

(2) The hospice determines that the patient is no longer terminally ill; or

(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:

(i) Advise the patient that a discharge for cause is being considered;

(ii) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;

(iii) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and

(iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

(b) *Discharge order.* Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

(c) *Effect of discharge.* An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice—

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under § 418.24(e); and

(3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

(d) *Discharge planning.* (1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

(2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

(e) *Filing a notice of termination of election.* When the hospice election is ended due to discharge, the hospice must file a notice of termination/revocation of election with its Medicare contractor within 5 calendar days after the effective date of the discharge, unless it has already filed a final claim for that beneficiary.

[70 FR 70547, Nov. 22, 2005, as amended at 79 FR 50509, Aug. 22, 2014; 84 FR 38544, Aug. 6, 2019]

§ 418.28 Revoking the election of hospice care.

(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period.

(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

(1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period.

(2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

(c) An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period—

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under § 418.24(f)(2); and

(3) May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

(d) When the hospice election is ended due to revocation, the hospice must file a notice of termination/revocation of election with its Medicare contractor within 5 calendar days after the effective date of the revocation,

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unless it has already filed a final claim for that beneficiary.

[48 FR 56026, Dec. 16, 1983, as amended at 79 FR 50509, Aug. 22, 2014; 84 FR 38544, Aug. 6, 2019]

§ 418.30 Change of the designated hospice.

(a) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

(b) The change of the designated hospice is not a revocation of the election for the period in which it is made.

(c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:

(1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.

(2) The date the change is to be effective.

Subpart C—Conditions of Participation: Patient Care

SOURCE: 73 FR 32204, June 5, 2008, unless otherwise noted.

§ 418.52 Condition of participation: Patient's rights.

The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.

(a) *Standard: Notice of rights and responsibilities.* (1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands.

(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.

(3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.

(b) *Standard: Exercise of rights and respect for property and person.* (1) The patient has the right:

(i) To exercise his or her rights as a patient of the hospice;

(ii) To have his or her property and person treated with respect;

(iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and

(iv) To not be subjected to discrimination or reprisal for exercising his or her rights.

(2) If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.

(3) If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.

(4) The hospice must:

(i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator;

(ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures;

(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State

survey agency or local law enforcement agency; and

(iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.

(c) *Standard: Rights of the patient.* The patient has a right to the following:

(1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;

(2) Be involved in developing his or her hospice plan of care;

(3) Refuse care or treatment;

(4) Choose his or her attending physician;

(5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.

(6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;

(7) Receive information about the services covered under the hospice benefit;

(8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.

§418.54 Condition of participation: Initial and comprehensive assessment of the patient.

The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

(a) *Standard: Initial assessment.* The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial as-

essment be completed in less than 48 hours.)

(b) *Standard: Timeframe for completion of the comprehensive assessment.* The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.

(c) *Standard: Content of the comprehensive assessment.* The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:

(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).

(2) Complications and risk factors that affect care planning.

(3) Functional status, including the patient's ability to understand and participate in his or her own care.

(4) Imminence of death.

(5) Severity of symptoms.

(6) *Drug profile.* A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:

(i) Effectiveness of drug therapy.

(ii) Drug side effects.

(iii) Actual or potential drug interactions.

(iv) Duplicate drug therapy.

(v) Drug therapy currently associated with laboratory monitoring.

(7) *Bereavement.* An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

(8) The need for referrals and further evaluation by appropriate health professionals.

(d) *Standard: Update of the comprehensive assessment.* The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.

(e) *Standard: Patient outcome measures.* (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.

(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.

§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.

The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

(a) *Standard: Approach to service delivery.* (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together

to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).

(ii) A registered nurse.

(iii) A social worker, marriage and family therapist, or a mental health counselor.

(iv) A pastoral or other counselor.

(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.

(b) *Standard: Plan of care.* All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

(c) *Standard: Content of the plan of care.* The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services

necessary for the palliation and management of the terminal illness and related conditions, including the following:

(1) Interventions to manage pain and symptoms.

(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.

(4) Drugs and treatment necessary to meet the needs of the patient.

(5) Medical supplies and appliances necessary to meet the needs of the patient.

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

(d) *Standard: Review of the plan of care.* The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.

(e) *Standard: Coordination of services.* The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to—

(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.

(2) Ensure that the care and services are provided in accordance with the plan of care.

(3) Ensure that the care and services provided are based on all assessments of the patient and family needs.

(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and

services are provided directly or under arrangement.

(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

[73 FR 32204, June 5, 2008, as amended at 88 FR 79539, Nov. 16, 2023]

§ 418.58 Condition of participation: Quality assessment and performance improvement.

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

(a) *Standard: Program scope.* (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

(b) *Standard: Program data.* (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.

(2) The hospice must use the data collected to do the following:

(i) Monitor the effectiveness and safety of services and quality of care.

