) Physical therapy, occupational therapy, and speech-language pathology services		141.204 B	437.432 (E)	
	(vii) Short-term inpatient care		L704-715, L	141.204 H	437.421 (D) 437.423 (H) 437.424 (A), (B)
	(viii) Medical supplies (including drugs and biologicals) and medical appliances	L652	141.204 B	437.432(G)	
	2) Nursing services, physician services, and drugs and biologicals (as specified in 418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family	L653	141.204 C (i)		
d) Continuation of care	A hospice may not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for that care.	L654			
e) Professional management responsibility	A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care.	L655	141.204 (H)	437.421 (D), 437.423 (H), 437.424 (A) (B)	
	Arranged services must be supported by written agreements that require that all services be-				
	1) Authorized by the hospice				
	2) Furnished in a safe and effective manner by qualified personnel; and				
	3) Delivered in accordance with the patient's plan of care				
f) Hospice multiple locations	If a hospice operates multiple locations, it must meet the following requirements.	L656			

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	1) Medicare approval.				
	i) All hospice multiple locations must be approved by Medicare before providing hospice care and services to Medicare patients.				
	ii) The multiple location must be part of the hospice and must share administration, supervision, and services with the hospice issued the certification number.	L657			
	iii) The lines of authority and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice, and must be traced to the location that issued the certification number.	L658			
	iv) The determination that a multiple location does or does not need the definition of a multiple location, as set forth in this part, is an initial determination, as set forth in 498.3.	L659			
	2) The hospice must continually monitor and manage all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and ensure that each patient and family receives the necessary care and services outlined in the plan of care, in accordance with the requirements of this subpart and subparts A and C of this section.	L660			
g) Training	1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact.	L661			
	2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.	L662			
	3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.	L663			
418.102	<b>Medical Director</b>	L664			Clarification of CMS IG - Each hospice should have only ONE (1) Medical Director
	The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.	L655	141.204 C		DPH contains slightly more detailed language regarding the medical director
a) Medical director contract	1) A hospice may contract with either of the following - i) A self-employed physician; or ii) A physician employed by a professional entity or physicians group. When contracting for medical director services, the contract must specify the physician who assumes the medical director responsibilities and obligations.	L666			
b) Initial certification of terminal illness	The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination: 1) The primary terminal condition; 2) Related diagnosis(es), if any; 3) Current subjective and objective medical findings; 4) Current medication and treatment orders; and 5) Information about the medical management of any of the patient's conditions unrelated to the terminal illness.	L667			
c) Recertification of the terminal illness	Before the recertification period for each patient, as described in 418.21(a), the medical director or physician designee must review the patient's clinical information.	L668			
d) Medical director responsibility	The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.	L669			

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<b>418.104</b>	<b>Clinical Records</b>	L670	141.209		
	A clinical record contain past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.	L671	141.209 (A)		
a) Content	1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.	L672	141.209 (E)(1,2,5,6,12,13)		DPH includes "identification data as part of the contents of the clinical record"
	2) Signed copies of the notice of patient rights in accordance with 418.52 and election statement in accordance with 418.24	L673	141,209 (E)(4)		
	3) Responses to medications, symptom management, treatments, and services	L674	141.209 (E)(1)(8)		
	4) Outcome measure data elements, as described in 418.54(e) of this subpart.	L675			
	5) Physician certification and recertification of terminal illness as required in 418.22 and 418.25 and described in 418.102(b) and 418.102( c) respectively, if appropriate.	L676	141.209 (E)(5,10,11)		
	6) Any advance directives as described in 418.52(a)(2).	L677	141.209(E)(2)		
	7) Physician Orders	L678	141.209 (E)(7)		
b) Authentication	All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.	L679	141.209 C)		<b>Clarification of CMS IG -</b> The hospice must have and authentication system for signatures; NO stamped signatures allowed.
c) Protection of information	The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164.	L680	141.209 (H)		
d) Retention of records	Patient clinical records must be retained for <u>6</u> years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its stored and how they may be accessed.	L681	141.209 (G) -		DPH requires the retention of medical records for <u>seven (7)</u> years after death or discharge which is longer than the CoPs.
e) Discharge or transfer of care	1) If the care of a patient is transferred to another Medicare/Medicaid-certified facility, the hospice must forward to the receiving facility, a copy of _	L682	141.209 (E)(9), (14)	437.412 (C) (2)	
	i) The hospice discharge summary; and				
	ii) The patient's clinical report, if requested.				
	2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with 418.26, the hospice must forward to the patient's attending physician, a copy of -	L683			
	i) The hospice discharge summary; and				
	ii) The patient's clinical record, if requested.				
	3) The hospice discharge summary as required in paragraph (e)(1) and (e)(2) of this section must include -	L684			
	i) A summary of the patient's stay including treatments, symptoms and pain management.				
	ii) The patient's current plan of care				
	iii) The patient's latest physician orders and				
	iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.				
f) Retrieval of clinical records	The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.	L685	141.209 (B)		

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418.106	<b>Drugs and biologicals, medical supplies, and durable medical equipment</b>	L686	141.207 A		DPH requires current written policies and procedures regarding the administration and recording of drugs and biologicals.
	Medical supplies and appliances, as described in 410.36 of this chapter; durable medical equipment, as described in 410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.	L687	141.207 B		Additional DPH reference 105 CMR 700.000
	a) Managing drugs and biologicals	L688			<b>Clarification of CMS IG</b> - As required in the CoP, an employee or contracted individual that has "training in drug management " may include a licensed pharmacist, board certified MD in palliative medicine; palliative care certified nurses or physicians, nurses, N.P.s who have completed a specific hospice and palliative drug management course; 2) The IDT must assess the family's capability to administer drugs and; 3) The surveyor may ask probe questions to the patient and family about drug education, disposal and storage and DME operation and safety.
		L689			
	b) Ordering of drugs	L690	141.207 (E)		
			141.207 (E)(5)		
	c) Dispensing of drugs and biologicals	L691			
	d) Administration of drugs and biologicals	L692	141.207 (E)(5)		

