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Dear Mr. Chiplin:

I received your electronic mail message dated July 10, 2002, regarding clarification of rules regarding access to the Medicare hospice benefit. I appreciate your interest in the hospice program. You posed several questions centered on provider and physician interpretation of the rules pertaining to hospice. The questions were thought provoking and I would like to address them in further detail below.

#### Question

1. Can a Medicare beneficiary who has elected the hospice benefit and who also qualifies for the state's home and community based waiver program, utilize the benefits from both programs simultaneously? How are services to be coordinated in such situations?

#### Response

An eligible Medicare beneficiary who elected the hospice benefit and who also qualifies for a state's home and community based waiver program may utilize the benefits from both programs simultaneously. In accordance with the Medicare Conditions of Participation (CoPs), the Medicare certified hospice provider is responsible for coordinating the hospice patient's plan of care (42 CFR 418.58(a) and (c)) and is responsible for the professional management of the hospice patient's care in any setting (42 CFR 418.56(c)). Therefore, it is incumbent upon the hospice provider to initiate the coordination with the Home and Community Based Waiver program Case Manager so that the hospice patient receives all of the care and services necessary to support and maintain them in their home environment. The Home and Community Based Waiver program's case manager is responsible for adjusting the waiver services so that there is no duplication of services provided by the hospice or the state.

**Question**

2. How does the patient appeal this result when the hospice has already received the daily rate for services but has not provided care to the level required?

**Response**

Under the Medicare Hospice Benefit (MHB), the hospice is responsible for “providing the care and services described in §418.202 and must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis”. The hospice must also “make all other covered services available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;” and “provide these services in a manner consistent with accepted standards of practice.” (42 CFR 418.50(b)(1)(2)(3)) Based on the hospice regulations, it is incumbent upon the hospice to continually assess the patient's needs so that quality services are provided in sufficient quantities to meet the identified needs. Therefore, we believe that this is a quality of care issue. Patients have the right to complain to their State agency responsible for the regulatory oversight of hospice services. Each state is required to have a toll free hotline that patients can call to complain or inquire about any hospice provider from whom they have received services. Patients should be encouraged to contact their state agency anytime that they have a complaint about a provider.

**Question**

3. What is the level of detail to be included in a hospice's notice of non-coverage of Medicare covered services?

**Response**

Hospices are required to give an Advance Beneficiary Notice (ABN) to Medicare beneficiaries when the hospice believes that Medicare will deny payment on one of the bases listed in §IV.2. The detail in the ABN must include the approved language for filling in the "Items or Services" and "Because" boxes on the ABN (CMS-R-131-G) form, as follows:

(A) Ineligibility:

Box 1: Item or Services: "the Medicare hospice benefit."

Box 2: Because: "we have determined that you are not eligible under Medicare rules for certification as having a terminal prognosis as defined in the law."

(B) Level of Care:

Box 1: Item or Services: "the hospice General Inpatient Care level of care." OR "the hospice Continuous Home Care level of care."

Box 2: Because: "we have determined that you do not require this level of service."

**Question**

4. Recent studies by MEDPAC indicate that patients on average are dying within the first week of hospice usage. We find that physicians often wait far too late in the course of an illness to certify a patient for hospice. What information is available for physicians to assist to assist them in recognizing and referring terminally ill patients to hospice?

**Response**

The Centers for Medicare & Medicaid Services (CMS) is aware that the average length of stay for a hospice patient is relatively short, somewhere in the 14 to 21 day range. We believe that there may be several reasons why physicians are waiting until late in the course of the patient's illness to refer them to hospice, but recognize physician reluctance to refer to hospice as one of those reasons. Therefore, CMS has begun an initiative to educate physicians about the benefits of hospice and to work with some physician associations to sponsor end-of-life care education to physicians in the hopes of changing their opinions about hospice.

To help bring more attention to hospice and end-of-life care, CMS has published an article recently in the Physician Executive Journal, McKnight's Long Term Care News, and Caring Magazine entitled, "End-of Life Care Enhances Dignity and Peace as Life Nears Its End". The article provides information about the benefits of hospice services to terminally ill patients and reinforces CMS's commitment to ensure that beneficiaries receive appropriate end-of-life care tailored to meet their own needs.

In addition, the CMS Administrator recently sent a letter to numerous physician associations to address the concerns that the physician community has expressed to CMS about the difficulty in making end-of-life care prognoses and in particular, about making accurate or exact prognoses. The letter contained the following paragraph:

"We recognize that making these determinations is not an exact science and that the impact of a hospice's services may, initially, improve the patient's condition. Thus, Medicare regulations uses the terms "expectancy" and "if the terminal illness runs its normal course" in its definition to indicate that it is entirely possible for hospice services to be needed for more than a 6-month period. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses. In further recognition of the difficulty in making exact predictions,

physicians certifying Medicare patients for hospice care are expected only to use their best "clinical judgment regarding the normal course of the individual's illness."

We have received feedback from two of the associations expressing their gratitude to CMS for sending the letter and its continued support of the hospice industry.

**Question**

5. In some instances, patients who meet hospice coverage criteria and receive palliative chemotherapy, radiation, or surgery, are being denied access to the hospice benefit. What specific appeals process is available to beneficiaries who have been denied services in this regard?

**Response**

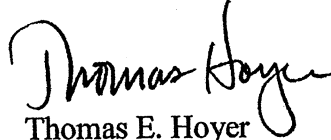
The Medicare claims appeal process only provides appeal rights to the Medicare beneficiary if a claim is filed on their behalf. Therefore, in the instance described above, there would not be any relief for the beneficiary under the Medicare program. However, we believe that this is a quality of care and regulatory compliance issue. The Balanced Budget Act of 1997 changed the law so that hospice providers are required to provide "any other item or service which is specified in the plan and for which payment may otherwise be made under this title". (§1861(dd)(1)(I))

Based on the change in law described above, beneficiaries should be encouraged to contact their state agency responsible for providing regulatory oversight for quality of care if this situation happens to them. Also, CMS encourages any person that knows of a hospice provider that consistently denies a Medicare beneficiary access to hospice because of the contents of their proposed plan of care (to include the need for palliative chemotherapy, palliative radiation, etc.), should report that hospice to their state agency's toll free hotline.

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In conclusion, we appreciate your interest in the Medicare Hospice Benefit, as well as the Medicare program and thank you for bringing these questions to our attention. Please feel free to contact Carol Blackford, of my staff at (410) 786-5909 with any additional questions or comments.

Sincerely,

A handwritten signature in cursive script that reads "Thomas Hoyer". The signature is written in black ink and is positioned above the printed name.

Thomas E. Hoyer

Director

Chronic Care Policy Group

Center for Medicare Management