(ii) Identify opportunities and priorities for improvement.

(3) The frequency and detail of the data collection must be approved by the hospice's governing body.

(c) *Standard: Program activities.* (1) The hospice's performance improvement activities must:

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(i) Focus on high risk, high volume, or problem-prone areas.

(ii) Consider incidence, prevalence, and severity of problems in those areas.

(iii) Affect palliative outcomes, patient safety, and quality of care.

(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.

(d) *Standard: Performance improvement projects.* Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.

(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.

(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

(e) *Standard: Executive responsibilities.* The hospice's governing body is responsible for ensuring the following:

(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.

(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.

(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

§ 418.60 Condition of participation: Infection control.

The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.

(a) *Standard: Prevention.* The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.

(b) *Standard: Control.* The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—

(1) Is an integral part of the hospice's quality assessment and performance improvement program; and

(2) Includes the following:

(i) A method of identifying infectious and communicable disease problems; and

(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.

(c) *Standard: Education.* The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

[73 FR 32204, June 5, 2008, as amended at 86 FR 61616, Nov. 5, 2021; 88 FR 36510, June 5, 2023]

§ 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.

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 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 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/

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IID 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.

§ 418.66 Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.

(a) CMS may waive the requirement in § 418.64(b) that a hospice provide nursing services directly, if the hospice is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services. CMS may waive the requirement that nursing services be furnished by employees based on the following criteria:

(1) The location of the hospice's central office is in a non-urbanized area as determined by the Bureau of the Census.

(2) There is evidence that a hospice was operational on or before January 1, 1983 including the following:

(i) Proof that the organization was established to provide hospice services on or before January 1, 1983.

(ii) Evidence that hospice-type services were furnished to patients on or before January 1, 1983.

(iii) Evidence that hospice care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983.

(3) By virtue of the following evidence that a hospice made a good faith effort to hire nurses:

(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.

(ii) Job descriptions for nurse employees.

(iii) Evidence that salary and benefits are competitive for the area.

(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contacts with nurses at other providers in the area).

(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.

(c) Waivers will remain effective for 1 year at a time from the date of the request.

(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period, and certify that the conditions under which it originally requested the initial waiver have not changed since the initial waiver was granted.

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.

§ 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.

§ 418.74 Waiver of requirement—Physical therapy, occupational therapy, speech-language pathology, and dietary counseling.

(a) A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. The hospice may seek a waiver of the requirement that it make physical therapy, occupational therapy, speech-language pathology, and dietary counseling services (as needed) available on a 24-hour basis. The hospice may also seek a waiver of the requirement that it provide dietary counseling directly. The hospice must provide evidence that it has made a good faith effort to meet the requirements for these services before it seeks a waiver. CMS may approve a waiver application on the basis of the following criteria:

(1) The hospice is located in a non-urbanized area as determined by the Bureau of the Census.

(2) The hospice provides evidence that it had made a good faith effort to make available physical therapy, occupational therapy, speech-language pathology, and dietary counseling services on a 24-hour basis and/or to hire a dietary counselor to furnish services directly. This evidence must include the following:

(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.

(ii) Physical therapy, occupational therapy, speech-language pathology, and dietary counselor job descriptions.

(iii) Evidence that salary and benefits are competitive for the area.

(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contact discussions with physical therapy, occupa-

tional therapy, speech-language pathology, and dietary counseling service providers in the area).

(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.

(c) An initial waiver will remain effective for 1 year at a time from the date of the request.

(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period and certify that conditions under which it originally requested the waiver have not changed since the initial waiver was granted.

§ 418.76 Condition of participation: Hospice aide and homemaker services.

All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.

(a) *Standard: Hospice aide qualifications.* (1) A qualified hospice aide is a person who has successfully completed one of the following:

(i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively.

(ii) A competency evaluation program that meets the requirements of paragraph (c) of this section.

(iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of § 483.151 through § 483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry.

(iv) A State licensure program.

(2) A hospice aide is not considered to have completed a program, as specified in paragraph (a)(1) of this section, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual as described in § 409.40 of this chapter were for compensation. If there has been a 24-month lapse in furnishing services, the individual must complete another

program, as specified in paragraph (a)(1) of this section, before providing services.

(b) *Standard: Content and duration of hospice aide classroom and supervised practical training.* (1) Hospice aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse. Classroom and supervised practical training combined must total at least 75 hours.

(2) A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours.

(3) A hospice aide training program must address each of the following subject areas:

(i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff.

(ii) Observation, reporting, and documentation of patient status and the care or service furnished.

(iii) Reading and recording temperature, pulse, and respiration.

(iv) Basic infection control procedures.

(v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.

(vi) Maintenance of a clean, safe, and healthy environment.