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e) Labeling, disposing, and storing of drugs and biologicals.	1) Labeling. Drugs and biologicals must be labeled in accordance with currently accepted professional practice and must include appropriate usage and cautionary instructions, as well as an expiration date (if applicable).	L693	141.207 (B)	436.423 (G)	
	2) Disposing.	L694			
	i) Safe use and disposal of controlled drugs in the patient's home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home.				
	A) Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family.	L695			
	B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and	L696			
	C) Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.	L697			
	ii) Disposal of controlled drugs in hospices that provide inpatient care directly. The hospice that provides inpatient care directly in its own facility must dispose of controlled drugs in compliance with the hospice policy and in accordance with State and Federal requirements. The hospice must maintain current and accurate records of the receipt and disposition of all controlled drugs.	L698			
	3) Storing. The hospice that provides inpatient care directly in its own facility must comply with the following additional requirements -	L699			
	i) All drugs and biologicals must be stored in secure areas. All controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 must be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled drugs as noted in paragraph (d)92) of this section may have access to the locked compartments; and				
	ii) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and where required reported to the appropriate State authority. A written account of the investigation must be made available to State and Federal officials if required by law or regulation.	L700			
418.106 cont. f) Use and maintenance of equipment and supplies.	1) The hospice must ensure that manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment are followed. The equipment must be safe and work as intended for use in the patient's environment. Where a manufacturer recommendation for a piece of equipment does not exist, the hospice must ensure that repair and routine maintenance policies are developed. The hospice may use person under contract to ensure the maintenance and repair of durable medical equipment.	L701			
	2) The hospice must ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of durable medical equipment and supplies. The hospice may use persons and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.	L702			
	3) Hospices may only contract for durable medical equipment services with a durable medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR 424.57.	L703			
418.108 Short-term inpatient care	Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.	L704	41.204 (H)(3)(c)		
	a) Inpatient care for symptom management and pain control.	L705	141.204 (H)(1-4)	437.423 (H)	DPH regulations contains language that includes "the hospice program shall make available appropriate hospice care training of
	1) A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in 418.110.	L706	141.204 (H)(2)	437.423 (H)	

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	2) A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in 418.110(b) and (e) regarding 24-hour nursing services and patient areas.	L707	141.204 (H)	437.423 (H) 437.424 (A) (4), (B)	hospital or long term facility personnel who provide care under the agreement including staff orientation."
b) Inpatient care for respite purposes	1) Inpatient care for respite purposes must be provided by one of the following:	L708	141.204 (H)(1-4)	437.432 (H)	
	i) A provider specified in paragraph (a) of this section				
	ii) A Medicare of Medicaid-certified nursing facility that also meets the standards specified in 418.110(f).	L709			
	2) The facility providing respite care must provide <u>24-hour nursing services</u> that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable ie, clean, well-groomed, and protected from accident, injury, and infection.	L710	141.204 (H) (4) (c) (ii)		DPH requires a Registered Nurse to be on duty in the hospice inpatient facility to supervise nursing care and nursing personnel 24 hours a day.
c) Inpatient care provided under arrangements.	If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice, and at a minimum specifies-	L711	141.204 (H)(3)	437.424 (A) (4), (B) 437.421 (D)	
	(1) That the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;		141.204 (H)(3)(a)		
	(2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;	L712	141.204 (H)(3)(a)		
	(3) That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge.	L713	141.204 (H)(3)(b)		
	(4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;	L714			
	(5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training are documented; and	L715	141.204 (H)(3)(c)		
	(6) A method for verifying that the requirements in paragraphs ( c)(1) through ( c)(5) of this section are met.	L716			
d) Inpatient care limitation	The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.	L717		437.423 (H)	
e) Exemption from limitation	Before October 1, 1986, any hospice that began operation before January 1, 1975, is not subject to the limitation specified in paragraph (d) of this section.	L718			
<b>418.110 Hospices that provide inpatient care directly</b>		L719	141.204(H) 141.299		
	A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:	L720	141.204 (H)(3)(4)		
a) Staffing	The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.	L721	141.204 (H)(3)(4)		
b) Twenty-four hour nursing services	1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.	L722	141.204 (H)(3)(4)		

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	2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.	L723	41.204 (H) (4) c		
c) Physical environment	The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.	L724	141.204(H) 141.299		
	1) Safety management.	L725			
	i) The hospice must address real or potential threats to the health and safety of the patients, others, and property.				
	ii) The hospice must have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan must be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.	L726			
	2) Physical plant and equipment. The hospice must develop procedures for controlling the reliability and quality of-	L727			
	i) The routine storage and prompt disposal of trash and medical waste;				
ii) Light, temperature, and ventilation/air exchanges throughout the hospice;					
iii) Emergency gas and water supply; and					
iv) The scheduled and emergency maintenance and repair of all equipment.					
d) Fire protection	1) Except as otherwise provided in this section-	L728			
	i) The hospice meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). The Director of the Office of the Federal Register has approved the NFPA 101 @ 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the national Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <a href="http://www.archives.gov/federalregister/codeoffederalregulations/ibrlocations.html">http://www.archives.gov/federalregister/codeoffederalregulations/ibrlocations.html</a> . Copies may be obtained from the national Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the Federal Register to announce the changes.				
	ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospices.				
	2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship for the hospice, but only if the waiver would not adversely affect the health and safety of patients.				
	3) The provisions of the adopted edition of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in hospices.				
	4) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a hospice may place alcohol-based hand rub dispensers in its facility if-				
	i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;				
	ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;				
	iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and				

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	<p>iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00-1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00-1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:  <a href="http://www.archives.gov/federal_register/codeoffederal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/codeoffederal_regulations/ibr_locations.html</a>. Copies may be obtained from the national Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the <b>Fede</b></p>				
e) Patient areas	<p>The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.</p> <p>1) The hospice must provide-</p> <p>i) Physical space for private patient and family visiting;</p> <p>ii) Accommodations for family members to remain with the patient throughout the night; and</p> <p>iii) Physical space for family privacy after a patient's death.</p> <p>2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.</p>	L729			
f) Patient rooms	<p>1) The hospice must ensure that patient rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of patients</p> <p>2) The hospice must accommodate a patient and family request for a single room whenever possible.</p> <p>3) Each patient's room must -</p> <p>i) Be at or above grade level;</p> <p>ii) Contain a suitable bed and other appropriate furniture for each patient;</p> <p>iii) Have closet space that provides security and privacy for clothing and personal belongings;</p> <p>iv) Accommodate no more than two patients and their family members;</p>	L730	<p>141.209 (D)</p> <p>141.299 (G)</p> <p>141.299 Patient Bedrooms -- Nursing Care Units (B)</p>		<p>DPH requires that the patient's room must have a floor level at least six (6) ins above the grade level adjacent to the building.</p> <p>DPH more specific regarding closet space (including drawers)</p> <p>DPH specifies that all rooms must be private</p>

