December 2008
in this issue
The Journal
Hospice Administrators with a Crosswalk of the New CoPs

One Administrator's View of Hospice

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I was asked to write an article concerning hospice. With all the new conditions of participation, QAPI issues, and views of state surveyors, there are different opinions of where hospice is going and how fast it will get there. This is my take on the topic.

I have been an administrator for the past 9 years and have seen many changes come over that time. From the beginning, hospice has been a ministry. Yes, I have to look at the business side because I am responsible to my staff, but ultimately hospice is for the patient and their families. We are to glorify God by the way that we serve the patients that He has sent us. The phrase for National Hospice Month is "Love, Hope, Dignity… It must be Hospice." As administrators, we are responsible for the daily operations of our agencies (MS Reg, 109.03) and we are also a part of a much larger picture.

The new COPs take effect in December, but are they really new. Yes, there are some changes, but I feel that most of us already go above and beyond these conditions. The question may be why have theses conditions been presented? The answer can be all over the board. My view is that these conditions were needed to pull every provider onto a level playing field. For at least the past 6 years, myself along with other providers have said that we need to police ourselves, along with the department of health, to make sure that we do not put ourselves out of business. This may be a very hard statement, but if you think about it, we are our own worst enemies.

The QAPI issue is something that will wake you up at night with a cold sweat. In our meeting, the entire staff had their heads down hoping that they would not be called upon to work on it. I have talked to different administrators from around the area and their feeling is that clinical issues are being met, but we need to uphold our policies to a higher standard. A big question could be how is the QAPI program being implemented into the agency and how is that implementation being used to improve the care for the patients.

We are to maintain the best care available for our patients, but we are also to follow the different policies, regulations and conditions that have been established and presented to us. Hospice care has not changed since its inception, what has changed is that providers have shifted their focus from the patient to the board room or the bottom line. I know that I lost my focus a few years back, but getting out from behind my desk and visiting the patients and talking to my staff brought me back in line. Hospice is about the patient and the care that we are to provide. We should never forget that hospice is and will always be a ministry. We are called to this very important part of healthcare and we are dealing with patients at one of the most important times of their lives.

I will end as I began. Hospice is very near and dear to my heart and I am sure that I have been talking to the choir. We are in for a long, hard climb to the next plateau. Some may not make it for different reasons, but the ultimate goal is that patients are given the BEST care that they deserve.

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next month: QAPI - Quality Assessment/ Performance Improvement

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Calendar

January 15, 2009
Area Code 662 Quarterly Luncheon
For more information contact Nancy Dunn at nancy@LMHPCO.org

February 11-13, 2009
CAHSAH Hospice Administrator Certificate Program
Hotel Monteleone, New Orleans, LA
For more information go to:
http://www.cahsah.org/educational_events/education/2009/HACP%20Brochure.pdf

March 25-28, 2009
AAHPM & HPNA Annual Assembly
Austin, TX
For more information go to:
http://www.hpna.org/DisplayPage.aspx?Title=Annual%20Conferences

April 16, 2009
Area Code 662 Quarterly Luncheon
For more information contact Nancy Dunn at nancy@LMHPCO.org

April 23-25, 2009
NHPCO's 24th Management & Leadership Conference
Omni-Shoreham Hotel, Washington, DC
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

April 29, 2009
16th Annual National HFA Living with Grief Teleconference (12:30-3:00PM)
Diversity & End-of-Life Care
For more information, go to:
www.hospicefoundation.org

July 29-31, 2009
LMHPCO Annual Leadership Conference & Annual Meeting
Loews Hotel, New Orleans, LA
Details: TBA

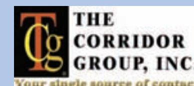
September 24-26, 2009
NHPCO's 10th Clinical Team Conference
Hyatt Regency, Denver, CO
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

December 4-6, 2009
NHPCO's 6th National Conference on Volunteerism & Family Caregiving
Walt Disney Swan Hotel, Olando, FL
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

Hospice Administrator Certificate Program (HACP)

February 11-13, 2009 – New Orleans, LA - Hotel Monteleone

Brought to you by: CAHSAH, TCG, NAHC
Co-sponsored by: LMHPCO
Supported by: HospiScript



The goal of the Hospice Administrator Certificate Program (HACP) is to provide a supportive learning environment for administrators and senior managers. The HACP will strengthen your competencies to position your organization for success and help you integrate the complexities of quality, compliance, financial management, and strategic performance. The HACP is broken down into a three module curriculum. Each participant will receive a comprehensive manual that is a must-have resource for years to come.

PROGRAM GOALS:

- Identify key health care trends that will influence positioning strategies of your hospice organization
- Integrate data management and analysis methods into your quality assessments and performance improvement program
- Implement key financial management strategies to prepare and interpret financial documents and to understand the impact of current changes in health care
- Understand leadership responsibilities in promoting a quality driven organization
- Integrate corporate compliance issues with clinical, financial and legal integrity of the organization

Registration brochure available at:
http://www.lmhpco.org/blahdocs/uploads/hacpfebbrochurerevised_1051.pdf

Hospice Administrators crosswalk

LA State Minimum Standards

Current as of December, 1999
Proposed Changes in Red

Subchapter A. General Provisions
§8201. Definitions

Branch— a location or site from which a hospice agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the parent hospice agency and is located within a 50 mile radius of the parent agency and shares administration and supervision.

Contracted Services— services provided to a hospice provider or its patients by a third party under a legally binding agreement that defines the roles and responsibilities of the hospice and service provider.

Core Services— nursing services, physician services, medical social services, and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

Employee— an individual whom the hospice pays directly for services performed on an hourly or per visit basis and the hospice is required to issue a form W-2 on his/her behalf. If a contracting service or another agency pays the individual, and
is required to issue a form W-2 on the individual's behalf, or if the individual is self-employed, the individual is not considered a hospice employee. An

Medicare Conditions of Participation (CoPs)

Revised June 5, 2008 with Effective Date of Revisions December 2, 2008

§ 418.3 Definitions.
Cap period means the twelve-month period ending October 31 used in the application of the cap on overall hospice reimbursement specified in Sec. 418.309.

Employee means a person who: (1) Works for the hospice and for whom the hospice is required to issue a W–2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice.

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

Licensed professional means a person licensed to provide patient care services by the State in which services are delivered.

Multiple location means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices.

Palliative care means patient and family-centered care that optimizes quality

MS State Minimum Standards

Current as of February 22, 2008

101 **DEFINITIONS**

101.01 **Administrator** - Means the person, designated by the governing body, who is responsible for the management of the overall operation of the hospice.

101.05 **Autonomous** – Means a separate and distinct operational entity which functions under its own administration and bylaws, either within or independently of a parent organization.

101.08 **Branch Office/Alternate Site** –A location or site from which a hospice agency provides services within a portion of the total geographic area served by the parent agency. The branch is a part of the parent hospice agency and is located within the 50 mile radius of the parent agency and shares administration and supervision. No branch office site shall be opened unless the parent office has had full licensure for the immediately preceding 12 months and has admitted 10 patients within the last twelve (12) months. A branch office does not extend the Geographic Service Area of the Parent Agency.

101.12 **Change of Ownership** – Means but is not limited to, intervivos, gifts, transfers, leases, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (fifty percent (50%) or more) of the facility or service. Changes of ownership from partnerships, single proprietorships or corporations to another form of ownership are specifically included.

LA State Minimum Standards

individual is also considered a hospice employee if the individual is a volunteer under the jurisdiction of the hospice.

Facility Based Care— hospice services delivered in a place other than the patient's home, such as an inpatient hospice facility, nursing home or hospital inpatient unit.

Geographic Area— area around location of licensed agency which is within 50 mile radius of the agency premises. Each hospice must designate the geographic area in which the agency will provide services.

Governing Body— the person or group of persons that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation. The governing body must designate an individual who is responsible for the day-to-day management of the hospice program, and must also insure that all services provided are consistent with accepted standards of practice. Written minutes and attendance of governing body meetings are to be maintained.

Hospice— an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his family. It employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospice Inpatient Facility— organized facilities where specific levels of care ranging from residential to acute, including respite, are provided in order to meet the needs of the patient/family.

Medicare Conditions of Participation (CoPs)

of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

Subpart B--Eligibility, Election and Duration of Benefits
§ 418.20 Eligibility requirements.
In order to be eligible to elect hospice care under Medicare, an individual must be--
(a) Entitled to Part A of Medicare; and
(b) Certified as being terminally ill in accordance with Sec. 418.22.

§ 418.21 Duration of hospice care coverage—Election periods.
(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.

Sec. 418.22 Certification of terminal illness.
(a) *Timing of certification*—
(1) General rule. 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).
(2) Basic requirement. Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification before it submits a claim for payment.
(3) Exception. If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it

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Provided, however, "Change of Ownership" shall not include any inherited interest acquired as a result of a testamentary instrument or under the laws of descent and distribution of the State of Mississippi. The change of IRS exemption status also constitutes a change of ownership.

101.15 **Contracted Services** – Services provided to a hospice provider or its patients by a third party under a legally binding agreement that defines the roles and responsibilities of the hospice and service provider.

101.16 **Core Services** – Nursing services, physician services, medical social services, and counseling services, including bereavement counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

101.18 **Criminal History Record Check**
1. **Affidavit** -For the purpose of fingerprinting and criminal background history checks, the term "affidavit" means the use of Mississippi State Department of Health (MDH) form #210, or a copy thereof, which shall be placed in the individual's personal file.
2. **Employee** -For the purpose of fingerprinting and criminal background history checks, employee shall mean **any individual employed by a covered entity**. The term "employee" also includes any individual who by contract with a covered entity provides patient care in a patient's, resident's, or client's room or in treatment rooms. The term employee does not include healthcare professional/ technical students, as defined in Section 37-29-232, performing clinical training in a licensed entity under contracts between their schools

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Hospice Premises— the physical site where the hospice maintains staff to perform administrative functions, and maintains its personnel records, or maintains its client service records, or holds itself out to the public as being a location for receipt of client referrals.

Hospice Services— a coordinated program of palliative and supportive care, in a variety of appropriate settings, from the time of admission through bereavement, with the focus on keeping terminally ill patients in their place of residence as long as possible.

License (Hospice)— a document permitting an organization to practice hospice care for a specific period of time under the rules and regulations set forth by the State of Louisiana.

Non Core Services— services provided directly by hospice employees or under arrangement. These services include, but are not limited to:
a. home health aide and homemaker;
b. physical therapy services;
c. occupational therapy services;
d. speech-language pathology services;
e. inpatient care for pain control and symptom management and respite purposes; and
f. medical supplies and appliances including drugs and biologicals.

