Form APA-3
11/96

CERTIFICATION OF ADMINISTRATIVE RULES
FILED WITH THE LEGISLATIVE REFERENCE SERVICE
JERRY L. BASSET, DIRECTOR

(Pursuant to Code of Alabama 1975, § 41-22-6, as amended).

I certify that the attached is/are a correct copy/copies of rule/s as promulgated and adopted on the 26th day of October, and filed with the agency secretary on the 2nd day of November 2012.

AGENCY NAME: State Health Planning and Development Agency
(Statewide Health Coordinating Council)

___X___ Amendment; _____New; _____Repeal; (Mark appropriate space)

Rule No. 410-2-4-.15(4)(a)

(If amended rule, give specific paragraph, subparagraphs, etc., being amended)

Rule Title: Inpatient Hospice Services

ACTION TAKEN: State whether the rule was adopted without changes from the proposal due to written or oral comments;

Public comments were made; however, the rule was adopted without changes, as published in the Alabama Administrative Monthly.

NOTICE OF INTENDED ACTION PUBLISHED IN VOLUME XXX,

ISSUE NO. 11, AAM, DATED August 31, 2012.

Statutory Rulemaking Authority: Code of Alabama, 1975 § 22-21-260(13)(15) and -274

(Date Filed)
(For LRS Use Only)

REC'D & FILED

NOV 02 2012

LEGISLATIVEREFSERVICE

Alva M. Lambert, Executive Director
State Health Planning and Development Agency
(Certifying Officer or his or her Deputy)

(NOTE: In accordance with § 41-22-6(b), as amended, a proposed rule is required to be certified within 90 days after completion of the notice.

410-2-4-.15 Inpatient Hospice Services

(1) Discussion.

(a) Hospice care is a choice made to enhance end of life. Hospice focuses on caring and comfort for patients and not curative care. In most cases, care is provided in the patient's place of residence.

(b) It is the intent of this section to address health planning concerns relating to hospice services provided on an inpatient basis. For coverage of hospice services provided primarily in the patient's place of residence, please see Section 410-2-3-.10.

(c) A hospice program is required by federal statutes as a Condition of Participation for hospice care (Title 42- Public Health; Chapter IV – CMS, Department of Health and Human Services; Part 418 – Hospice care; Section 418.98 or successors) and state statutes and regulations (Alabama State Board of Health, Department of Public Health; Administrative Code, Chapter 420-5-17; Section 420-5-17-.01 or successors) to provide general inpatient level of care and inpatient respite level of care as two of the four levels of hospice care. As per the Medicare Condition of Participation (418.108), 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 twenty (20) percent of the total number of hospice days consumed in total by this group of beneficiaries.

(d) A hospice program per federal statute **must** provide the inpatient levels of care that meets the conditions of participation specified. The approved locations for inpatient hospice care are a hospital, a skilled nursing facility ("SNF") or an inpatient hospice facility.

(e) A hospice program may provide the inpatient levels of care in a freestanding inpatient facility/unit which the hospice program owns and manages, through beds owned by either a hospital or a skilled nursing facility ("SNF") but leased and managed by a hospice program or through contracted arrangements with another hospice program's inpatient facility/unit.

(2) Definitions.

(a) All definitions included in Section 410-2-3-.10 are incorporated herein by reference.

(b) Inpatient hospice facility. An "Inpatient Hospice Facility" is defined as a freestanding hospice facility or a designated unit, floor or specific number of beds located in a skilled nursing facility or hospital that is leased or under the management of a hospice services provider.

(c) General Inpatient Level of Care: The general inpatient ("GIP") level of hospice care is intended for short term acute care for pain control and symptomatic management. It is not intended for long term care, residential or rehabilitation.

(d) Inpatient Respite Level of Care: The inpatient respite level of care is limited per Medicare and Medicaid to a maximum of 5 days per episode for the purpose of family respite.

(3) Availability and Accessibility.

(a) Hospice services must be obtainable by all of the residents of the State of Alabama.

(b) Physicians and other referral sources may be unfamiliar with the total scope of services offered by hospice; accessibility may be limited due to lack of awareness. Every provider should provide an active community informational program to educate consumers and professionals to the availability, nature, and extent of their hospice services provided.