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	v) Provide at least 80 square feet for each residing patient in a single room; and		141.299 Patient Bedrooms -- Nursing Care Units (B)		DPH specifies that each room shall not be less than 125 square feet
	vi) Be equipped with an easily-activated, functioning device accessible to the patient, that is used for calling for assistance.				
	4) For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that-				
	i) Imposition of the requirements would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and				
	ii) The waiver serves the needs of the patient and does not adversely affect their health and safety.				
g) Toilet and bathing facilities.	Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.	L731	141.299 (I) 141.299 Bathing Facilities		DPH specifies direct access for bathroom facilities
h) Plumbing facilities.	The hospice must-	L732	141.299 Water Supply		
	1) Have an adequate supply of hot water at all times; and				
	2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.				
i) Infection control	The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in 418.60.	L733			
j) Sanitary environment	The hospice must provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions, and avoid sources and transmission of infections and communicable diseases.	L734			
k) Linen	The hospice must have available at all times a quantity of clean linen in sufficient amounts for all patient uses. Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of contaminants.	L735			
l) Meal service and menu planning	The hospice must furnish meals to each patient that are-	L736	141.299 Meal Service Facilities		
	1) Consistent with the patient's plan of care, nutritional needs, and therapeutic diet;				
	2) Palatable, attractive, and served at the proper temperature; and				
	3) Obtained, stored, prepared, distributed, and served under sanitary conditions.				
m) Restraint or seclusion	All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.	L737			<b>Clarification of CMS IG</b> - Restraints for falls should <u>not</u> be considered routine.
	1) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.	L738			
	2) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.	L739			
	3) The use of restraint or seclusion must be-	L740			
	i) In accordance with a written modification to the patient's plan of care; and				
	ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospice policy in accordance with State law.				

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	4) The use of restraint or seclusion must be in accordance with the order of a physician authorized to order restraint or seclusion by hospice policy in accordance with State law.	L741			
	5) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).	L742			
	6) The medical director or physician designee must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.	L743			
	7) Unless superseded by State law that is more restrictive- i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:	L744			
	A) 4 hours for adults 18 years of age or older;				
	B) 2 hours for children and adolescents 9-17 years of age; or				
	C) 1 hour for children under 9 years of age; and				
	After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician authorized to order restraint or seclusion by hospice policy in accordance with State law must see and assess the patient.				
	ii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospice policy.				
	8) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.	L745			
	9) The condition of the patient who is restrained or secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph (n) of this section at an interval determined by hospice policy.	L746			
	10) Physician, including attending physician, training requirements must be specified in hospice policy. At a minimum, physicians and attending physicians authorized to order restraint or seclusion by hospice policy in accordance with State law must have a working knowledge of hospice policy regarding the use of restraint or seclusion.	L747			
	11) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention-	L748			
	i) By a-				
	A) Physician; or				
	B) Registered nurse who has been trained in accordance with the requirements specified in paragraph (n) of this section.				
	ii) To evaluate-				
	A) The patient's immediate situation;				
	B) The patient's reaction to the intervention				
	C) The patient's medical and behavioral condition; and				
	D) The need to continue to terminate the restraint or seclusion.				
	12) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (m)(11)(i) of this section.	L749			
	13) If the face-to-face evaluation specified in 418.110(m)(11) is conducted by a trained registered nurse, the trained registered nurse must consult the medical director or physician designee as soon as possible after the completion of the 1-hour face-to-face evaluation.	L750			
	14) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored-	L751			

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	<ul style="list-style-type: none"> <li>i) Face-to-face by an assigned, trained staff member; or</li> <li>ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient</li> </ul>				
	15) When restraint or seclusion is used, there must be documentation in the patient's clinical record of the following:	L752			
	<ul style="list-style-type: none"> <li>i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;</li> <li>ii) A description of the patient's behavior and the intervention used;</li> <li>iii) Alternatives or other less restrictive interventions attempted (as applicable);</li> <li>iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and the patient's response to the intervention(s) used, including the rationale for continued use of the intervention.</li> </ul>				
n) Restraint or seclusion staff training requirements	The patient has the right to safe implementation of restraint or seclusion by trained staff.	L753			
	1) Training intervals. All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion-	L754			
	<ul style="list-style-type: none"> <li>i) Before performing any of the actions specified in this paragraph;</li> <li>ii) As part of orientation; and</li> <li>iii) Subsequently on a periodic basis consistent with hospice policy.</li> </ul>				
	2) Training content. The hospice must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:	L755			
	<ul style="list-style-type: none"> <li>i) Techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.</li> <li>ii) The use of nonphysical intervention skills.</li> <li>iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.</li> <li>iv) The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).</li> <li>v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.</li> <li>vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the 1-hour face-to-face evaluation.</li> <li>vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.</li> </ul>				
	3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient's behaviors.	L756			
	4) Training documentation. The hospice must document in the staff personnel successfully completed.	L757			
o) Death reporting requirements.	Hospices must report deaths associated with the use of seclusion or restraint.	L758			CMS State Ops Manual Update from previous version - An unexpected death must be reported to CMS Regional Office if it occurs while the patient is in restraints or seclusion, within twenty-four (24) hours after it was discontinued or within one (1) week after its use if it is reasonable to assume that restraint
	1) The hospice must report the following information to CMS:				
	<ul style="list-style-type: none"> <li>i) Each unexpected death that occurs while a patient is in restraint or seclusion.</li> <li>ii) Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.</li> </ul>				