Residential Care— hospice care provided in a nursing facility or any residence or facility other than the patient's private residence.

Respite Care— short-term care generally provided in a nursing facility or hospice facility to provide relief for the family from daily care of the patient.

Sub Unit— a semi-autonomous organization, licensed separately, which serves patients in a different geographic location from that of the parent agency. The sub-unit is located outside of the

Medicare Conditions of Participation (CoPs)

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--
(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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and the licensed entity, and does not include students at high schools who observe the treatment and care of patients in a licensed entity as part of the requirements of an allied health course taught in the school if:
a. The student is under the supervision of a licensed healthcare provider; and
b. The student has signed the affidavit that is on file at the student's school stating that he or she has not been convicted of or plead guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offenses listed in section 45-33-23 (g), child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.
c. Further, applicants and employees of the University of Mississippi Medical Center for whom criminal history record checks and fingerprinting are obtained in accordance with Section 37-115-41 are exempt from application of the term employee under Section 43-11-13.
3. **Covered Entity** - For the purpose of criminal history record checks, "covered entity" means a licensed entity or a healthcare professional staffing agency.
4. **Licensed Entity** - For the purpose of criminal history record checks, the term "licensed entity" means a hospital, nursing home, personal care home, home health agency or hospice.
5. **Health Care Professional/ Vocational Technical Academic Program** - For purpose of criminal history record checks, "health care professional/vocational technical academic program" means an academic program in medicine, nursing , dentistry, occupational therapy, physical therapy, social services, speech therapy, or other allied-health professional

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50-mile radius and does not share administration/staff/services on a daily basis with the parent agency.

Terminally Ill— a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

§8203. Licensing

A. Except to the extent required by §8205A(1), it shall be unlawful to operate or maintain a hospice without first obtaining a license from the department. The Department of Health and Hospitals is the only licensing authority for hospice in the State of Louisiana.

B. A separately licensed hospice may not use a name which is substantially the same as the name of another hospice licensed by the department unless the agency is part of a corporation or is chain affiliated.

C. Issuance of a License. The licensing agency shall have authority to issue two licenses as described below.

1. Full license is issued only to those agencies that are in substantial compliance with applicable federal, state, and local laws. The license shall be valid until the expiration date shown on the license.

2. Provisional license is issued to those existing licensed agencies which do not meet criteria for Full licensure. The license shall be valid for six months or until termination date.

a. An agency with a provisional license shall pay an additional amount equal to the annual licensing renewal fee for each follow-up survey. Fee shall be paid to the state agency prior to the follow-up survey being performed and is nonrefundable.

b. An agency with a provisional license may be issued a full license, if at the follow-up survey the agency has cor-

Medicare Conditions of Participation (CoPs)

Sec. 418.24 Election of hospice care.

(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. 418.3) may file the election statement.

(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.

(4) 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).

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whose purpose is to prepare professionals to render patient care services.

6. **Health Care Professional/ Vocational Technical Student** - For purposes of criminal history record checks, the term means a student enrolled in a healthcare professional/ vocational technical academic program.

7. **Direct Patient Care or Services** - For the purposes of fingerprinting and criminal background history checks, the term "direct patient care" means direct hands-on medical patient care and services provided by an individual in a patient, resident or client's room, treatment room or recovery room. Individuals providing direct patient care may be directly employed by the facility or provides patient care on a contractual basis.

8. **Documented disciplinary action** - For the purpose of fingerprinting and criminal background history checks, the term "documented disciplinary action" means any action taken against an employee for abuse or neglect of a patient.

101.25 **Freestanding Hospice**– Freestanding Hospice means a hospice that is not a part of any other type of health care provider.

101.26 **Geographic Service Area** – Area around the Parent Office, which is within 50 miles radius of the Parent Office premises. Each hospice must designate the geographic service area in which the agency will provide services. Should the referenced 50 mile radius fall within the geographic region of a county, the facility shall be allowed the entire county. The full range of hospice services, as specified, must be provided to the entire designated geographic service area.

101.27 **Governing Body** – Means the board of directors, trustees, partnership, or association, consisting of a minimum of seven (7) persons who are represen-

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rected the violations. A full license will be issued for the remainder of the year until the hospice agency's license anniversary date.
c. DHH may re-issue a provisional license or initiate licensing revocation of a provisional license when the hospice fails to correct violations within sixty (60) days of being cited, or at the time of the follow-up survey, whichever occurs first.
d. A provisional license may be issued by DHH for the following non-exclusive reasons:
i. agency has more than five violations of hospice
regulations during one survey;
ii. agency has more than three valid complaints in a one year period;
iii. there is a documented incident that places a patient at risk;
iv. agency fails to correct violations within 60 days of being cited, or at the time of a follow-up survey, whichever occurs first;
v. agency has an inadequate referral base, other than at the time of the initial survey for licensure, has less than twenty new patients admitted since the last annual survey.
e. Agency fails to submit assessed fees after notification by DHH.
f. Documented evidence that agency has bribed, or harassed any person to use the services of any particular hospice agency.

D. Display of License. The current license shall be displayed in a conspicuous place inside the hospice program office at all times. A license shall be valid only in the possession of the agency to which it is issued. A license shall not be subject to sale, assignment, or other transfer, voluntary or involuntary. A license shall not be valid for any hospice other than the hospice for which originally issued. If an agency is also licensed as a hospice inpatient facility, both licenses shall be displayed.

Medicare Conditions of Participation (CoPs)

(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
(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.
(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.

§ 418.62 Condition of participation: Licensed professional services.
(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.
(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 ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education; and
(c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training.

MS State Minimum Standards

tative of the local community at large, which has autonomous authority for the conduct and operation of the hospice program. (Section: 41-85-19) This governing body is required to meet quarterly.

101.29 **Hospice Inpatient Facility** – Organized facilities where specific levels of care ranging from residential to acute, including respite, are provided on a 24-hour basis within the confines of a licensed hospital, nursing home, or freestanding hospice in order to meet the needs of the patient/family. A hospice inpatient facility shall
meet the Condition of Participation for providing inpatient care directly as specified in Title 42, Section 418.100 of the Code of Federal Regulations.

101.30 **Hospice** – Means an autonomous, centrally administered, nonprofit or for profit medically directed, nurse-coordinated program providing a continuum of home, outpatient and homelike inpatient care for not less than four (4) terminally ill patients and their families. It employs a hospice care team (see definition of hospice care team) to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. This care is available twenty-four (24) hours a day, seven (7) days a week, and is provided on the basis of need regardless of inability to pay. (Section 41-85-3)

101.32 **Hospice Premises** – The physical site where the hospice maintains staff to perform administrative functions, maintains its personnel records, maintains its client service records, and holds itself out to the public as being a location for receipt of client referrals. A hospice must be physically located within the State of Mississippi. A

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E. Initial Licensure. All requirements of the application process must be completed by the applicant before the application will be processed by DHH.
1. No application will be reviewed until payment of the application fee.
2. The applicant must become fully operational and prepared for an initial survey within ninety days after payment of the application fee. If the agency is unable to do so, the application shall be considered closed and the agency shall be required to submit a new application packet including fees.
3. An initial applicant shall, as a condition of licensure, submit the following:
a. a complete and accurate Hospice Application Packet. (This packet is purchased from DHH and contains the forms required for initial hospice licensure. The fee for this packet is set by DHH). The address provided on the application must be the address from which the agency will be operating;.
b. current licensing fee by certified check, company check, or money order. Refer to the Fees section of this manual for information on fees;
c. line of credit from a federally insured, licensed lending agency for at least $50,000 as proof of adequate finances to sustain the hospice agency for at least six months;
d. proof of general and professional liability insurance, and worker's compensation of at least $300,000. The certificate holder shall be The Department of Health and Hospitals
e. documentation of qualifications for administrator, director of nursing, and medical director. Any changes in the individuals designated or in their qualifications must be submitted to and approved by DHH prior to the initial survey;.
f. disclosure of any financial and/or familial relationship with any other entity receiving third party payor funds, or any entity which has previously been licensed in Louisiana;
g. proof of criminal background inves-

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Core Services
§ 418.64 Condition of participation: Core services.
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.
(a) Standard: 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 requirement by either providing the services directly or through coordinating patient care with the attending physician.
(3) If the attending physician is

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license for a hospice program shall not be issued if the hospice is to be located in an area in violation of any local zoning ordinance or regulation

101.43 **Non-Core Services** – Services provided directly by hospice employees or under arrangement that are not considered Core Services. These services include, but are not limited to:
a. Hospice aide and homemaker
b. Physical therapy services
c. Occupational therapy services
d. Speech-language pathology services
e. General inpatient care
f. Respite care
g. Medical supplies and appliances including drugs and biologicals.

101.48 **Parent Office** – The primary location or site from which a hospice agency provides services within a Geographic Service Area. The Parent Office is used to determine the base of the Geographic Service Area.

101.61 **Terminally Ill**- A medical prognosis of limited expected survival of approximately six months or less, if the disease follows its normal course, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone is no longer appropriate.

PART II CLASSIFICATION OF HOSPICE
103 CLASSIFICATION
103.01 For the purpose of these rules, regulations, and minimum standards, hospice shall be classified as:
1. Freestanding Hospice
2. Hospital Hospice
3. Nursing Home Hospice
4. Home Health Agency Hospice

103.02 **Hospice Core Service**
To be classified as a Hospice these core services shall be provided but need not be limited to the following:

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tigations on the administrator and all owners. If a corporation, submit proof of criminal background investigations on all Board of Directors and principal owners; F. Denial of Initial Licensure. An applicant may be denied a license for the following reasons:
1. failure to comply with applicable federal, state, and local laws;
2. failure to complete the application process;
3. conviction of a felony by an owner, administrator, or director of nursing, as shown by a certified copy of the record of the court, of the conviction of the above individual; or if the applicant is a firm or corporation, conviction of any of its members or officers, or of the person(s) designated to manage or supervise the Hospice agency.

§8205. Survey
A. Initial Survey. An initial on-site survey will be conducted to assure compliance with all hospice minimum standards.
1. Within 90 days after submitting its application and fee, the hospice must complete the application process, must become operational to the extent of providing care to two and only two patients, must be in substantial compliance with applicable federal, state, and local laws, and must be prepared for the initial survey. If the applicant fails to meet this deadline, the application shall be considered closed and the agency shall be required to submit a new application packet including the license application fee.
2. The initial survey will be scheduled after the agency notifies the department that the agency has become operational and is ready for the survey as provided in §8205A(1). In cases of a vast number of requests for surveys by different applicants, agencies will be surveyed according to the date the request is received by DHH.

