STORAGE NAME: h0771a.lt
DATE: March 2, 1999

HOUSE OF REPRESENTATIVES
COMMITTEE ON
Elder Affairs & Long Term Care
ANALYSIS

BILL #: HB 771

RELATING TO: Hospice/Elderly Affairs Dept.

SPONSOR(S): Representative Bilirakis

COMPANION BILL(S):

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) Elder Affairs & Long Term Care YEAS 10 NAYS 0
(2) Health Care Licensing & Regulation
(3)
(4)
(5)

I. SUMMARY:

HB 771 amends part VI, chapter 400, F.S., relating to hospice, to: expand and specify the Department of Elder Affairs' (DOEA) rule-making authority. It clarifies that a hospice may contract for physician services, and that a hospice patient living in a residential environment subject to state regulation is considered to be a hospice patient. The hospice program is then responsible for the delivery of hospice care and services to such patient.

No direct fiscal impact is anticipated.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Hospice care is a unique and cost-effective form of care that addresses the medical, social, psychological and spiritual needs of terminally-ill patients and their families. Hospice patients typically are in their last six months of life. Historically, most hospice patients have been elderly people diagnosed with cancer. Hospice services however, are available for any person with a terminal, or life-limiting, illness, including end-stage heart, lung and neurological disorders. Patients must be certified as terminally ill by two physicians. There are currently 40 licensed hospices in Florida.

Hospice care is available to all Floridians regardless of the patient's ability to pay. Most hospices are Medicare/Medicaid certified and accept reimbursement with no deductible or co-pay. Most private insurance companies also have a hospice benefit. Some programs offer sliding scale fees, while others do not bill patients for services, relying on charitable contributions to fund un-reimbursed care.

Hospice Care in Non-Domestic Settings

Although originally conceived to permit terminally ill patients to die in their own homes, hospice care is now routinely provided in other residential settings such as nursing homes, assisted living facilities, adult family care homes, etc. Because these settings are also often subject to state regulation including responsibility for patient care, some confusion has arisen over assigning responsibility for the care of hospice patients.

A July 28, 1997 HCFA Program Issuance Transmittal Notice, # 41-97, relating to Medicare Hospice Conditions of Participation, specifically addresses these issues. As stated in transmittal notice, for patients residing in skilled nursing facilities or other place of residence:

> **The professional services usually provided by the hospice to the patient in his/her home should continue to be provided by the hospice to the resident. This includes furnishing any necessary medical services to those patients that the hospice would normally furnish to patients in their homes. In addition, substantially all hospice core services must be routinely provided directly by hospice employees and cannot be delegated. The hospice may involve the residential staff who are permitted by the facility and by law in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of a hospice patient's family/care giver in the implementing the plan of care. The hospice may involve residential staff who are permitted by the facility and by law in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of a hospice patient's family/care giver in implementing the plan of care.**
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> **Hospices and home health agencies generally train family members to administer medications for patients in the home; however, most nurse practice acts require that this be done by registered nurses. Accordingly, we believe it is appropriate for a hospice to arrange with nursing facility staff to administer medications as would be done by family members . . .**
>
> **The hospice assumes full responsibility for the professional management of the hospice patient's care related to the terminal illness. It is the responsibility of the hospice to ensure that all**

services are provided in accordance with the plan of care at all times and in all settings (e.g., the home, place of residence, outpatient, and inpatient settings.

Physician Services

Federal regulations governing Medicare reimbursed hospice care require certain core services to be provided directly by hospice (42 CFR 418.80). These include nursing services, medical social services, physician services, and counseling services. Prior to the 1997 federal Balanced Budget Amendments, such services were required to be provided by hospice employees. Amendments to the Social Security Act now allow the hospice to contract for physician services and for the position of medical director. In addition to the core services, a hospice must also ensure the provision certain other services either directly by hospice employees or under arrangements made by the hospice including: physical therapy, occupational therapy, and speech-language pathology; home health aide and homemaker services; medical supplies; and short term inpatient care.

B. EFFECT OF PROPOSED CHANGES:

This bill amends hospice statute to expand and limit DOEA's authority to promulgate administrative rules related to hospice standards and procedures; clarify that hospices. The bill provides that a hospice may contract for physician services. Further, it clarifies that a hospice patient living in a residential facility is a hospice patient, subject to hospice care standards.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes, more specific rule authority is provided to the Department of Elder Affairs. Specifically, DOEA is authorized to prepare rules related to the patient plan of care; procedures relating to advance directives and DNROs; standards of care for patients residing in residential settings other than their home; physical plant standards for hospice residential facilities; components of a disaster plan; procedures relating to the activities of quality assurance and utilization review committees; and the collection of hospice data.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No new roles are prescribed.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

None.

(2) what is the cost of such responsibility at the new level/agency?

None.

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

N/A

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

N/A

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

No.

(5) Are families penalized for not participating in a program?

No.

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

400.605, 400.6085, 400.609, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 400.605, F.S., relating to DOEA rule promulgation authority for hospice, to:

(1) Add rule authority relating to the patient plan of care; procedures relating to advance directives and DNROs; standards of care for patients residing in residential settings other than their home; physical plant standards for hospice residential facilities; components of a disaster plan; procedures relating to the activities of quality assurance and utilization review committees; and the collection of hospice data.

(2) Delete rule authority relating to hospice contractual arrangements.

Section 2. Amends s. 400.6085, F.S., relating to hospice contractual services, to make a conforming amendment.

Section 3. Amends s. 400.609, F.S., relating to responsibilities for the provision of hospice services, to:

(1) Permit physician services to be provided through contract; and

(2) Specify that a hospice patient residing in facility subject to state regulation shall be subject to hospice standards and requirements.

Section 4. Provides an effective date of July 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

None are projected.

2. Direct Private Sector Benefits:

None are projected.

3. Effects on Competition, Private Enterprise and Employment Markets:

No effect.

D. FISCAL COMMENTS:

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

Not applicable.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

Not applicable.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

Not applicable.

V. COMMENTS:

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

Amendment 1 clarified the provisions in section 3 related to the core services a Hospice must provide. It provides that a hospice may use contracted staff if necessary to supplement hospice employees during times of peak patient load or under extraordinary circumstances. Further, it specifies that a hospice must provide or arrange for home health aide services. This language conforms the state statute to federal Medicare language.

VII. SIGNATURES:

COMMITTEE ON Elder Affairs & Long Term Care:

Prepared by:	Staff Director:
Melanie Meyer	Tom Batchelor, Ph.D.