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	<p>iii) Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction breathing or asphyxiation.</p> <p>2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death</p> <p>3) Staff must document in the patient's clinical record the date and time the death was reported to CMS.</p>				<p>or seclusion was a factor.  <b>NOTE:</b> CMS Regional Office contact: Richard Shaw, Branch Chief, Certification and Enforcement, 617 565 4487; William Dunhyan, Branch Chief, Survey, 617 565 9160; or Susan Albrecht, CMS Regional Surveyor, 617 565 1304.</p>
418.112	<b>Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.</b>	L759	141.212		CoPs contain more specific language
	In addition to meeting the conditions of participation at 418.10 through 418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/MR must abide by the following additional standards.	L760	141.112		
	a) Resident eligibility, election, and duration of benefits.	L761			
	b) Professional management.	L762	141.204 (H)(3) 141.205 C) 141.206 (B)(5) 141.112 (D)		<b>Clarification of CMS IG -</b> 1) Core hospice services may not be delegated to facility staff; 2) The facility must offer the same services to its residents who have elected hospice as it furnished to those who have not elected hospice; 3) The Hospice and Nursing Home Plans of Care need not be the same document but need to be connected, showing the collaboration between the two providers and that the goals of the Plan of Care are the same , and 4) If there are concerns related to the patients Plan of Care for pain and symptom management, the surveyor may talk with the facility's nurses aides.
	c) Written agreement.	L763	141.204 (H)(3) 141.112 (C, E)		
	The hospice and SNF/NF or ICF/MR must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services. The written agreement must include at least the following:				
	1) The manner in which the SNF/NF or ICF/MR and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.	L764			
	2) A provision that the SNF/NF or ICF/MR immediately notifies the hospice if-	L765			
	i) A significant change in a patient's physical, mental, social, or emotional status occurs;				
	ii) Clinical complications appear that suggest a need to alter the plan of care;				
	iii) A need to transfer a patient from the SNF/NF or ICF/MR, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or				
	iv) A patient dies.				
	3) A provision stating that the hospice assumes responsibility for deterring the appropriate course of hospice care, including the determination to change the level of services provided.	L766			

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p>4) An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.</p> <p>5) An agreement that it is the hospice's responsibility to provide services at the same level and the same extent as those services would be provided if the SNF/NF or ICF/MR resident were in his or her own home.</p> <p>6) A delineation of the hospice's responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>7) A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.</p> <p>8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.</p> <p>9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.</p>	<p>L767</p> <p>L768</p> <p>L769</p> <p>L770</p> <p>L771</p> <p>L772</p>	<p>141.112 (c3, e)</p> <p>141.112</p>		
d) Hospice plan of care.	<p>In accordance with 418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.</p> <p>1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.</p> <p>2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extend possible.</p> <p>3) Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.</p>	<p>L773</p> <p>L774</p> <p>L775</p> <p>L776</p>	<p>141.204 (H)(3)(a) 141.112 C)</p>		
e) Coordination of services.	<p>The hospice must:</p> <p>1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR. The designated interdisciplinary group member is responsible for</p> <p>i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives; and</p>	<p>L777</p> <p>L778</p>	<p>141.112 C)</p>		CoPs contain more specific language

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	<p>ii) Communicating with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.</p> <p>2) Ensure that the hospice IDG communicates with the SNF/NF or ICF/MR medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.</p> <p>3) Provide the SNF/NF or ICF/MR with the following information:</p> <p>i) The most recent hospice plan of care specific to each patient;</p> <p>ii) Hospice election form and any advance directives specific to each patient;</p> <p>iii) Physician certification and recertification of the terminal illness specific to each patient;</p> <p>iv) Names and contact information for hospice personnel involved in hospice care of each patient;</p> <p>v) Instructions on how to access the hospice's 24 -hour on-call system;</p> <p>vi) Hospice medication information specific to each patient; and</p> <p>vii) Hospice physician and attending physician (if any) orders specific to each patient.</p>	L779			<p><b>CMS State Ops Manual Update from previous version -</b> _____ A lengthy section has been added concerning the coordination of the patient's Plan of Care for pain control and symptom management and measures to be taken if there are complaints or problems</p>
		L780			
		L781	141.204(H)(3)(b)		
f) Orientation and training of staff.	Hospices staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.	L782	141.204 (C, H), 141.212 (E)(7)		DPH language includes "the hospice program shall make available appropriate hospice care training of hospital or long term care facility personnel who provide care under the agreement including staff orientation".
<b>418.114</b>	<b>Personnel qualifications.</b>	L783	141.112		
a) General qualification requirements.	Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.	L784			
b) Personnel qualifications for certain disciplines.	The following qualifications must be met:	L785			
	1) <b>Physician.</b> Physicians must meet the qualifications and conditions as defined in section 1861 ® of the Act and implemented at 410.20 of this chapter.				
	2) <b>Hospice aide.</b> Hospice aides must meet the qualifications required by section 1891(a)(3) of the Act and implemented at 418.76.	L786	141.204	437.423 (F)	
	3) <b>Social Worker.</b> A person who-	L787			
	(i)				
	A) Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or		141.204		

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	<p>B) Has baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in paragraph (b)(3)(i)(A) of this section; and</p> <p>ii) Has 1 year of social work experience in healthcare setting;</p> <p>or</p> <p>iii) Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.</p>				
	<p>4) <b>Speech language pathologist.</b> A person who meets either of the following requirements:</p>	L788			
	<p>i) The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association.</p>				
	<p>ii) The educational requirements for certification and is in the process of accumulating the supervised experience required for certification.</p>				
	<p>5) <b>Occupational therapist.</b> A person who-</p>	L789			
	<p>i)</p>				
	<p>A) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply;</p>				
	<p>B) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and</p>				
	<p>C) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the national Board for Certification in Occupational Therapy, Inc. (NBCOT).</p>				
	<p>ii )On or before December 31, 2009-</p>				
	<p>A) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing; or</p>				
	<p>B) When licensure or other regulation does not apply-</p>				
	<p>1) Graduated after successful completion of an occupational therapist education program accredited by the accreditation Council for Occupational therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and</p>				
	<p>2) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the national Board for Certification in Occupational Therapy, Inc., (NBCOT).</p>				
	<p>iii) On or before January 1, 2008-</p>				
	<p>A) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and Accreditation of the American medical Association and the American Occupational Therapy Association; or</p>				
	<p>B) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.</p>				
	<p>iv) On or before December 31, 1977-</p>				
	<p>A) Had 2 years of appropriate experience as an occupational therapist; and</p>				
	<p>B) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.</p>				
	<p>v) If educated outside the United States-</p>				
	<p>A) Must meet both of the following:</p>				