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unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.
(b) Standard: 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) Highly 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.
(c) Standard: 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.
(d) Standard: 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:
(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.
(ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1

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1. Physician Service
2. Nursing Service
3. Medical Social Service
4. Pastoral/Counseling Services

103.03 **Inpatient Hospice**
To be classified as an Inpatient Hospice that provides inpatient care, the core services (physician, nursing, medical, social and counseling) shall be provided on the premises. Inpatient Hospice must have a registered nurse on duty seven days a week, twenty four hours a day to provide direct patient care. Other members and types of personnel sufficient to meet the total needs of the patient shall be provided.

PART III LICENSING
It shall be unlawful to operate or maintain a hospice without first obtaining a license from the department. The Mississippi State Department of Health is the licensing authority for hospice in the State of Mississippi.

104 TYPES OF LICENSES
104.01 **Regular License** – A license shall be issued to each hospice that meets the requirements as set forth in these regulations. The license shall show the classification Home Health, Nursing Home, Hospital or Freestanding.

104.02 **Provisional License** – Within its discretion, the Mississippi State Department of Health may issue a provisional license when a temporary condition of non compliance with these regulations exists in one or more particulars. A provisional license shall be issued only if the Department of Health is satisfied that preparations are being made to qualify for a regular license and that the health and safety of patients will not be endangered. One condition on which a provisional license may be issued is as follows: A new hospice agency may be issued a provisional license prior to opening and

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3. If, at the initial licensure survey, the agency is in substantial compliance with all regulations, a Full license will be issued.
4. If, at the initial licensure survey, an agency has five or fewer violations of hospice minimum standards in an area other than personnel qualifications and/or patient care, the agency shall submit an acceptable plan of correction within ten (10) days from receipt of the Statement of Deficiencies. A follow-up survey may be conducted to assure compliance.
5. If, at the initial licensure survey, an agency has more than five violations of any minimum standards or if the violations are determined to be of such a serious nature that they may cause or have the potential to cause actual harm, DHH shall deny licensure and the agency may not re-apply for a period of two years from the date of the survey.

B. Annual Licensing Survey. An unannounced annual on-site visit, or any other survey, which may include home visits, will be conducted to assure compliance with all applicable federal, state, and local laws and/or any other requirements.

C. Follow-up Survey. An on-site follow-up may be conducted whenever necessary to assure correction of violations. When applicable, DHH may clear violations at exit interview and/or by mail.

§8207. Revocation or Denial of Renewal of License
A. If an agency's license, whether full or provisional, is revoked, or denied renewal, subsequently no other hospice license application may be approved by DHH for two years from date of termination.
B. The Secretary of DHH may deny an application for a license, or refuse to renew a license or revoke a license in accordance with LA R.S. 40:2187-

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year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.
(iii) Ensure that bereavement services reflect the needs of the bereaved.
(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(c).
(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.
(3) ***Spiritual counseling.*** The hospice must:
(i) Provide an assessment of the patient's and family's spiritual needs.
(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.
(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.
(iv) Advise the patient and family of this service.

Non-Core Services
§ 418.70 Condition of participation: Furnishing of non-core services.
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.

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subsequent to meeting the required minimum staffing personnel. The license issued under this condition shall be valid until the issuance of a regular license or June 30 following date of issuance whichever may be sooner. A provisional license may be reissued only if it is satisfactorily proven to the Department of Health that efforts are being made to fully comply with these regulations by a specified time. A hospice program against which a revocation or suspension proceeding is pending at the time of licensure renewal may be issued a conditional license effective until final disposition by the department of such proceedings. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional permit for the duration of the judicial proceeding.

105 APPLICATION FOR LICENSE
105.01 A Hospice shall not be operated in Mississippi without a valid license from Mississippi State Department of Health.
105.02 Any person or organization desiring to operate a hospice shall file with the Department of Health:
(a) Application on a form prescribed and furnished by the Department of Health; and
(b) Fees as applicable per State law
105.03 The application shall include complete information concerning the address of the applicant; the ownership of the hospice; if organized as a corporation, the names and addresses of each officer and director of the corporation; if organized as a partnership, the names and addresses of each partner; membership of the governing body; the identities of the medical director and administrator; and any other relevant information which the Mississippi State Department of Health may require.
105.04 Ownership of the hospice shall be fully disclosed in the application. This disclosure shall include names and addresses of all corporate officers and

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2188. An agency's license may not be renewed and/or may be revoked for any of the following:
1. failure to be in substantial compliance with hospice minimum standards;
2. failure to provide services essential to the palliative care of terminally ill individuals;
3. failure to uphold patient rights whereby violations may result in harm or injury;
4. failure of agency to protect patients/persons in the community from harmful actions of the agency employees; including, but not limited to, health and safety, coercion, threat, intimidation, and harassment;
5. failure to notify proper authorities of all suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause harm to the patient;
6. failure to maintain staff adequate to provide necessary services to current active patients;
7. failure to employ qualified personnel;
8. failure to remain fully operational at any time for any reason other than a disaster;
9. failure to submit fees including, but not limited to, annual fee, renewal fee, provisional follow-up fee, or change of agency address or name, or any fines assessed by DHH;
10. failure to allow entry to hospice agency or access to any requested records during any survey;
11. failure to protect patient from unsafe skilled and/or unskilled care by any person employed by the agency;
12. failure of agency to correct violations after being issued a provisional license;
13. agency staff or owner has knowingly, or with reason to know, made a false statement of a material fact in:
a. application for licensure;
b. data forms;
c. clinical record;

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§ 418.72 Condition of participation: Physical therapy, occupational therapy, and speech-language pathology. 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.

§ 418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients. 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.

(a) Standard: 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.
(b) Standard: Laboratory services.
(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 be in compliance with all applicable requirements of part 493 of this chapter.
(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.

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any person(s) having a five percent (5%) financial interest.
105.05 A license shall be issued to the person(s) named only for the premises listed on the application for licensure. Separate applications and licenses are required for hospices maintained separately, even if they are owned or operated by the same person(s), business or corporation, and may be doing business under the same trade name. With the exception of existing hospices with in-patient hospice units licensed as such prior to the effective date of these regulations, no hospices shall establish a branch/satellite facility outside a 50 mile radius from the Parent facility. All existing satellite branch offices, not connected to such licensed in-patient units shall seek application and separate licensure prior to July 01, 2009.

105.06 Licenses are not transferable or assignable.
105.07 Each planned change of ownership or lease shall be reported to the Department at least thirty (30) days prior to such change along with an application from the proposed new owners/lessees for a new license.
105.08 The application is considered a continuing application. A written amendment to the current application shall be filed when there is a change in any of the information reported in the application.
105.09 Fees: Prior to review for an initial license and prior to license renewal, the facility shall submit fees as established under Section 41-85-7 (1), (b), (c), Mississippi Code of 1972.

105.10 **Operational Requirements/Conditions of Operation** – In order for a hospice program to be considered operational, the program must:
a. Have admitted at least ten patients since the last annual survey;

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d. matter under investigation by the department;
e. information submitted for reimbursement from any payment source;
f. the use of false, fraudulent or misleading advertising;
g. that the agency staff misrepresented or was fraudulent in conducting hospice business;
h. convictions of a felony by an owner, administrator, director of nursing or medical director as shown by a certified copy of the record of the court of conviction of the above individual; or if the applicant is a firm or corporation, of any of its members or officers, or of the person designated to manage or supervise the hospice agency;
14. failure to maintain proper insurance; and
15. failure to comply with all reporting requirements in a timely manner.

§8209. License Renewal Process
A. License must be renewed at least annually.
B. Renewal packet includes forms required for renewal of license.
C. An agency seeking a renewal of its hospice license Shall:
1. request a renewal packet from the bureau if one is not received at least 45 days prior to license expiration;
2. complete all forms and return to bureau at least 30 days prior to license expiration;
3. submit the current annual licensure fees with packet.
An application is not considered to have been submitted unless the licensure fees are received.

§8211. Notice and Appeal Procedure
A. Notice shall be given in accordance with the current State Statutes.
B. Administrative Reconsideration. The hospice agency may request an administrative reconsideration of the violation(s) which support the department's actions. This reconsideration shall be conducted by a designated official(s) of

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b. Be able to accept referrals at any time;
c. Have adequate staff to meet the needs of their current patients;
d. Have required designated staff on the premises at all times during business hours;
e. Be immediately available by telecommunications 24 hours per day. A registered nurse must answer calls from patients and other medical personnel after hours;
f. Be open for business of providing hospice services to those who need assistance.

105.11 **License Renewal Process**
a. A license issued for the operation of a hospice program, unless sooner suspended or revoked, shall expire automatically on June 30 of each calendar year.
b. Renewal packet includes forms required for renewal of license.
c. An agency seeking a renewal of its hospice license shall:
1. Request a renewal packet from the bureau if one is not received at least 45 days prior to license expiration;
2. Complete all forms and return to bureau at least 30 days prior to license expiration;
3. Submit the current annual licensure fees with packet. An application is not considered to have been submitted unless the licensure fees are received.
105.12 **Notification of Changes**
Mississippi State Department of Health shall be notified, in writing, of any of the following within five working days following the occurrence:
a. Address/location (An Inpatient Hospice facility must notify and receive approval by Mississippi State Department of Health prior to a change of address/location);
b. Agency name;
c. Phone number;
d. Hours of operation/24 hour contact procedure;

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the department who did not participate in the initial decision to impose the actions taken. Reconsideration shall be made solely on the basis of documents before the official and shall include the survey report and statement of violations and all documentation the agency submits to the department at the time of the agency's request for reconsideration. Correction of a violation shall not be a basis for reconsideration. A hearing shall not be held. Oral presentations can be made by the department's spokesperson(s) and the agency's spokesperson(s). This process is not in lieu of the appeals process and does not extend the time limits for filing an administrative appeal. The designated official shall have authority only to affirm the decision, to revoke the decision, to affirm part and revoke part, or to request additional information from either the department or the agency.

C. Administrative Appeal Process. Upon refusal of the DHH to grant a license as provided in the current State Statutes, or upon revocation or suspension of a license, or the imposition of a fine, the agency, institution, corporation, person, or other group affected by such action shall have the right to appeal such action by submitting a written request to the Secretary of the Department within thirty (30) days after receipt of the notification of the refusal, revocation, suspension of a license, or imposition of a fine.

