NEW HOSPICE REGULATIONS:
One Step Forward, Two Steps Back?

Since 1997, Congress has attempted to expand access to the Medicare hospice benefit by making several changes to Medicare law. On November 22, 2005, the Centers for Medicare & Medicaid Services (CMS) issued a final rule which incorporated these changes. Final Rule, 70 FR 70532, Nov. 22, 2005, ¶ 180.554. However, in the final rule, the positive gains sought by the promulgated laws have been tempered by the infusion of CMS policy and inattention to detail. Consequently, the new regulations may make it more difficult, rather than less, for Medicare beneficiaries to obtain appropriate hospice care.

PHYSICIAN CERTIFICATION:

The Balanced Budget Act of 1997 (BBA), the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) all contain provisions intended to expand access to Medicare covered hospice care. They include: (1) Expanding the duration of available hospice care to two 90 day periods followed by an unlimited number of 60 day periods; (2) Permission for physician certification of terminal illness to be obtained by the hospice program orally within two calendar days of the start of the benefit period when the hospice is unable to obtain written certification, so long as written certification is obtained before a claim for Medicare payment is submitted; (3) Making the hospice election continuous, such that the election continues through all election periods unless the election is revoked or the hospice beneficiary is discharged; and (4)Clarifying that the hospice certification of terminally ill status will be based on the physician’s clinical judgment regarding the normal course of the individual’s illness.

The clarification regarding hospice certification is from §322 of BIPA which amended §1814(a) of the Social Security Act. Specifically, §322 states that a hospice certification “shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.” Moreover, to assuage physician concerns regarding the difficulty of predicting a beneficiary’s life expectancy, the law explains that “prognostications of life expectancy” are “not always exact.”

Overall, the goal of §322 was to encourage access to hospice care for Medicare beneficiaries. However, the way this law has been incorporated into the new hospice regulations may have the opposite effect. Per 42 C.F.R. § 418.22 of the new regulations, Medicare coverage will only be granted if the hospice certification conforms to the following requirements: (1) The certification specifies that the individual’s prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course and (2) Clinical information and other documentation that support the medical prognosis accompanies the written certification. The new regulations do state that the
certification will be “based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.” However, by requiring that clinical information and other documentation accompany the certification, the regulations are also indicating that the physician’s clinical judgment will be reviewed. And thus the actual arbiter as to whether the beneficiary is terminally ill will not be the beneficiary’s physician, as Congress intended, but an individual who works for an insurance company.

**DISCHARGE APPEAL RIGHTS:**

In BIPA Congress recognized that Medicare beneficiaries receiving care from skilled nursing facilities, home health agencies, and hospices are vulnerable. In light of this recognition, Congress created special appeal rights for beneficiaries who are at risk of discharge or termination of services from a skilled nursing facility, home health agency, or hospice. Consequently, on November 26, 2004, CMS promulgated new regulations entitled Expedited Determination Procedures for Provider Service Terminations. Final Rule, 69 FR69253. Per the new regulations, prior to “any termination of service, the provider of the service must deliver valid written notice to the beneficiary of the provider’s decision to terminate services.” 42 C.F.R. §405.1200. In the case of hospice patients this notice triggers the Medicare beneficiary’s right to request an expedited determination. 42 C.F.R. §405.1202. That is, the hospice patient now has the right to have an independent agency review the hospice program’s discharge decision. Given the medical vulnerability of hospice patients, this right to an independent review is obviously very important. This rule became effective on July 1, 2005.

The new hospice Medicare regulations permit hospice programs to discharge patients under only three circumstances:

1. The patient moves out of the hospice’s service area or transfers to another hospice;
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 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. 42 C.F.R. §418.26(a).

When asked for comments by CMS on the proposed rule, one respondent asked that the “beneficiary [be] advised of appeal rights when a discharge for cause is being considered.” Another respondent pointed out the “potential of misuse of the discharge for cause rule to discharge high-cost patients.” In response to these comments, CMS stated, “There are no specific appeal rights for the beneficiary regarding such considerations. However, for the protection of the beneficiary, we added to the new regulation, a provision that the beneficiary must be notified, by the hospice, that discharge for cause is being considered.”

To this end, the new regulations state that prior to discharge for cause, the hospice must:

1. Advise the patient that a discharge for cause is considered;
2. Make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation;
Ascertain that the patient’s proposed discharge is not due to the patient’s use of necessary hospice services; and

Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical record. 42 C.F.R. §418.26(a).

Clearly, however, this obligation to document is without meaning if it cannot be reviewed by an independent entity prior to the beneficiary’s discharge from the hospice program. To protect the rights of dying people, CMS must issue clarification indicating that Medicare beneficiaries who are at risk of discharge by a hospice agency for any reason, including cause, have a right to an expedited determination by an independent agency.

**DISCHARGE PLANNING:**

The new Medicare regulations require that hospice programs perform discharge planning. Specifically, “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.” Furthermore, “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.” 42 C.F.R. §418.26(d).

This new discharge planning requirement is a positive development, but it does not go far enough, as it only applies to individuals who are facing discharge because they are no longer terminally ill. Those who move out of the service area or choose to revoke their hospice election also need discharge planning, as do individuals who are discharged for cause. Consequently, the regulation should be changed to require discharge planning for all hospice patients, regardless of the reason for the discharge.

**CONCLUSION:**

Far too few terminally ill Medicare beneficiaries access the hospice benefit. Congress has recognized this problem and attempted to rectify it. However, the final rules promulgated by CMS have failed to adequately facilitate Congress’ intent. They have granted insurance companies, rather than physicians, ultimate control over determining who is eligible for hospice care. They have failed to recognize the importance of expedited determinations for beneficiaries discharged from hospices “for cause” and failed to recognize that such a right exists. And finally, they have failed to grant discharge planning rights to hospice beneficiaries who are discharged for reasons other than a change in their terminal status. These failures may result in Medicare beneficiaries getting less rather than more hospice care.

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