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	<p>1) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by one of the following:</p> <p>i) The Accreditation Council for Occupational Therapy Education (ACOTE).</p> <p>ii) Successor organizations of ACOTE.</p> <p>iii) The World Federation of Occupational Therapists.</p> <p>iv) A credentialing body approved by the American Occupational Therapy Association.</p> <p>v) Successfully completed the entry level certification examination for occupational therapist developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).</p> <p>2) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing.</p> <p>6) <b>Occupational therapy assistant.</b> A person who</p> <p>i) Meets all of the following:</p> <p>A) Is licensed or otherwise regulated, if applicable, as an occupational therapy assistant by the State in which practicing, unless licensure does apply.</p> <p>B) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOE) of the American Occupational Therapy Association, Inc. (AOTA), or its successor organizations.</p> <p>C) Is eligible to take or successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).</p> <p>ii) On or before December 31, 2009-</p> <p>A) Is licensed or otherwise regulated as an occupational therapy assistant, if applicable, by the State in which practicing; or any qualifications defined by the State in which practicing, unless licensure does not apply; or</p> <p>B) Must meet both of the following:</p> <p>1) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association.</p> <p>2) After January 1, 2020, meets the requirements in paragraph (b)(6)(i) of this section.</p> <p>iii) After December 31, 1977 and on or before December 31, 2007-</p> <p>A) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association; or</p> <p>B) Completed the requirements to practice as an occupational therapy assistant applicable in the State in which practicing.</p> <p>iv) On or before December 31, 1977-</p> <p>A) Had 2 years of appropriate experience as an occupational therapy assistant; and</p> <p>B) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.</p> <p>v) If educated outside the United States, on or after January 1, 2008-</p> <p>A) Graduated after successful completion of an occupational therapist assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by-</p> <p>1) The Accreditation Council for Occupational Therapy Education (ACOTE).</p>	L790			

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p>2) Its successor organizations.</p> <p>3) The World Federation of Occupational Therapists.</p> <p>4) By a credentialing body approved by the American Occupational Therapy Association; and</p> <p>5) Successfully completed the entry level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).</p> <p>7. <b>Physical therapist.</b> A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:</p> <p>A) Graduated after successful completion of a physical therapist education program approved by one of the following:</p> <p>B) The Commission on Accreditation in Physical Therapy Education (CAPTE).</p> <p>C) Successor organizations of CAPTE.</p> <p>D) An education program outside the United States determined to be substantially equivalent to physical therapist entry level education in the United States by credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15 (e) as it relates to physical therapists.</p> <p>E) Passed examination for physical therapists approved by the State in which physical therapy services are provided.</p> <p>i) On or before December 31, 2009-</p> <p>A) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE);</p> <p>or</p> <p>B) Meets both of the following:</p> <p>1) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15 (e) as it relates to physical therapists.</p> <p>2) Passes an examination for physical therapists approved by the State in which physical therapy services are provided.</p> <p>ii) Before January 1, 2008-</p> <p>A) Graduated from a physical therapy curriculum approved by one of the following:</p> <p>1) The American Physical Therapy Association.</p> <p>2) The Committee on Allied Health Education and Accreditation of the American Medical Association.</p> <p>3) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.</p> <p>iii) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following:</p> <p>A) Has 2 years of appropriate experience as a physical therapist.</p> <p>B) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.</p> <p>iv) Before January 1, 1966-</p> <p>A) Was admitted to membership by the American Physical Therapy Association.</p> <p>B) Was admitted to registration by the American Registry of Physical Therapists; and</p> <p>C) Graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education.</p>	L791			

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	<p>vi) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of fulltime experience in the treatment of illness or injury through the practice of order and direction of attending and referring doctors of medicine or osteopathy.</p> <p>vii) If trained outside the United States before January 1, 2008, meets the following requirements  A) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.  B) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.</p> <p>8) <b>Physical therapist assistant.</b> A person who is licensed, registered or certified as a physical therapist assistant, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:  i) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and  ii) Passed a national examination for physical therapist assistants.  A) On or before December 31, 2009, meets one of the following:  1) Is licensed, or otherwise regulated in the State in which practicing.  2) In States where licensure or other regulations do not apply, graduated before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and after January 1, 2010, meets the requirements of paragraph (b)(8) of this section.  3) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college level program approved by the American Physical Therapy Association.  4) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.</p>	L792			
	<p>C) Personnel qualifications when no State licensing, certification or registration requirements exist. If no State licensing laws, certification or registration requirements exist for the profession, the following requirements must be met:</p>	L793			
	<p>1) Registered nurse. A graduate of a school of professional nursing.</p>				
	<p>2) Licensed practical nurse. A person who has completed a practical nursing program.</p>	L794			
	<p>d) Criminal background checks.</p>				
	<p>1) The hospice must obtain a criminal background check on all hospice employees who have a direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.</p>	L795			
	<p>2) Criminal background checks must be obtained in accordance with State Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment.</p>	L796			
418.116	Compliance with Federal, State, and local laws and regulations related to the health and safety of patients.	L797			