§8213. Fees

A. Any remittance submitted to DHH in payment of a required fee must be in the form of a company or certified check or money order made payable to the Department of Health and Hospitals.

B. Fee amounts are determined by DHH. (Check with DHH to determine the current required fees.)

C. Fees paid to DHH are not refundable.

D. A licensing fee is required for:

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e. Change in address or phone number of any branch office;

f. Administrator;

g. Director of nursing; and

h. Cessation of business.

105.13 **Name of Institution** – Every hospice shall be designated by a permanent and distinctive name which shall be used in applying for a license and shall not be changed without first notifying the licensing agency in writing and receiving written approval of the change from the licensing agency. Such notice shall specify the name to be discontinued as well as the new name proposed. Only the official name by which the institution is licensed shall be used in telephone listing, on stationery, in advertising, etc. Two or more facilities shall not be licensed under similar names in the same vicinity.

105.14 **Number of Beds** – Each application for license shall specify the maximum number of inpatient beds in the hospice as determined by these regulations. The maximum number of inpatient beds for which the facility is licensed shall not be exceeded.

105.15 A license for a hospice program shall not be issued if the hospice is to be located in an area in violation of any local zoning ordinances or regulations.

105.16 Following inspection and evidence of compliance with these regulations, the Mississippi State Department of Health may issue a license. Only licensed hospices shall be authorized to use the name “hospice.”

105.17 A license shall be displayed in a prominent place in the hospice’s administrative offices.

105.18 **Inspections**

1. Observation and examination of the hospice operation shall be available at all reasonable hours to properly identified representatives of the Department.
2. The Department shall conduct inspections of all Parent and Branch units annually.

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1. an initial application;
2. a renewal;
3. a change of controlling ownership.

E. Additional licensure fees are required for inpatient hospice facilities.

§8215. Changes

A. DHH shall be notified, in writing, of any of the following within five working days following the occurrence:

1. address/location (An Inpatient Hospice facility must notify and receive approval by DHH prior to a change of address/location) - fee required;
2. agency name - fee required;
3. phone number;
4. hours of operation/24 hour contact procedure;
5. ownership (Controlling) - fee required;
6. change in address or phone number of any branch office;
7. administrator (completed Key Personnel Change Form, obtained from DHH, is required); and
8. director of nursing (completed Key Personnel Change Form required);
9. cessation of business. (See §8245.)

B. Change of Ownership. A representative of the buyer must request approval for a change of ownership prior to the sale.

1. Submit a written request to DHH for written approval to undergo a Change of Ownership. Change of Ownership (CHOW) Packets may be obtained from DHH. If the hospice had less than two active patients at the time of the most recent survey, and less than twenty new patients admitted since the last annual survey, the department may have issued a provisional license. Only an agency with a full license shall be approved to undergo a change of ownership.
2. Submit the following with the request for CHOW:

a. a new license application and the current licensing fee. The purchaser of the agency must meet all criteria

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3. Hospice inspections shall include personal contacts with recipients of the hospice service.

105.19 **Change of Ownership**

Should a hospice program/facility wish to undergo a change of ownership, the facility must:

1. Submit a written request to Mississippi State Department of Health to obtain a Change of Ownership (CHOW) Package.
2. Submit the following with the request for CHOW within five (5) working days after the act of sale:

a. A new license application and the current licensing fee. The purchaser of the agency must meet all criteria required for initial licensure for hospice;

b. Any changes in the name and or address of the agency;

c. Any changes in administrative personnel;

d. Copy of the Bill of Sale and/or legal document reflecting change;

e. Copy of Articles of Incorporation.

106 DENIAL, SUSPENSION, OR REVOCATION OF LICENSE

106.01 **Denial or Revocation of License: Hearing and Review** –

The licensing agency is authorized to deny, suspend, or revoke a license. Any of the following actions shall be grounds for action by the department against a hospice program.

1. A violation of the provisions of the Mississippi Hospice Law of 1995 or any standard or rule of these regulations, including but not limited to, in any case the Department finds that there has been substantial failure to comply with
the requirements established under the law and these regulations. These are inclusive of the following:

a. Fraud on the part of the licensee in applying for license.

b. Willful or repeated violations by the licensee of any of the provisions of the Mississippi Law of 1995,

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required for initial licensure for hospice;
b. any changes in the name and or address of the agency;
c. any changes in administrative personnel;
d. disclosure of ownership forms.
3. Within five working days after the act of sale, submit a copy of the Bill of Sale and Articles of Incorporation.

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as amended, and /or of the rules, regulations, and minimum standards established by the Department of Health.
c. Addiction to narcotic drug(s) by the licensee or the management staff of the hospice.
d. Use of alcoholic beverages by the licensee or other personnel of the hospice to the extent which threatens the well being or safety of the patient or resident.
e. Conviction of the licensee of a felony.
f. Publicly misrepresenting the hospice and/or its services.
g. Permitting, aiding, and abetting the commission of any unlawful act.
h. Misappropriation of the money or property of a patient or resident.
2. An intentional or negligent act materially affecting the health and safety of a patient. These acts include but are not necessarily limited to:
a. Cruelty to patient or resident or indifference to their needs which are essential to their general well-being and health.
b. Failure to provide food adequate for the needs of the patient or resident, when residing in an inpatient facility.
c. Inadequate staff to provide safe care and supervision of patient or resident.
d. Failure to call a physician when required by patient's or resident's condition.
e. Failure to notify next of kin or designated individual when patient's or resident's conditions become critical.
f. Failure to provide appropriate level of care.
3. If, three (3) months after the date of obtaining a license, or at any time thereafter, a hospice does not have in operation the home-care component of hospice care, the department shall immediately revoke the license of such hospice.
4. If, twelve (12) months after the date of obtaining a license, or at any time thereafter, a hospice does not have in operation the outpatient and homelike

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Subchapter B. Organization and Staffing
§8217. Personnel Qualifications/Responsibilities

A. Administrator. A person who is designated, in writing, by the Governing Body as administratively responsible for all aspects of hospice operations. When the administrator serves more than one licensed agency, he/she shall designate, in writing, an alternate to serve as administrator for each site where he/she is not physically housed continuously. The alternate shall be a full-time, on-site employee of the hospice and shall meet the same qualifications as the administrator. The administrator and the Director of Nurses/ Alternates may be the same individual if that individual is dually qualified. NOTE: A Director of Nurses, while employed by the hospice, may not be employed by any other licensed health care agency.
1. Qualifications. The administrator must be a licensed physician, a licensed registered nurse, a social worker with a masters degree, or a college graduate with a bachelor's degree, and must have at least three years of documented management experience in health care service delivery. However, a person who was employed by a licensed Louisiana hospice as the administrator as of December 20, 1998 shall be exempt from these requirements as long as he/she remains employed by that hospice as the administrator. If the hospice is sold to, acquired by, or merged into another legal entity, such transaction shall have no effect on the exemption provided in the preceding sentence.
2. Responsibilities. The Administrator shall be responsible for compliance with all regulations, laws, policies

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Subpart D--Conditions of Participation: Organizational Environment
§ 418.100 Condition of Participation: Organization and administration of services.
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.
(a) Standard: Serving the hospice patient and family.
The hospice must provide hospice care that—
(1) Optimizes comfort and dignity; and
(2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.
(b) Standard: 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 the hospice's governing body.
(c) Standard: 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:
(i) Nursing services.
(ii) Medical social services.
(iii) Physician services.
(iv) Counseling services, including

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inpatient components of hospice care, the department shall immediately revoke the license of such hospice

PART IV ADMINISTRATION
109 ADMINISTRATION
109.01 **Governing Body** – A hospice shall have a governing body (See Definition) that assumes full legal responsibility for compliance with these regulations and for setting policy, appointing persons to carry out such policies, and monitoring the hospice's total operation.

109.03 **Administrator** – A person shall be designated by the governing body or its designee to be responsible for the management of the hospice program in matters of overall operation. This person may be a member of the hospice care team.

109.04 **Advertising** – If a hospice advertises its services, such advertisement shall be factual and not contain any element which might be considered coercive or misleading. Any written advertising describing services offered by the hospice shall contain notification that services are available regardless of ability to pay.

109.05 **Annual Budget**
1. The annual budget shall include income plus expenses related to overall cost of the program.
2. The overall plan and budget shall be reviewed and updated at least annually by the governing body.
3. The annual budget should reflect a comparative analysis of the cost savings of the volunteers.

PART V POLICIES AND PROCEDURES
110 GENERAL
110.01 The hospice shall maintain operational policies and procedures, which shall be kept current.
110.02 Such policies and procedures

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and procedures applicable to hospice specifically and to Medicare/Medicaid issues when applicable:
a. ensure the hospice employs qualified individuals;
b. be on-site during business hours or immediately available by telecommunications when off-site conducting the business of the hospice, and available after hours as needed;
c. be responsible for and direct the day-to-day operations of the hospice;
d. act as liaison among staff, patients, and governing board;
e. ensure that all services are correctly billed to the proper payer source;
f. designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the hospice if the administrator is unavailable; and
g. designate in advance the IDG he/she chooses to establish policies governing the day-to-day provisions of hospice care.

Proposed Changes:
A. Administrator. A person who is designated, in writing, by the Governing Body as administratively responsible for all aspects of hospice operations. The Administrator may not serve more than 2 licensed agencies. When the administrator serves more than one licensed agency, he/she shall designate, in writing, an alternate to serve as administrator for each site where he/she is not physically housed continuously. The alternate shall be a full-time, on-site employee of the hospice and shall meet the same qualifications as the administrator. The administrator and the Director of Nurses/Alternates may be the same individual if that individual is dually qualified. NOTE: A Director of Nurses, while employed by the hospice, may not be employed by any other licensed health care agency.

1. Qualifications. The administrator must be a licensed physician, a licensed

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spiritual counseling, dietary counseling, and bereavement counseling.
(v) Hospice aide, volunteer, and homemaker services.
(vi) Physical therapy, occupational therapy, and speech-language pathology services.
(vii) Short-term inpatient care.
(viii) Medical supplies (including drugs and biologicals) and medical appliances.
(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.
(d) Standard: 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.
(e) Standard: 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. 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) Standard: Hospice multiple locations.
If a hospice operates multiple locations, it must meet the following requirements:
(1) Medicare approval.
(i) All hospice multiple locations must be approved by Medicare before providing hospice care and services to

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shall accurately reflect a description of the hospice's goals, methods by which these goals are sought, and mechanisms by which the basic hospice care services are delivered.
110.03 Policies and procedures shall be available to hospice team members, patients and their families/primary care person, potential applicants for hospice care, and the Department.
111 PERSONNEL POLICIES
111.01 **Personnel Policies** – Each licensed hospice agency shall adopt and enforce personnel policies applicable and available to all full and part time employees. These policies shall include but not be limited to the following:
1. Fringe benefits, hours of work and leave time;
2. Requirements for initial and periodic health examinations;
3. Orientation to the hospice and appropriate continuing education;
4. Job descriptions for all positions utilized by the agency;
5. Annual performance evaluations for all employees;
6. Compliance with all applicable requirements of the Civil Rights Act of 1964;
7. Provision for confidentiality of personnel records.