(vii) Recognizing emergencies and the knowledge of emergency procedures and their application.

(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property.

(ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:

(A) Bed bath.

(B) Sponge, tub, and shower bath.

(C) Hair shampoo (sink, tub, and bed).

(D) Nail and skin care.

(E) Oral hygiene.

(F) Toileting and elimination.

(x) Safe transfer techniques and ambulation.

(xi) Normal range of motion and positioning.

(xii) Adequate nutrition and fluid intake.

(xiii) Any other task that the hospice may choose to have an aide perform. The hospice is responsible for training hospice aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section.

(4) The hospice must maintain documentation that demonstrates that the requirements of this standard are met.

(c) *Standard: Competency evaluation.* An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section.

(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient or a pseudo-patient during a simulation.

(2) A hospice aide competency evaluation program may be offered by any organization, except as described in paragraph (f) of this section.

(3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.

(4) A hospice aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. An aide must not perform that task without direct supervision by a registered nurse until after he or she has received training in the task for which he or she was evaluated as "unsatisfactory," and successfully completes a subsequent evaluation. A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required areas.

(5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met.

(d) *Standard: In-service training.* A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient.

(1) In-service training may be offered by any organization, and must be supervised by a registered nurse.

(2) The hospice must maintain documentation that demonstrates the requirements of this standard are met.

(e) *Standard: Qualifications for instructors conducting classroom and supervised practical training.* Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of 2 years nursing experience, at least 1 year of which must be in home care, or by other individuals under the general supervision of a registered nurse.

(f) *Standard: Eligible competency evaluation organizations.* A hospice aide competency evaluation program as specified in paragraph (c) of this section may be offered by any organization except by a home health agency that, within the previous 2 years:

(1) Had been out of compliance with the requirements of §484.80 of this chapter.

(2) Permitted an individual that does not meet the definition of a “qualified home health aide” as specified in §484.80(a) of this chapter to furnish home health aide services (with the exception of licensed health professionals and volunteers).

(3) Had been subjected to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State).

(4) Had been assessed a civil monetary penalty of \$5,000 or more as an intermediate sanction.

(5) Had been found by CMS to have compliance deficiencies that endangered the health and safety of the home health agency’s patients and had temporary management appointed to oversee the management of the home health agency.

(6) Had all or part of its Medicare payments suspended.

(7) Had been found by CMS or the State under any Federal or State law to have:

(i) Had its participation in the Medicare program terminated.

(ii) Been assessed a penalty of \$5,000 or more for deficiencies in Federal or State standards for home health agencies.

(iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled.

(iv) Operated under temporary management that was appointed by a governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency’s patients.

(v) Been closed by CMS or the State, or had its patients transferred by the State.

(g) *Standard: Hospice aide assignments and duties.* (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.

(2) A hospice aide provides services that are:

(i) Ordered by the interdisciplinary group.

(ii) Included in the plan of care.

(iii) Permitted to be performed under State law by such hospice aide.

(iv) Consistent with the hospice aide training.

(3) The duties of a hospice aide include the following:

(i) The provision of hands-on personal care.

(ii) The performance of simple procedures as an extension of therapy or nursing services.

(iii) Assistance in ambulation or exercises.

(iv) Assistance in administering medications that are ordinarily self-administered.

(4) Hospice aides must report changes in the patient’s medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment

and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.

(h) *Standard: Supervision of hospice aides.* (1) A registered nurse must make an on-site visit to the patient's home:

(i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.

(ii) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.

(iii) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skill(s) in accordance with paragraph (c) of this section.

(2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.

(3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to—

(i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.

(ii) Creating successful interpersonal relationships with the patient and family.

(iii) Demonstrating competency with assigned tasks.

(iv) Complying with infection control policies and procedures.

(v) Reporting changes in the patient's condition.

(i) *Standard: Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit.* An individual may furnish personal care services, as defined in § 440.167 of this chapter, on behalf of a hospice agency.

(1) Before the individual may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services. The individual only needs to demonstrate competency in the services the individual is required to furnish.

(2) Services under the Medicaid personal care benefit may be used to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care.

(3) The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services he or she needs.

(j) *Standard: Homemaker qualifications.* A qualified homemaker is—

(1) An individual who meets the standards in § 418.202(g) and has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness; or

(2) A hospice aide as described in § 418.76.

(k) *Standard: Homemaker supervision and duties.* (1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group.

(2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.

(3) Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services.

[73 FR 32204, June 5, 2008, as amended at 74 FR 39413, Aug. 6, 2009; 82 FR 4578, Jan. 13, 2017; 84 FR 51815, Sept. 30, 2019; 86 FR 42605, Aug. 4, 2021]

§ 418.78 Conditions of participation—Volunteers.

The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.

(a) *Standard: Training.* The hospice must maintain, document, and provide volunteer orientation and training that