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The hospice and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of patients. If State or local law provides for licensing of hospices, the hospice must be licensed.		L798			
a) Multiple locations. Every hospice must comply with the requirements of 420.206 of this chapter regarding disclosure of ownership and control information. All hospice multiple locations must be approved by Medicare and licensed in accordance with State licensure laws, if applicable, before providing Medicare reimbursed services.		L799			
	1) If the hospice engages in laboratory testing other than assisting a patient in self-administering a test with an appliance that has been approved for that purpose by the FDA, the hospice must in be in compliance with all applicable requirements of part 493 of this chapter.	L800			
	2) If the hospice chooses to refer specimens for laboratory testing to a reference laboratory, the reference laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.	L801			
<b>Subpart E-Removed and Reserved</b>					
<b>Subpart F--Covered Services</b>					
<b>418.200</b>	<b>Requirements for coverage</b>				
	To be covered, hospice services must meet the following requirements. They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The individual must elect hospice care in accordance with Sec. 418.24 and a plan of care must be established as set forth in Sec. 418.56 before Services are provided. The services must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in Sec. 418.22				
<b>418.202</b>	<b>Covered services.</b>				
	All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services.				
	<b>a) Nursing care</b> provided by or under the supervision of a registered nurse.		141.204 (D)		
	<b>b) Medical social services</b> provided by a social worker under the direction of a physician.		141.204 (E)		

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	<p><b>c) Physician's services</b> performed by a physician as defined in Sec. 410.20 of this chapter except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.</p>				
	<p><b>d) Counseling services</b> provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.</p>		141.205 (G)		
	<p><b>e) Short-term inpatient care</b> provided in a participating hospice inpatient unit, or a participating hospital or SNF, that additionally meets the standards in Sec. 418.202 (a) and (e) regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished as a means of providing respite for the individual's family or other persons caring for the individual at home. Respite care must be furnished as specified in Sec. 418.108(b). Payment for inpatient care will be made at the rate appropriate to the level of care as specified in Sec 418.302.</p>		141.204 (H) (4)	437.423 (H)	

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p><b><u>f) Medical appliances and supplies, including drugs and biologicals.</u></b> Only drugs as defined in section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as described in Sec. 410.38 of this chapter as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.</p>				
	<p><b><u>g) Home health aide</u></b> services furnished by qualified aides as designated in Sec. 418.6 and homemaker services. Home health aides may provide personal care services as defined in Sec. 409.45(b) of this chapter. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.</p>				

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p><u>h) Physical therapy, occupational therapy and speech-language pathology</u>  services in addition to the services described in Sec. 409.33 (b) and (c) of this chapter provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.</p>				
	<p>i) Effective April 1, 1998, any other service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicare.</p>				

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences	
418.204	<b>Special coverage requirements</b>					
	<p><b>a) Periods of crisis.</b> Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis a necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.</p>				437.424 (A) (2)	<p>Continuous Home Care.  <u>Medicare Benefit Policy Manual</u>, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance 40.2.1 Continuous Home Care (CHC), Issued 09/24/04, Implementation 06/04.  <u>CMS Medicare Claims Processing Transmittal</u> 1022, 07/28/2006, Change Request 5245, Effective date 01/01/07, Implementation Date 01/02/07, 30.1</p>
	<b>b) Respite care.</b>	<p>1) Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.  2) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time.</p>			437.424 (A)(3)	
	<b>c) Bereavement counseling.</b> Bereavement counseling is a required hospice service but it is not reimbursable.			141.204 (G)(3)		
	<b>Subpart G -- Payment for Hospice Care</b>					
418.301	<b>Basic rules</b>					
	a) Medicare payment for covered hospice care is made in accordance with the method set forth in 418.302.					
	b) Medicare reimbursement to a hospice in a cap period is limited to cap amount specified in Sec. 418.309.					
	c) The hospice may not charge a patient for services for which the patient is entitled to have payment made under Medicare or for services for which the patient would be entitled to payment, as described in 489.21 of this chapter.					
418.302	<b>Payment procedures for hospice care</b>					

Medicare CoP's 2008		State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
a) HCFA establishes payment amounts for specific categories of covered hospice care					
b) Payment amounts are determined within each of the following categories:	<b>1) Routine home care day.</b> A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care as defined in paragraph (b)(2) of this section.			437.424(A)(1)	
	<b>2) Continuous home care day.</b> A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as described in Sec 418.204 (a) and only as necessary to maintain the terminally ill patient at home.			437.424 (A)(2)	Continuous Home Care. <u>Medicare Benefit Policy Manual</u> , Chapter 9 - Coverage of Hospice Services Under Hospital Insurance 40.2.1 Continuous Home Care (CHC), Issued 09/24/04, Implementation 06/04. <u>CMS Medicare Claims Processing Transmittal</u> 1022, 07/28/2006, Change REquest 5245, Effective date 01/01/07, Implementation Date 01/02/07, 30.1
	<b>3) Inpatient respite care day.</b> An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.		141.204 (H)(4)	437.424 (A) (3)	
	<b>4) General inpatient care day.</b> A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.			437.424 (A) (4) 437.424 (B)	
c) The payment amounts for the categories of hospice care are fixed payment rates that are established by HCFA in accordance with the procedures described in Sec. 418.306. Payment rates are determined for the following categories:	1) Routine home care.				
	2) Continuous home care.				
	3) Inpatient respite care.				
	4) General inpatient care.			437.424 (A)(4) 437.424 (B)	
d) The intermediary reimburses the hospice at the appropriate payment amount for each day for which an eligible Medicare beneficiary is under the hospice's care.					
e) The intermediary makes payment according to the following procedures:	1) Payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day.				
	2) Payment is made for only one of the categories of hospice care described in Sec. 418.302(b) for any particular day.				