111.02 **Personnel Records** – Each licensed hospice shall maintain complete personnel records for all employees on file at each licensed site. Personnel records for all employees shall include and application for employment including name and address of the employee, social security number, date of birth, name and address of next of kin, evidence of qualifications, (including reference checks), current licensure and/or registration (if applicable), performance evaluation, evidence of health screening, evidence of orientation, and a contract (if applicable), date of employment and separation from the hospice and the reason for separation. A

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registered nurse, a social worker with a masters degree, or a college graduate with a bachelor's degree. Each shall have at least three years of documented management experience in health care service delivery. However, a person who was employed by a licensed Louisiana hospice as the administrator as of December 20, 1998 shall be exempt from these requirements as long as he/she remains employed by that hospice as the administrator. If the hospice is sold to, acquired by, or merged into another legal entity, such transaction shall have no effect on the exemption provided in the preceding sentence.
2. Responsibilities. The Administrator shall be responsible for compliance with all regulations, laws, policies and procedures applicable to hospice specifically and to Medicare/Medicaid issues when applicable:
a. ensure the hospice employs qualified individuals;
b. be on-site during business hours or immediately available by telecommunications when off-site conducting the business of the hospice, and available after hours as needed;
c. be responsible for and direct the day-to-day operations of the hospice;
d. act as liaison among staff, patients, and governing board;
e. ensure that all services are correctly billed to the proper payer source;
f. designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the hospice if the administrator is unavailable; and
g. designate in advance the IDT he/she chooses to establish policies governing the day-to-day provisions of hospice care.

F. Governing Body
1. The hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the

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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.
(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.
(iv) The determination that a multiple location does or does not meet the definition of a multiple location, as set forth in this part, is an initial determination, as set forth in § 498.3.
(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 to 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.
(g) Standard: Training.
(1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact.
(2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.
(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 inservice training provided during the previous 12 months

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Hospice that provides other services under arrangement through a contractual purchase of services shall ensure that these services are provided by qualified personnel; currently licensed and/or registered if applicable, and are under the supervision of the agency.

111.03 **Criminal History Record Checks**
1. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require to be performed a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary action has been taken against the employee by the agency, and a criminal history record check on:
a. Every new employee of a covered entity who provides direct patient care or services and who is employed after or on July 01, 2003.
b. Every employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer.
2. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history check have revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check by any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check. 3. If such criminal history record check discloses a felony conviction; a guilty plea; and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which has not been reversed on appeal, or for which a par-

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hospice's total operation.
2. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.
3. The governing body shall:
a. designate an individual who is responsible for the day to day management of the hospice program;
b. ensure that all services provided are consistent with accepted standards of practice;
c. develop and approve policies and procedures which define and describe the scope of services offered;
d. review policies and procedures at least annually and revise them as necessary; and
e. maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

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§ 418.114 Condition of participation: Personnel qualifications.
(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.

(b) Personnel qualifications for certain disciplines.
The following qualifications must be met:
(1) ***Physician.*** Physicians must meet the qualifications and conditions as defined in section 1861(r) of the Act and implemented at § 410.20 of this chapter.
(2) ***Hospice aide.*** Hospice aides must meet the qualifications required by section 1891(a)(3) of the Act and implemented at § 418.76.
(3) ***Social worker.*** A person who—
(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
(B) Has a 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
(ii) Has 1 year of social work experience in a healthcare setting; or
(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

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don has not been granted, the applicant/employee shall not be eligible to be employed at the licensed facility:
a. Possession or sale of drugs
b. Murder
c. Manslaughter
d. Armed robbery
e. Rape
f. Sexual battery
g. Sex offense listed in Section 45-33-23, Mississippi Code of 1972
h. Child abuse
i. Arson
j. Grand larceny
k. Burglary
l. Gratification of lust
m. Aggravated assault
n. Felonious abuse and/or battery of vulnerable adult
4. Documentation of verification of the employee's disciplinary status, if any, with the employee's professional licensing agency as applicable, and evidence of submission of the employee's fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of verification of the
employee's disciplinary status from any applicable professional licensing agency and submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual's suitability for such employment.
5. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require every employee of a licensed facility employed prior to July 01, 2003, to sign an affidavit stating that he or she does not have a criminal history as outlined in paragraph (c) above.
6. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed the affidavit

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	to be supervised by an MSW. (4) ***Speech language pathologist.*** A person who meets either of the following requirements: (i) The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association. (ii) The educational requirements for certification and is in the process of accumulating the supervised experience required for certification. (5) ***Occupational therapist.*** A person who— (i) (A) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply; (B) 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 (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). (ii) On or before December 31, 2009— (A) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing; or (B) When licensure or other regulation does not apply— (1) Graduated after successful completion of an occupational therapist education program	required by this section. The covered entity shall place the affidavit in the employee's personnel file as proof of compliance with this section. 7. If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or plea has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility's policies and procedures. 8. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (g) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the licensed entity's hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The **covered entity**, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility. 9. The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars ($50.00). 10. Should results of an employee

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accredited by the accreditation Council for Occupational therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and
(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).
(iii) On or before January 1, 2008—
(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
(B) Is eligible for the National Registration Examination of
the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.
(iv) On or before December 31, 1977—
(A) Had 2 years of appropriate experience as an occupational therapist; and
(B) Had achieved a satisfactory grade on an occupational
therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
(v) If educated outside the United States—
(A) Must meet both of the following:
(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:
(i) The Accreditation Council for Occupational Therapy Education (ACOTE).
(ii) Successor organizations of ACOTE.

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applicant's criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying, event provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant's suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi Department of Health without the necessity of an additional criminal record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant's criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history record check as required in this subsection.
11. For individuals contracted through a third party who provide direct patient care as defined herein, the covered entity shall require proof of a criminal history record check.
12. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency, the covered entity, and their agents, officers, employees, attorneys and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this section. The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment discrimination suit in which an allegation of discrimination is made regarding an employment decision authorized under this section.

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(iii) The World Federation of Occupational Therapists.
(iv) A credentialing body approved by the American Occupational Therapy Association.
(v) Successfully completed the entry level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).
(2) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing.
(6) ***Occupational therapy assistant.*** A person who
(i) Meets all of the following:
(A) Is licensed or otherwise regulated, if applicable, as an occupational therapy assistant by the State in which practicing, unless licensure does apply.
(B) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations.
(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).
(ii) On or before December 31, 2009—
(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
(B) Must meet both of the following:
(1) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy

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111.04 **Employee Health Screening** – Every employee of a hospice who comes in contact with patients shall receive a health screening by a licensed physician, nurse practitioner or employee health nurse who conduct exams prior to employment and annually thereafter. The employee health screening shall include, but not be limited to, tuberculosis screening.
111.05 **Staffing Schedule** – Each hospice and alternate site shall maintain on site current staffing patterns for all health care personnel including full-time, part-time, contract staff and staff under arrangement. The staffing pattern shall be developed at least one week in advance, updated daily as needed, and kept on file for a period of one year. The staffing pattern shall indicate the following for each working day:
1. Name and position of each staff member.
2. Patients to be visited.
3. Scheduled on call after office hours.

112 CONTRACT SERVICES

112.01 **Contract Services** – Contract services may be provided when necessary to supplement hospice employees in order to meet the needs of patients during peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial and administrative responsibility for the services. The hospice must assure that the personnel contracted are legally and professionally qualified to perform the services.

112.02 The hospice must assure that contracted staff are providing care that is consistent with the Hospice philosophy and the patient's plan of care.

113 ORGANIZATION AND STAFFING PERSONNEL QUALIFICATIONS/RESPONSIBILITIES

113.01 **Administrator** – A person who is designated, in writing, by the

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Association.
(2) After January 1, 2010, meets the requirements in paragraph (b)(6)(i) of this section.
(iii) After December 31, 1977 and on or before December 31, 2007—
(A) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association; or
(B) Completed the requirements to practice as an occupational therapy assistant applicable in the State in which practicing.
(iv) On or before December 31, 1977—
(A) Had 2 years of appropriate experience as an occupational therapy assistant; and
(B) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
(v) If educated outside the United States, on or after January 1, 2008—
(A) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by—
(1) The Accreditation Council for Occupational Therapy Education (ACOTE).
(2) Its successor organizations.
(3) The World Federation of Occupational Therapists.
(4) By a credentialing body approved by the American Occupational Therapy Association; And
(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).
(7) ***Physical therapist.*** A person who is

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Governing Body as administratively responsible for all aspects of hospice operations. When the administrator serves more than one licensed agency, he/she shall designate, in writing, an alternate to serve as administrator for each site where he/she is not physically housed continuously. The alternate shall be a full-time, on-site employee of the hospice and shall meet the same qualifications as the administrator. The administrator and the Director of Nurses/Alternates may be the same individual if that individual is dually qualified.
1. Qualifications – Licensed physician, a licensed registered nurse, a social worker with a Bachelor's degree, or a college graduate with a bachelor's degree and two (2) years of health care management experience or an individual with one (1) year of healthcare management experience and three (3) years of healthcare service delivery experience that would be relevant to managing the day-to-day operations of a hospice. EXEMPTION: Any person who is employed by a licensed Mississippi hospice as the administrator, as of the effective date of these regulations, shall be exempt from these requirements as long as he/she remains employed by that hospice as the administrator. If the hospice is sold to, acquired by, or merged into another legal entity, such transaction shall have no effect on the exemption provided in the preceding sentence.
2. Responsibilities – The administrator shall be responsible for compliance with all regulations, laws, policies and procedures applicable to hospice specifically and to Medicare/Medicaid issues when applicable:
a. Ensure the hospice employs qualified individuals;
b. Be on-site during business hours or immediately available by telecommunications when working within the geographic service area.
c. Be responsible for and direct the

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licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:
(A) Graduated after successful completion of a physical therapist education program approved by one of the following:
(B) The Commission on Accreditation in Physical Therapy Education (CAPTE).
(C) Successor organizations of CAPTE.
(D) An education program outside the United States 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 an organization identified in 8 CFR 212.15(e) as it relates to physical therapists.
(E) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.
(i) On or before December 31, 2009—
(A) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE);
or
(B) Meets both of the following:
(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.
(2) Passed an examination for physical therapists
approved by the State in which physical therapy services are provided.
(ii) Before January 1, 2008—
(A) Graduated from a physical therapy curriculum approved by one of the fol-

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day-to-day operations of the hospice;
d. Act as liaison among staff, patients, and governing board;
e Designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the hospice if the administrator is unavailable; and
f Designate in advance the IDT he/she chooses to establish policies governing the day-to-day provisions of hospice care.