(c) In order for a SNF to provide the inpatient levels of care for hospice patients, the SNF **must** meet the standards specified by CMS, which have included at least the following: (a) twenty-four-hour nursing services with each shift requiring a registered nurse who provides direct, on site patient care and (e) patient areas that provide comfort and privacy for the patient and family; allows for private patient/family visiting; accommodations for family privacy for family members to remain with patient throughout the night, accommodations for family privacy after a patient's death, homelike décor, and allows visitors, including children at any hour. (Currently the Alabama Licensure rules for hospice dictate a RN must be on site for both GIP and Inpatient Respite levels of care. However, the updated federal Condition of Participation which were implemented December 2008 eliminated the requirement for a RN for Inpatient Respite care. At the time the Alabama Licensure rules are updated to mirror the federal Conditions of Participation, that rule will be applied to this document without additional document changes required by SHCC.)

(d) At the time this section was adopted, many SNF facilities do not meet these minimum requirements.

(e) Hospice agencies are limited in establishing contracts with hospitals for the inpatient levels of care. This is due to (a) the increased number of hospice providers over the past five (5) years that request contracts from the same hospitals in the same service areas and (b) the reimbursement hospitals receive from the hospice providers for the hospice inpatient levels of care.

(4) Inventory.

(a) At this time, there are only three freestanding inpatient hospice facilities in the state of Alabama with a total of 30 inpatient hospice beds. (After adoption of this methodology, this notation of inventory shall be deleted without further action of the SHCC and inventory shall be listed as part of all future statistical updates to this section)

(b) The establishment of an inpatient hospice facility does not eliminate the need for contractual arrangements with hospitals or SNF for inpatient levels of care. If the inpatient hospice facility is at full capacity and a hospice patient is eligible for/requires inpatient care, the hospice remains responsible to provide that level of care at a contracted facility.

(5) Quality.

(a) Quality is that characteristic which reflects professionally and technically appropriate patient services. Each provider must establish mechanisms for quality assurance, including procedures for resolving concerns identified by patients, physicians, family members, or others in patient care or referral. Providers should also develop internal quality assurance and grievance procedures.

(b) Providers are encouraged to achieve a utilization level, which promotes cost effective service delivery.

(c) Hospice programs are required to meet the most stringent or exceed the current Medicare Hospice Conditions of Participation, as adopted by CMS, and codified in the Code of Federal Regulations, along with State Licensure Regulations of the Department of Public Health.

(6) Inpatient Hospice Facility Need Methodology.

(a) Purpose. The purpose of this inpatient hospice services need methodology is to identify, by region, the number of hospice providers needed to assure the continued availability, accessibility, and affordability of quality of care for residents of Alabama.

(b) General. Formulation of this methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee, which provided its recommendations to the SHCC, was composed of providers and consumers of health care, and received input from hospice providers and other affected parties. Only the SHCC, with the Governor's final approval, can make changes to this methodology, except that SHPDA staff shall annually update statistical information to reflect more current population and utilization. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (e) below.

(c) Basic Methodology.

1. The purpose of this need methodology is to identify, by region, the number of inpatient hospice beds needed to assure the continued availability, accessibility, and affordability of quality hospice care for residents of Alabama.

2. The need methodology shall be calculated by aggregating the reported average daily censuses (ADC) for all licensed hospices in the designated Region, as reported annually to SHDPA, and multiplying that aggregate regional ADC by 3%. The resulting figure shall be the regional need. The need cannot be established until after the most current year's completed annual reports are received and compiled by SHDPA.

3. Any increase in regional need shall be limited to no more than five percent (5%) per year with the sole exclusion of any need determined under Planning Policy 7 of this section.

(d) Planning Policies

1. Planning will be on a regional basis. Please see the attached listing for regional descriptions as designated by the SHCC.

2. An applicant for an inpatient hospice facility must be an established and licensed hospice provider and has been operational for at least thirty-six (36) months.

3. An applicant for an inpatient hospice facility must demonstrate the ability to comply with Medicare/Medicaid regulations.

4. An applicant for an inpatient hospice facility must demonstrate that existing inpatient hospice beds in the region cannot meet the community demand for inpatient hospice services.

5. An applicant for an inpatient hospice facility must demonstrate that sharing arrangements with existing facilities have been studied and implemented when possible.

6. An applicant for an inpatient hospice facility may provide supplemental evidence in support of its application from other data reported by licensed hospices on an annual basis to the State of Alabama or the Federal Government.