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p>3) On any day on which the beneficiary is not an inpatient, the hospice is paid the routine home care rate, unless the patient receives continuous care as defined in paragraph (b)(2) of this section for a period of at least 8 hours. In that case, a portion of the continuous care day rate is paid in accordance with paragraph (3)(4) of this section.</p> <p>4) The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous care provided during a continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of 8 hours of care must be furnished on a particular day to qualify for the continuous home care rate.</p> <p>5) Subject to the limitations described in paragraph (f) of this section, on any day on which the beneficiary is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care furnished. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the beneficiary is discharged, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the beneficiary is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day. Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.</p>			<p>437.424 (A) (2)</p> <p>437.424 (A) (2)</p>	<p>Continuous Home Care. <u>Medicare Benefit Policy Manual</u>, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance 40.2.1 Continuous Home Care (CHC), Issued 09/24/04, Implementation 06/04. <u>CMS Medicare Claims Processing Transmittal</u> 1022, 07/28/2006, Change Request 5245, Effective date 01/01/07, Implementation Date 01/02/07, 30.1</p> <p>Continuous Home Care. <u>Medicare Benefit Policy Manual</u>, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance 40.2.1 Continuous Home Care (CHC), Issued 09/24/04, Implementation 06/04. <u>CMS Medicare Claims Processing Transmittal</u> 1022, 07/28/2006, Change Request 5245, Effective date 01/01/07, Implementation Date 01/02/07, 30.1</p>
f) Payment for inpatient care is limited as follows:	<p>1) The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicare patients not exceed 20 percent of the total days for which these patients had elected hospice care.</p> <p>2) At the end of a cap period, the intermediary calculates a limitation on payment for inpatient care to ensure that Medicare payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicare patients.</p> <p>3) If the number of days of inpatient care furnished to Medicare patients is equal to or less than 20 percent of the total days of hospice care to Medicare patients, no adjustment is necessary. Overall payments to a hospice are subjected to the cap amount specified in Sec. 418.309.</p> <p>4) If the number of days of inpatient care furnished to Medicare patients exceeds 20 percent of the total days of hospice care to Medicare patients, the total payment for inpatient care is determined in accordance with the procedures specified in paragraph (f)(5) of this section. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice. Overall payments to the hospice are subjected to the cap amount specified in Sec. 418.309.</p> <p>5) If a hospice exceeds the number of inpatient care days described in paragraph (f)(4), the total payment for inpatient care is determined as follows:</p>				

Medicare CoP's 2008		State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
		i) Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients.			
		ii) Multiply this ratio by the total reimbursement for inpatient care made by the intermediary.			
		iii) Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate			
		iv) Add the amounts calculated in paragraphs (f)(5)(ii) and (iii) of this section.			
	a) Payment for routine home care and continuous home care is made on the basis of the geographic location where the service is provided.				
<b>418.304</b>	<b>Payment for physician services</b>				
		1) General supervisory services of the medical director.			
		2) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.			
	b) For services not described in paragraph (a) of this section, a specified Medicare contractor pays the hospice an amount equivalent to 100 percent of the physician fee schedule for those physician services furnished by hospice employees or under arrangements with the hospice. Reimbursement for these physician services included in the amount subject to the hospice payment limit described in Sec. 418.309. Services furnished voluntarily by physicians are not reimbursable.				
	Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the hospice payment limit described in Sec. 418.309. These services are paid by the carrier under the procedures in subparts D or E, part 405 of this chapter.				

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p>c) Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the hospice payment limited described in Sec. 418.309. These services are paid by the carrier under the procedures in subparts B, part 414 of this chapter.</p>				
<b>418.306</b>	<b>Determination of payment rates.</b>				
	<p>a) Applicability. HCFA establishes payment rates for each of the categories of hospice care described in Sec. 418.302(b). The rates are established using the methodology described in section 1814(i)(1)(C) of the Act.</p> <p>b) Payment rates. The payment rates for routine home care and other services included in hospice care are as follows:</p> <p>1) The following rates, which are 120 percent of the rates in effect on September 30, 1989, are effective January 1, 1990 through September 30, 1990 and October 21, 1990 through December 31, 1990:</p> <p>Routine home care - \$75.80</p> <p>Continuous home care:</p> <p>Full rate for 24 hours - \$442.40</p> <p>Hourly rate - \$18.43</p> <p>Inpatient respite care - \$78.40</p> <p>General inpatient care - \$337.20</p> <p>2) Except for the period beginning October 21, 1990, through December 31, 1990, the payment rates for routine home care and other services included in hospice care for Federal fiscal years 1991, 1992, and 1993 and those that begin on or after October 1, 1997, are the payment rates in effect under this paragraph during the previous fiscal year increased by the market basket percentage increase as defined in section 1886(b)(3)(B)(iii) of the Act, otherwise applicable to discharges occurring in the fiscal year. The payment rates for the period beginning October 21, 1990, through December 31, 1990, are the same as those shown in paragraph (b)(1) of this section.</p> <p>3) For Federal fiscal years 1994 through 2002, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase minus-</p> <p>i) 2 percentage points in FY 1994;</p> <p>ii) 1.5 percentage points in FYs 1995 and 1996;</p> <p>iii) 0.5 percentage points in FY 1997; and</p> <p>iv) 1 percentage points in FY 1998 through FY 2002.</p>				

Medicare CoP's 2008		State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p>4) For Federal fiscal year 2001, the payment rate is the payment rate in effect during the previous fiscal year increased by a factor equal to the market basket percentage increase plus 5 percentage points. However, this payment rate is effective only for the period April 1, 2001 through September 30, 2001. For the period October 1, 2000 through March 31, 2001, the payment rate is based upon the rule under paragraph (b)(3)(iv) of this section. The payment rate in effect during the period April 1, 2001 through September 30, 2001 is considered the payment rate in effect during fiscal year 2001.</p> <p>5) The payment rate for hospice services furnished during fiscal years 2001 and 2002 is increased by an additional 0.5 percent and 0.75 percent, respectively. This additional amount is not included in updating the payment rate as described in paragraph (b)(3) of this section.</p>				
	<p>c) Adjustment of wage differences. HCFA will issue annually, in the Federal Register, a hospice wage index based on the most current available HCFA hospital wage data, including any changes to the definitions of Metropolitan Statistical Areas. The payment rates established by HCFA are adjusted by the intermediary to reflect local differences in wages according to the revised wage index.</p>				
	<p>d) Federal Register notices. HCFA publishes as a notice in the Federal Register any proposal to change the methodology for determining the payment rates.</p>				
<b>418.307</b>	<b>Periodic Interim payments</b>				