113.06 **Governing Body**
1. The hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation.
2. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.
3. The governing body shall:
a. Designate an individual who is responsible for the day to day management of the hospice program;
b. Ensure that all services provided are consistent with accepted standards of practice;
c. Develop and approve policies and procedures which define and describe the scope of services offered;
d. Review policies and procedures at least annually revise them as necessary; and
e. Maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

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	lowing: (1) The American Physical Therapy Association. (2) The Committee on Allied Health Education and Accreditation of the American Medical (3) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association. (iii) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following: (A) Has 2 years of appropriate experience as a physical therapist. (B) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service. (iv) Before January 1, 1966— (A) Was admitted to membership by the American Physical Therapy Association; (B) Was admitted to registration by the American Registry of Physical Therapists; and (C) Graduated from a physical therapy curriculum in a 4- year college or university approved by a State department of education. (vi) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy. (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	

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	World Confederation for Physical Therapy. (8) ***Physical therapist assistant.*** 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	

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	Service. (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: (1) Registered nurse. A graduate of a school of professional nursing. (2) Licensed practical nurse. A person who has completed a practical nursing program. (d) ***Standard: Criminal background checks.*** (1) The hospice must obtain a criminal background check on all hospice employees who have 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. (2) 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	
Subchapter C. Patient Care Services **§8225. Pathology and Laboratory Services** Hospice provides or has access to pathology and laboratory services which comply with CLIA guidelines; and meet patient's needs. **§8227. Radiology Services** Radiology services provided by hospice either directly; or under arrangements that must comply with Federal and State regulations.	**§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment.** 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.	**114 PATIENT CARE SERVICES** 114.06 **Pathology and Laboratory Services** The hospice must provide or have access to pathology and laboratory services which comply with CLIA guidelines and that meets the patient's plan of care. 114.07 **Radiology Services** The hospice must provide radiology services in accordance with the patient's plan of care.
Subchapter D. Administration **§8235. Agency Operations** A. Premises (see definition of Hospice Premises). 1. Staff must be able to distinguish and	**§ 418.108 Condition of participation: Short-term inpatient care.** Inpatient care must be available for pain control, symptom management, and respite purposes, and must be pro-	**115 ADMINISTRATION** 115.01 **Agency Operations** 1. The hospice must have adequate space and resources for all operational and patient care needs.

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describe the scope and delineation of all activities being provided by the hospice.
2. Staff working areas are to be designed so that when planning for services, patient confidentiality is maintained.
3. The hospice must have a distinct telephone number. If the telephone number is shared with other health care related agencies, the telephone operator(s) must demonstrate knowledge and ability to distinguish and direct calls to the appropriate persons. If an answering service is used after normal hours, there must be evidence of distinct hospice staff and the answering service should be able to direct calls to the appropriate persons for each service.
4. The hospice shall not share office space with a non-health care related entity. When office space is shared with another health care related entity the hospice agency must operate separate and apart.

B. Hours of Operation
1. The hospice shall be required to have regular posted (in a prominent and easily accessible manner) business hours and be fully operational at least eight hours a day, five days a week between 7:00 a.m. and 6:00 p.m. Hospice services are available 24 hours per day, seven days a week, which include, at a minimum:
a. professional Registered Nurse services;
b. palliative medications;
c. other services, equipment or supplies necessary to meet the patient's immediate needs.
2. Hospice provides on-call medical and nursing services to assess and meet changing patient/family needs, provide instruction and support, and conduct additional on-site assessment or treatment, 24 hours a day, seven days per week.

C. Policies and Procedures:

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vided in a participating Medicare or Medicaid facility.
(a) Standard: Inpatient care for symptom management and pain control. Inpatient care for pain control and symptom management must be provided in one of the following:
(1) A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in § 418.110.
(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.
(b) Standard: Inpatient care for respite purposes.
(1) Inpatient care for respite purposes must be provided by one of the following:
(i) A provider specified in paragraph (a) of this section.
(ii) A Medicare or Medicaid-certified nursing facility that also meets the standards specified in § 418.110(f).
(2) The facility providing respite care 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.
(c) Standard: 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—
(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;
(2) That the inpatient provider has established patient care policies consistent with those of the hospice and

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2. The hospice shall not share office space with a non-healthcare related entity.

115.02 **Hours of Operation**
1. The hospice shall be required to have regular posted (in a prominent and easily accessible manner) business hours and be fully operational at least eight hours a day, five days a week between 7:00 a.m. and 6:00 p.m. Hospice services shall be available 24 hours per day, seven days a week, which include, at a minimum:
a. Professional registered nurse services;
b. Palliative medications;
c. Other services, equipment or supplies necessary to meet the patient's immediate needs.
2. Hospice provides on-call medical and nursing services to assess and meet changing patient/family needs, provide instruction and support, and conduct additional on-site assessment or treatment, 24 hours a day, seven days per week.

115.03 **Policies and Procedures**
1. Must be written, current, and reviewed annually by appropriate personnel.
2. Must contain policies and procedures specific to the agency addressing personnel standards and qualifications, agency operations, patient care standards, problem and complaint resolution, purpose and goals of operation, management/operation of the hospice's defined service area and a formal disaster preparedness plan as referenced in Section 142.

115.04 **Contract Services**
1. When the hospice provides services on a contractual basis
to a patient the hospice is responsible for all actions of the contract personnel.
2. The hospice shall not at any time use contract employees as
administrator/alternate or for the provi-

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1. must be written, current, and annually reviewed by appropriate personnel;
2. must contain policies and procedures specific to agency addressing personnel standards and qualifications, agency operations, patient care standards, problem and complaint resolution, purpose and goals of operation, the hospice's defined service area, as well as regulatory and compliance issues; and
3. must meet or exceed requirements of the Minimum Standards and all applicable federal, state, and local laws.

D. Operational Requirements
1. Hospice's responsibility to the community:
a. shall not accept orders to assess or admit from any source other than licensed physician or authorized physician representative (e.g. hospital discharge planner). Although the hospice may provide care to relatives of employees, the order to admit to the hospice must be initiated by the primary attending physician;
b. shall use only factual information in advertising;
c. shall not participant in door to door solicitation;
d. shall not accept as a patient any person who is not terminally ill;
e. shall develop policy/procedure for patients with no or limited payor source;
f. shall have policy and procedures and a written plan
for emergency operations in case of disaster;
g. provide all services needed in a timely manner, least within 24 hours, unless physicians orders indicate otherwise. However, admission time-frames shall be followed as indicated in the Admission Procedures subsection;
h. is prohibited from harassing or coercing a prospective patient or staff member to use a specific hospice or to change to another hospice;
i. must have policy and procedures for post-mortem

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agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;
(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;
(4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;
(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
(6) A method for verifying that the requirements in paragraphs (c)(1) through (c)(5) of this section are met.
(d) Standard: 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.
(e) Standard: 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.

§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.
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

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sion of core services unless the facility provides documentation that a waiver has been granted in accordance with certification requirements.
3. Whenever services are provided by an organization or individual other than the hospice, a written agreement will delineate services available and procedures for accessing those services.
4. Whenever services are provided by an outside agency or individual, a legally binding written agreement must be effected. The legally binding written agreement shall include at least the following items:
a. Identification of the services to be provided;
b. A stipulation that services may be provided only with the express authorization of the hospice;
c. The manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;
d. The delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment, and the IDT conferences;
e. Requirements for documenting that services are furnished in accordance with the agreement;
f. The qualifications of the personnel providing the services;
g. Assurance that the personnel contracted complete the clinical record in the same timely manner as required by the staff personnel of the hospice;
h. Payment fees and terms; and
i. Statement that the hospice retains responsibility for appropriate hospice care training of the personnel who provide care under the agreement.
5. The hospice shall document review of its contract on an annual basis.
6. The hospice is to coordinate services with contract personnel to assure continuity of patient care.
7. Hospice maintains professional management responsibilities for those services and ensures that they are furnished in a safe and effective manner by qualified persons and in accordance with the

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care in compliance with all applicable federal, state, and local laws;
j. may participate as community educators in community/health fairs; and
k. may provide free non-invasive diagnostic tests, such as blood pressure screening.

2. Hospice's responsibility to the patient shall include but is not limited to, the following:
a. be in compliance with Minimum Standards and applicable federal, state, and local laws at all times;
b. provide all Core services directly by the agency and any non-core services required to meet the patient/family's needs; c. act as the patient advocate in medical affecting the patient;
d. protect the patient from unsafe skilled and unskilled practices;
e. protect the patient from being harassed, bribed, and/or any form of mistreatment by any employee or volunteer of the agency;
f. provide patient information on the patient's rights and responsibilities;
g. provide information on advanced directives in compliance with all applicable federal, state, and local laws;
h. protect and assure that patient's rights are not violated; i. focus on enabling the patient remaining in the familiar surroundings of his/her place of residence as long as possible and appropriate;
j. encourage the patient/family to participate in developing the POC and provision of hospice services;
k. with the permission of the patient, include in the POC specific goals for involving the patient/family;
l. make appropriate referrals for family members outside the hospice's service area for bereavement follow-up;
m. whenever a hospice program manages and/or delivers care in a facility, ensure that an appropriate standard of care is provided to the patient in the facility, regardless of whether or not hospice is responsible for the direct

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additional standards.
(a) Standard: Resident eligibility, election, and duration of benefits. Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at § 418.20 through § 418.30.
(b) Standard: Professional management. The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to § 418.100 and § 418.108.
(c) Standard: Written agreement. 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.
(2) A provision that the SNF/NF or ICF/MR immediately notifies the hospice if—
(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

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patient's POC.

