



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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Division for Regulatory Services Guidance for Hospitals Providing Hospice Services March 2013

There has been a growing trend to provide streamlined and efficient access to end of life care delivery to patients in hospitals. DSHS was asked for guidance regarding hospice services provided in hospitals.

There are two ways that hospice services can be provided within a hospital: (1) the scatter bed approach and (2) co-location.

Scatter Bed

DSHS recognizes that there are situations when patients are too ill and fragile to be discharged from a hospital to receive hospice care. Hospice patients that are admitted to a hospital in this situation can be intermingled with other inpatients. This is commonly referred to as "scatter beds" or "direct sharing arrangements." In these types of arrangements, the beds remain licensed hospital beds and should not be confined to a specific geographic area within a hospital per Centers for Medicare and Medicaid Services (CMS) guidance. The Department of Aging and Disability Services (DADS) has indicated that in the "scatter bed" scenario, the hospice would have a parent license to provide services at the hospital so a separate DADS Alternative Delivery Site (ADS) license would not be required.

To illustrate this scenario, if a small child has a terminal illness and his parents elect for hospice services, ideally, the hospital should be able to allow for hospice services to be provided to the child in the pediatric wing of the hospital. While the patient is in the hospital, the hospital is still responsible for providing care to the patient and the development of the patient care plan, which can include a hospice component. A hospice and hospital may also develop an integrated care plan for the patient. The contract between the hospital and hospice should contain specific information related to the coordination of care and incidentals that are provided to the patient. Typically, the hospice is responsible for providing emotional support to the patient and family while the patient remains in the hospital and the hospice must ensure that the care being provided to the patient meet the patient's needs. Both the hospital and hospice Medicare Conditions of Participation (COPs) are applicable in this situation as well as any applicable DSHS or DADS requirements.

Per consultation with the CMS Central Office on 01/17/2013, a hospice can have inpatients in a hospital at any given time. The hospice is not contracting for "physical beds." When this type of arrangement occurs, traditional payments for inpatient services to the hospital for Medicare ends and Medicare will begin paying the hospice for services provided to the patient. However, as stated above, these types of arrangements should not be confined to a specific geographic area within a hospital.

In such a situation, both the hospice and hospital's COPs are applicable. If DSHS conducts a survey at a hospital that provides hospice services, DSHS will evaluate the situation based on the hospital's compliance with Medicare COPs and DSHS' licensure requirements. If DSHS discovers issues that raise concerns, DSHS will address DSHS' licensure issues and will contact DADS so that DADS can evaluate the situation to determine the hospices' compliance with Medicare COPs. Both agencies could cite deficiencies in response, if applicable.

When a patient elects for hospice services in a hospital, there must be a certification of terminal illness made by the attending physician. There should be an election form signed by the patient for hospice services. The medical record should reflect a change in the patient status to hospice and the transition should be documented. HIPPA will allow accessing of records between both entities. The hospital's Medicare COPs determine who can make entries into a patient's medical records.

Co-location of a Hospital and Hospice

The second way for hospice services to be provided is through co-location with hospital services. A hospital may decide to allow a hospice to use space that will be located on the same premises as the hospital. A hospice may occupy a separate wing or floor on the hospital premises. This is known as co-location.

DSHS has determined that if a licensed hospital wants to de-license/de-certify beds on a wing in order to make the space available for a hospice provider, it may do so. In such a situation, there must be a clear delineation between the hospital and hospice provider. It is similar to a hospice operating a "free standing hospice." The hospice must comply with state requirements for licensure as a hospice entity (the hospice must consult with DADS to obtain an ADS license) and must comply with the hospice Medicare COPs

A hospice that co-locates with a hospital must have a 2 hour firewall between the two entities as required under Life Safety Code requirements implemented in DSHS hospital licensing rules. Patients in the hospice must also be able to request assistance when needed so a separate nurse call system may be indicated. Other life safety code requirements may also be required of the hospice per DADS licensing requirements. CMS will not support the co-location of a hospital and hospice unless there is a clear delineation between providers as indicated above.

A hospice that co-locates with a hospital will not be a part of the licensed hospital. The beds in the hospice clearly belong to the hospice and the hospital cannot use hospice beds for the overflow of patients per CMS Central Office.