7. Additional need may be shown in situations involving a sustained high occupancy rate either for a region or for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. Once additional beds have been applied for under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON Authorized Inpatient Hospice beds shall be included in consideration of occupancy rate and bed need.

(i). If the total combined occupancy rate for all CON Authorized Inpatient Hospice facilities in a region is above 90% as calculated by SHPDA using data reported on the most recent full year 'Annual Report for Hospice Providers (Form HPCE-4)' published by or filed with SHPDA, an additional need of the greater of five percent (5%) of the current total CON Authorized bed capacity of that region or five (5) total beds may be approved for the expansion of an existing facility within that region. Once additional

bed need has been shown under this policy, no new need shall be shown in that region based upon this rule for twenty-four (24) months following issuance of the initial CON to allow for the impact of those beds in that region to be analyzed. Should the initial applicant for beds in a region not apply for the total number of beds allowed to be created under this rule, the remaining beds would then be available to be applied for by other providers in the region, so long as said providers meet the conditions listed in this rule.

(ii). If the occupancy rate for a single facility within a region is greater than 90% as calculated by SHPDA using data reported on the most recent full year 'Annual Report for Hospice Providers (Form HPCE-4)' published by or filed with SHPDA, irrespective of the total occupancy rate for all CON Authorized Inpatient Hospice facilities in that region, up to five (5) additional beds may be approved within that region for the expansion of that facility only. Once additional beds have been approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON to allow for the impact of those beds at that facility to be analyzed.

8. No application for the establishment of a new, freestanding Inpatient Hospice facility shall be approved for fewer than 10 beds to allow for the financial feasibility and viability of a project. Because of this, need may be modified by the Agency for any county currently showing a need of more than zero (0) but fewer than ten (10) total beds to a total need of ten (10) new beds, but only in the consideration of an application for the construction of a new, freestanding facility in a region in which no freestanding Inpatient Hospice currently exists. Need shall not be adjusted in consideration of an application involving the expansion of a CON Authorized Inpatient Provider, nor shall need be adjusted according to this rule in any region wherein a CON Authorized freestanding Inpatient Hospice facility already exists.

(e) Adjustments. The need for inpatient hospice beds, as determined by the methodology, is subject to adjustments by the SHCC. SHCC may adjust the need for inpatient hospice beds in a region if an applicant documents the existence of at least one of the following conditions:

1. Absence of available inpatient beds for a hospice certified for Medicaid and Medicare in the proposed region, and evidence that the applicant will provide Medicaid and Medicare-certified hospice services in the region; or

2. Absence of services by a hospice in the proposed region that serves patients regardless of the patient's ability to pay, and evidence that the applicant will provide services for patients regardless of ability to pay.

3. A community need for additional inpatient hospice services greater than those supported by the numerical methodology.

(7) Inpatient Hospice Regions. The attached chart, listing "Inpatient Hospice Regional County Listings" is hereby adopted as an Appendix "A" to Section 410-2-4-.15.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Filed February 1, 2010; effective March 8, 2010. Amended: Filed: January 24, 2012; effective: February 28, 2012. Amended: Filed: November 2, 2012; effective: December 7, 2012.

Appendix A

Inpatient Hospice Regional County Listings

Region 1	Region 2	Region 3	Region 4
Lauderdale	Limestone	Lawrence	Marshall
Colbert	Madison	Morgan	Blount
Franklin	Jackson	Winston	DeKalb
Marion		Cullman	Etowah
		Walker	

Region 5	Region 6	Region 7	Region 8
Jefferson	Cherokee	Lamar	Shelby
	St. Clair	Fayette	Chilton
	Calhoun	Pickens	Coosa
	Cleburne	Tuscaloosa	
		Greene	
		Hale	
		Bibb	

Region 9	Region 10	Region 11	Region 12
Talladega	Sumter	Autauga	Lee
Clay	Marengo	Elmore	Macon
Randolph	Perry	Lowndes	Russell
Tallapoosa	Choctaw	Montgomery	
Chambers	Dallas	Bullock	
	Wilcox	Butler	
		Crenshaw	
		Pike	

Region 13	Region 14	Region 15
Washington	Clarke	Barbour
Mobile	Monroe	Coffee
Baldwin	Conecuh	Dale
	Escambia	Henry
	Covington	Geneva
		Houston