115.06 **Branch Offices**
1. No Branch Office may be opened without written approval from Mississippi State Department of Health.
2. No Branch Office shall be opened unless the parent office has had full licensure for a full twelve(12) months preceding the request and has admitted at least ten (10) patients within the last annual renewal cycle.
3. Each Branch must serve the same or part of the geographic service area approved for the parent.
4. Each Branch Office shall be open for business the same hours as required for the parent office, must have a registered nurse immediately available to be on site, or on site in the branch office at all times during operating hours.
5. All hospice patient's clinical records must be maintained at the hospice site issued the provider license (S.O.M. 208.1).
Duplicate records may be maintained at the Branch Office.
6. Original personnel files are to be kept at the Parent office, but shall be made available, upon request, to federal/state surveyors during any review of the branch.
7. A statement of personnel policies is maintained in each Branch for staff usage.
8. Approval for Branch Offices will be issued, in writing, by Mississippi State Department of Health for one year and will be renewed at time of re-licensure, if the branch office meets the following criteria:
a. Is operational and providing hospice services;
b. Offer exact same services as the parent office; and
c. Parent office meets requirements for full licensure.

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provision of those services;
n. ensure that any facility where hospice care is provided meets appropriate licensing requirements and any payor source requirements when applicable;
o. ensure that any facility in which hospice care is provided have the following:
i. areas that are designed and equipped for the comfort and privacy of each patient and family member;
ii. physical space for private patient/family visiting;
iii. accommodations for family members to remain with the patient throughout the night;
iv. accommodations for family privacy after a patient's death;
v. decor which is homelike in design and function;
vi. patients must be permitted to receive visitors at any hour, including small children.

3. Responsibility of the hospice to the staff shall include, but is not limited to, the following:
a. provide safe environment whenever the hospice knows or has reason to know that environment might be dangerous;
b. have safety and emergency preparedness programs
that conform with federal, state, and local requirements and that include:
i. a plan for reporting, monitoring, and follow-up on all accidents, injuries, and safety hazards;
ii. documentation of all reports, monitoring activity, and follow-up actions, education for patient/family, care givers, employees and volunteers on the safe use of medical equipment;
iii. evidence that equipment maintenance and safety requirements have been met;
iv. policies and procedures for storing, accessing, and distributing abusable drugs, supplies and equipment;
v. a safe and sanitary system for identifying, handling, and disposing of haz-

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(iv) A patient dies.
(3) A provision stating that the hospice assumes responsibility
for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(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.
(5) An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/MR resident were in his or her own home.
(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.
(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.
(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

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120 **RESPITE – INPATIENT CARE**
120.01 If a hospice is not based in a licensed facility (hospital or nursing home); a contractual arrangement shall be made with one or more such facilities for provision of respite-inpatient services. Inpatient beds under such contract may be used by the hospice when needed or may remain otherwise available to the inpatient unit at other times without a change in licensing.
120.02 Such contract shall be maintained with an inpatient provider who contractually agrees to support the policies of hospice.
120.03 The hospice care team shall retain the responsibility for coordinating the patient's care during inpatient hospice care.
120.04 The aggregate number of inpatient days provided by a hospice through all contractual arrangements between the hospice and licensed health care facilities providing inpatient hospice care may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all patients receiving hospice care from the hospice during a twelve (12) month period.
120.05 The designation of a specific room or rooms for inpatient hospice care shall not be required if beds are available through contract between an existing healthcare facility and a hospice.
120.06 Licensed beds designated for inpatient hospice care through contract between an existing health care facility and a hospice shall not be required to be de-licensed from one type of bed in order to enter into a contract with a hospice, nor shall the physical plant of any facility be required to be altered, except that a homelike atmosphere may be required.
120.07 Staffing standards for inpatient hospice care provided through a contract may not exceed the staffing standards required under the license held by the contractee.

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ardous wastes; and
vi. a policy regarding use of smoking materials in all care settings;
c. have policies which encourage realistic performance expectations;
d. maintain insurance and workman's compensation at all times;
e. provide adequate time on schedule for required travel;
f. meet or exceed Wage and Hour Board requirements;
g. provide adequate information, in-service training,
supplies, and other support for all employees to perform to the
best of their ability; and
h. provide in-service training to promote effective, quality hospice care.

§8237. Contract Services
A. When the hospice provides services on a contractual basis to a patient the hospice is responsible for all actions of the contract personnel.
B. The hospice shall not at any time use contract employees as administrator/alternate or for the provision of core services, except that physician services may be provided through contract.
C. Whenever services are provided by an organization/individual other than the hospice, a written agreement will delineate services available and procedures for accessing those services.
D. Whenever services are provided by an outside agency or individual, a legally binding written agreement must be effected. The legally binding written agreement shall include at least the following items:
1. identification of the services to be provided;
2. a stipulation that services may be provided only with the express authorization of the hospice;
3. the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;
4. the delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment,

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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.
(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.
(d) Standard: Hospice plan of care. 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.
(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.
(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 extent possible.
(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.
(e) Standard: Coordination of services. The hospice must:
(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:
(i) Providing overall coordination of the hospice care of the SNF/NF or ICF/ MR resident with SNF/NF or ICF/MR representatives; and
(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

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120.08 Under no circumstance may a hospice contract for the use of a licensed bed in a health care facility or another hospice that has, or has had within the last eighteen (18) months, a suspended, revoked or conditional license, accreditation or rating.
121 **IN-SERVICE TRAINING**
121.01 The hospice shall provide ongoing, relevant in-service training for all members of the hospice care team. (For hospice aide training, refer to section titled Personnel Qualification/Responsibility.)
121.02 For each direct-care employee, the hospice shall require training of twelve (12) hours inservice education, at a minimum annually. Documentation of such training shall be maintained.
121.03 The hospice shall provide relevant inservice training on a quarterly basis for volunteers. Documentation of the offered inservices and attendees shall be maintained.
123 **SUPPLIES AND EQUIPMENT**
123.01 The hospice shall provide supplies and equipment related to the terminal illness.
124 **DRUG ADMINISTRATION**
124.01 The hospice shall have a written policy for procurement, administration and destruction of drugs.
124.02 Drug administration shall be in compliance with all applicable state and federal laws.
125 **PHYSICAL FACILITIES**
125.01 Each hospice office shall be commensurate in size for the volume of staff, patients, and services provided. Offices shall be well-lighted, heated and cooled. Offices shall be accessible to the individuals with disabilities.
126 **ADMINISTRATIVE OFFICES**
126.01 Each hospice shall provide adequate office space and equipment for all administrative and health care staff. An adequate number of
desks, chairs, filing cabinets, telephones, tables, etc., shall be available.
127 **STORAGE FACILITIES**
127.01 Each Hospice shall provide suf-

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and the IDG conferences;
5. requirements for documenting that services are furnished in accordance with the agreement;
6. the qualifications of the personnel providing the services;
7. assurance that the personnel contracted complete the clinical record in the same timely manner as required by the staff personnel of the hospice;
8. payment fees and terms; and
9. statement that the hospice retains responsibility for appropriate hospice care training of the personnel who provide care under the agreement.
E. The hospice and contractor shall document review of their contract on an annual basis.
F. The hospice is to coordinate services with contract personnel to assure continuity of patient care.
G. Hospice maintains professional management responsibilities for those services and ensures that they are furnished in a safe and effective manner by qualified persons and in accordance with the patient's POC.

§8241. Branch Offices
A. No branch office may be opened without written approval from DHH.
B. No branch office may be opened unless the parent office has had full licensure for at least the immediately preceding 12 months and has a current census of at least 10 active patients.
C. Each branch must serve the same or part of the geographic area approved for the parent.
D. Each branch office must have a registered nurse immediately available to be on site, or on site in the branch office at all times during operating hours.
E. All services provided by the parent agency must be available in the branch.
F. The branch site shall retain all Clinical Records for its practice. Duplicate records need not be maintained at the parent agency, but shall be made available to federal/state survey-

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conditions to ensure quality of care for the patient and family.
(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.
(3) Provide the SNF/NF or ICF/MR with the following information:
(i) The most recent hospice plan of care specific to each patient;
(ii) Hospice election form and any advance directives specific to each patient;
(iii) Physician certification and recertification of the terminal illness specific to each patient;
(iv) Names and contact information for hospice personnel involved in hospice care of each patient;
(v) Instructions on how to access the hospice's 24-hour on-call system;
(vi) Hospice medication information specific to each patient; and
(vii) Hospice physician and attending physician (if any) orders specific to each patient.
(f) Standard: Orientation and training of staff. Hospice 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.

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ficient areas for storage of:
1. Administrative records and supplies
2. Clinical Records
3. Medical equipment and supplies
128 **TOILET FACILITIES**
128.01 Each hospice office shall be equipped with an adequate number of toilet rooms. Each toilet room shall include: lavatories, soap, towels, and water closets.
129 **COMMUNICATION FACILITIES**
129.01 Each Hospice Agency shall have an adequate number of telephones and extensions, located so as to be quickly accessible from all parts of the building. The telephone shall be listed under the official licensed name of the agency.

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ors during any review upon request.
G. Original personnel files are to be kept at the parent agency, but shall be made available to federal/state surveyors during any review upon request.
H. A statement of personnel policies is maintained in each branch for staff usage.
I. Approval for branch offices will be issued, in writing, by DHH for one year and will be renewed at time of re-licensure if the branch office meets the following criteria:
1. is operational and providing hospice services;
2. serve only patients who are geographically nearer to branch than to parent office;
3. offer exact same services as the parent agency; and
4. parent office meets requirements for full licensure.

§8243. Sub-Units
A. A sub-unit shall have:
1. a separate license; and
2. not serve the same geographical area as the parent agency.
B. Sub-unit shall be:
1. administratively independent; and
2. must meet full licensure requirements independently of the parent agency.