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	<p>Subject to the provisions of Sec. 413.64(h) of this chapter, a hospice may elect to receive periodic interim payments (PIP) effective with claims received on or after July 1, 1987. Payment is made biweekly under the PIP method unless the hospice requests a longer fixed interval (not to exceed one month) between payments. The biweekly interim payment amount is based on the total estimated Medicare payments for the reporting period (as described in Secs. 418.302-418.306). Each payment is made 2 weeks after the end of a biweekly period of service as described in Sec. 413.64(h)(5) of this chapter. under certain circumstances that are described in Sec. 413.64(g) of this chapter, a hospice that is not receiving PIP may request an accelerated payment.</p>				
418.308	<b>Limitation on the amount of hospice payments</b>				
	<p>a) Except as specified in paragraph (b) of this section, the total Medicare payment to a hospice for care furnished during a cap period is limited by the hospice cap amount specified in Sec. 418.309.</p>				
	<p>b) Until October 1, 1986, payment to a hospice that began operation before January 1, 1975 is not limited by the amount of the hospice cap specified in Sec. 418.309</p>				
	<p>c) The intermediary notifies the hospice of the determination of program reimbursement at the end of the cap year in accordance with procedures similar to those described in Sec. 405.1803 of this chapter.</p>				

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	d) Payments made to a hospice during a cap period that exceed the cap amount are overpayments and must be refunded.				
418.309	<b>Hospice cap amount</b>				
	The hospice cap amount is calculated using the following procedures:				
	<p>a) The cap amount is \$6,500 per year and is adjusted for inflation or deflation for cap years that end after October 1, 1984, by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CIP from march 1984 to the fifth month of the cap year. The cap year runs from November 1 of each year until October 31 of the following year.</p>				
	b) Each hospice's cap amount is calculated by the intermediary by multiplying the adjusted cap amount determined in paragraph (a) of this section by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes --				
	1) Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care, in accordance with Sec. 418.24, from the hospice during the period beginning on September 28 (35 days before the end of the cap period).				
	2) In the case in which a beneficiary has elected to receive care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stay in all hospices that was spent in that hospice. (The hospice can obtain this information by contacting the intermediary.)				
418.310	<b>Reporting and record keeping requirements</b>				
	Hospices must provide reports and keep records as the Secretary determines necessary to administer the program.				
418.311	<b>Administrative appeals</b>				
	A hospice that believes its payments have not been properly determined in accordance with these regulations may request a review from the intermediary or the Provider Reimbursement Review Board (PRRB) if the amount in controversy is at least \$1,000 or \$10,000, respectively. In such a case, the procedure in 42 CFR part 405, subpart R, will be followed to the extent that it is applicable. The PRRB, subject to review by the Secretary under Sec. 405.1874 of this chapter, shall have the authority to determine the issues raised. The methods and standards for the calculation of the payment rates by HCFA are not subject to appeal.				

	Medicare CoP's 2008	State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
<b>Subpart H-- Coinsurance</b>					
418.400	<p><b>Individual liability for coinsurance for hospice care</b></p> <p>An individual who has filed an election for hospice care in accordance with Sec. 418.24 is liable for the following coinsurance payments. Hospices may charge individuals the applicable coinsurance amounts.</p>				
	<p>a) Drugs and biologicals. An individual is liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The amount of coinsurance for each prescription approximates 5 percent of the cost of the drug or biological to the hospice determined in accordance with the drug co-payment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed \$5. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The drug co-payment schedule must be reviewed for reasonableness and approved by the intermediary before it is used.</p>				
	<p>b) Respite care</p>	<p>1) The amount of coinsurance for each respite care day is equal to 5 percent of the payment made by HCFA for a respite care day.</p> <p>2) The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.</p> <p>3) The individual hospice coinsurance period--</p> <p>i) Begins on the first day an election filed in accordance with Sec. 418.24 is in effect for the beneficiary; and</p> <p>ii) Ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.</p>			
418.402	<p><b>Individual liability for services that are not considered hospice care</b></p>				
	<p>Medicare payment to the hospice</p>				

	<b>Medicare CoP's 2008</b>	<b>State Ops Manual, Ver 1.1</b>	<b>Mass. DPH Regulations</b>	<b>Mass Health</b>	<b>Key Differences</b>
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	<p>discharges an individual's liability for payment for all services, other than the hospice coinsurance amounts described in Sec. 418.400, that are considered covered hospice care (as described in Sec. 418.102). The individual is liable for the Medicare deductibles and coinsurance payments and for the difference between the reasonable and actual charge on unassigned claims on other covered services that are not considered hospice care. Examples of services not considered hospice care include: Services furnished before or after a hospice election period; services of the individual's attending physician, if the attending physician is not an employee of or working under an arrangement with the hospice; or Medicare services received for the treatment of an illness or injury not related to the individual's terminal condition.</p>				
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<b>418.405</b>	<b>Effect of coinsurance liability on Medicare payment</b>				
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	<p>The Medicare payment rates established by HCFA in accordance with Sec. 418.306 are not reduced when the individual is liable for coinsurance payments. Instead, when establishing the payment rates, HCFA offsets the estimated cost of services by an estimate of average coinsurance amounts hospices collect.</p>				
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<b>Mass DPH Licensure of Hospice Programs - Additional Regulations</b>					
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	#	Title			
	141.001	Purpose			
	141.002	Authority			
	141.003	Citation			
	141.010	Scope			

Medicare CoP's 2008		State Ops Manual, Ver 1.1	Mass. DPH Regulations	Mass Health	Key Differences
	141.020	Definitions			
	141.025	Special Projects			
	141.099	Compliance with Requirements			
	141.100	Requirement of License			
	141.101	Application for a License			
	141.102	Other Licensing Requirements			
	141.103	Timing of Application			
	141.104	Transfer of Ownership			
	141.105	Acceptance of Application			
	141.106	Updating of Ownership Information			
	141.107	Evaluation of Application			
	141.108	Evidence of Responsibility and Suitability			
	141.109	Right to Visit and Inspect			
	141.110	Frequency of Inspection			
	141.111	Deficiency statements			
	141.112	Plan of Correction			
	141.120	Issuance of License			
	141.121	Period of License			
	141.122	Posting of License			
	141.123	Renewal of License			
	141.130	Suspension of License			
	141.131	Denial, Revocation, and Refusal to renew Licenses			
	141.140	Closing of a Program			
	141.141	Temporary Interruption of Services			
	141.201	Administration, Personnel Policies, Administrative records			
	141.206	Policies and Procedures			
	141.299	Appendix A: General Standards of Construction: Hospice Inpatient facility Directly Owned and Operated by a Hospice Program			