§8245. Cessation of Business
A. If at any time the agency is no longer operational, the license shall be deemed to be invalid and shall be returned to DHH within five working days.
B. The agency owner is responsible for notifying DHH of the location of all records.
C. In order to be operational, an agency must:
1. have had at least twenty new patients admitted since the last annual survey;
2. be able to accept referrals at any time;
3. have adequate staff to meet the needs of their current patients;

LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
4. have required designated staff on the premises at all times during business hours; 5. be immediately available by telecommunications 24 hours per day. A registered nurse must answer calls from patients and other medical personnel after hours; 6. be open for the business of providing Hospice services to those who need assistance.		
Subchapter E. Hospice Inpatient Facility A. Hospice inpatient services may be provided directly by the hospice or through arrangements made by the hospice. An agency is prohibited from providing hospice inpatient services only. A hospice that elects to provide hospice inpatient services directly is required to be licensed both as a hospice inpatient facility and as a hospice (These are two separate licenses which require separate applications and fees). The application process to establish a hospice inpatient facility may be completed simultaneously with an application to provide hospice services. **§8249. Governing Body for Inpatient Hospice** A. The hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation. B. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body. C. The governing body shall: 1. designate an individual who is responsible for the day to day management of the hospice program; 2. ensure that all services provided are consistent with accepted standards of practice; 3. develop and approve policies and procedures which define and describe	**§ 418.110 Condition of participation: Hospices that provide inpatient care directly.** A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards: (a) ***Standard: 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. (b) ***Standard: 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. (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.	**PART VIII INPATIENT FACILITY** 130 **INPATIENT FACILITY** 130.01 Inpatient hospice staffing – An inpatient hospice must maintain the coverage of a registered nurse twenty-four (24) hours a day. Other medical/nursing personnel must be available to meet the needs of the patients. **EMERGENCY OPERATIONS PLAN (EOP)** 143.01 The licensed entity shall develop and maintain a written preparedness plan utilizing the "All Hazards" approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any act of terrorism or man-made or natural disaster as appropriate for the specific geographical location. The final draft of the Emergency Operations Plan (EOP), will be reviewed by the Office of Emergency Preparedness and Response, Mississippi State Department of Health, or their designates, for conformance with the "All Hazards Emergency Preparedness and Response Plan." Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required

LA State Minimum Standards

the scope of services offered;
4. review policies and procedures at least annually and
revise them as necessary; and
5. maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

Medicare Conditions of Participation (CoPs)

MS State Minimum Standards

as deemed necessary by the Office of Emergency Preparedness and Response. The six (6) critical areas of consideration are:

- Communications – Facility status reports shall be submitted in a format and a frequency as required by the Office of EOP.
- Resources and Assets
- Safety and Security
- Staffing
- Utilities
- Clinical Activities.

Emergency Operations Plans (EOPs) must be exercised and reviewed annually or as directed by the Emergency Preparedness and Response. Written evidence of current approval or review of provider EOPs, by the Office of Emergency Preparedness and Response, shall accompany all applications for facility license renewals.

144 **Facility Fire Preparedness**
144.01 **Fire Drills**. Fire drills shall be conducted one (1) per shift per quarter. Employees shall participate in a fire drill at least four (4) times per year.
144.02 **Written Records.** Written records of all drills shall be maintained, indicating content of and attendance at each drill.
144.03 A fire evacuation plan shall be posted in each facility in a conspicuous place and kept current.

Effective Communication Critical

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Approaching the deadline of compliance with the new Medicare Conditions of Participation (CoPs), Monday, December 2nd, hospice administrators are finalizing their organization readiness. Luckily Louisiana providers were already a step ahead in preparing for the new CoPs by means of the Department of Health and Hospitals Licensing Standards for Hospice Agencies issued in 1998. In many instances the revised CoPs mimic Louisiana's hospice minimum standards and require administrators to tweak their policies and procedures. Unfortunately for many states preparing for the CoPs implementation there was no preface of state minimum standards to assist hospice providers in the delivery of care.

Beginning the process of updating hospice to the new CoPs begins with a thorough examination of the CoPs. An overwhelming document of 700+ pages attentiveness to pages 659 thru the end of the document is essential. These pages provide distinct information relative to day to day operations of hospice. The Final Rule for Hospice Conditions of Participation is located at the CMS web site. Administrators should also become familiar with the Interpretive Guidelines which hopefully will soon be released by CMS. Interpretive Guidelines offer tangible insight to surveyors and providers presenting indicators and measures that assess the delivery of hospice care.

On review you the notice the semblance of the newly revised CoPs and DHH standards; however, the CoPs expand specific responsibilities of hospice, i.e., patient and/or family's instruction on the hospice controlled substance policy. Reinforcement of the interdisciplinary team participation is a constant theme with emphasis placed on comprehensive assessments conducted within five days of admission. Relationships with providers of contracted services requires hospice to take additional precautions with contractors, such as criminal background checks to ensure patient safety and protection of health care information. Another vital competent is hospice will have to demonstrate accountability in the delivery of patient services via the Quality Assurance Performance Improvement, "QAPI" initiative. A "QAPI" program should be developed based on individual agency's patient data. "QAPI" seeks to identify the effectiveness, quality, and measures utilize by the hospice in improving the delivery of patient care. This is only a small sample of the CoPs changes.

Current hospice policies and procedures should be scrutinized and revisions made to reflect the direction of the organization. New forms and/or processes will have to be initiated to guarantee capturing of clinical documentation in the delivery of care thus providing credibility of the hospice being compliant. Seeking the input from the hospice staff in developing realistic, useable procedures allows ownership of the policy and the reasoning behind steps to ensure compliance with the new CoPs. Utilize the hospice disciplines with identifying high risk, problematic patient issues for "QAPI" development. Adoption of your organization's "QAPI" must be approved by the hospice Governing Body prior to enacting.

Effective communication to all members of the hospice staff on the new CoPs will be crucial to the organization success in adhering and maintaining compliance. Of course, hospice staff needs to know what the regulations say but they need to understand the expectations of the regulations and requirements of being in compliance. The hospice administrator should encourage the managers of their organization to take advantage of the education programs offered by LMHPCO. As an example recent area code meetings have provided education on developing a "QAPI" program. Soon with the release of the Medicare Interpretive Guidelines LMHCPO will provide provider training on the CoPs. Programs are presented by LMHPCO staff or member hospice peers whom have received training provided through the collaborative efforts of CMS and NHPCO. Use these educational offerings to best equip your staff.

Members make the work of LMHPCO possible!

(2009 memberships received as of 12/2/2008)

PROVIDER MEMBERS:
Crossroads Hospice, Delhi, LA
Elayn Hunt Correctional Center, St Gabriel, LA
Gulf Coast Hospice, Ocean Springs, MS
Hospice of Shreveport/Bossier, Shreveport, LA
Magnolia Regional Health Center Home Health & Hospice Agency, Corinth, MS
Odyssey Healthcare of Lake Charles, Lake Charles, LA
St Joseph Hospice of Shreveport, LLC, Shreveport, LA
Trucare Hospice, Raymond, MS

ASSOCIATE MEMBERS
MUMMS Software, New Orleans, LA
ProCare Hospice Care, Duluth, GA

INDIVIDUAL MEMBERS
Patricia Andrews, New Orleans, LA
Susan Drongowshki, Las Vegas, NV

PROFESSIONAL MEMBERS
Jo Ann D Moore, MSW, LSW, Chalmette, LA

briefs

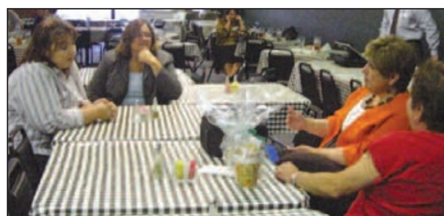
***Lana Ryland**, Hospice Manager in the Rate and Audit Division of Louisiana Medicaid, along with **Beatrice Williams**, Medicaid Monitor and **Delores Young** (not pictured) presented a Medicaid Update to members at Area Code meeting throughout the state this past Fall. The 1 hour presentation in Shreveport, Baton Rouge, New Orleans and Jennings, LA was a follow up session from the 2008 Leadership Conference, held this past summer in New Orleans. LMHPCO is grateful to **Jerry Phillips**, LA Medicaid Director for allowing Lana to tour the state and directly answer provider questions regarding Medicaid policy.*

***Kathryn Delcambre** (QAPI Coordinator for Hospice of Acadiana) conducted a 1 hour workshop at the quarterly 318 Area Code meeting, helping members understand the new CoP requirements regarding QAPI. Kathryn has agreed to also present this important material at the upcoming Area Code meetings in New Orleans, Baton Rouge and Jennings, LA early in the new year. LMHPCO is grateful to Kathryn and Hospice Acadiana for providing LMHPCO with fresh insights into the new CoPs QAPI requirements which go into effect on February 2, 2009.*

Area Code 228 Lunch & Learn

Hospice providers enjoyed a presentation by Dr. Scott Shreve, DO, National Director, Hospice and Palliative Care for the Department of Veterans Affairs titled "The Tipping Point for End of Life Care for Veterans: How One Person Caused and Avalanche of Change". The meeting was held November 13 at the VA Gulf Coast Veterans Health Care System Home in Biloxi, MS. LMHPCO and the VA are committed to continuing to foster a great relationship for hospice patients and their families.

Pictured left to right are: Mary Lee, RN, VA In-patient Nurse Manager; Dr. Khalid Khan, Assistant Chief for Extended Care, Biloxi VA; Dr. Scott Shreve; Jamey Boudreaux, LMHPCO Executive Director; Tony Beazley, M. Div, BCC, Staff Chaplain/Ethics Consultation Coordinator, G. V. (Sonny) Montgomery Veterans Affairs Medical Center; Melinda Adams, BSN, RN, VA Education Director; Laurie Grady, Hospice of Light/ LMHPCO Board Member; Nancy Dunn, LMHPCO Education Director.



QAPI

Isabel Cordua of Hospice Ministries kept everyone's interest as she conducted a presentation on QAPI at the 601 Area Code Meeting in Jackson, MS and again at the 662 Area Code Meeting in Oxford, MS. Isabel provided valuable insight into the requirements necessary for meeting the new CoP guidelines for quality. Pictured: Isabel provides some one on one after the meeting to answer specific questions regarding QAPI.

DHH Hospice Surveyors Receive CoP Training

LMHPCO provided training on the new CoPs for DHH Hospice Surveyors at Paragon Casino and Resort in Marksville, LA on October 21. Providing the training was Martha McDurmond with Hospice of Shreveport/Bossier and LMHPCO Board Member; Sylvia Marcantel with Odyssey Healthcare of Lake Charles and LMHPCO Board Member; and Nancy Dunn, LMHPCO Education Director.

Pictured: Mae Calvin and surveyors listen closely to the presentation.

MSDH Hospice Surveyors Receive CoP Training

LMHPCO provided training on the new CoPs for MSDH Surveyors at the Division of Licensure and Certification in Jackson, MS on October 7, 2008. Providing the training was Isabel Cordua of Hospice Ministries, Laurie Grady with Hospice of Light/LMHPCO Board Member, and Nancy Dunn, LMHPCO Education Director.

Pictured left to right are: Paula Sowell, Teresa Manning, Sherry Williams, Steve Egger, Judy Robinson and Isabel Houston

Networking

Bill Mearns, Dana Sterling and Linda Glick-Schmitz enjoy networking after the 662 Area Code meeting to discuss QAPI implementation.