DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

7500 Security Boulevard
Baltimore, MD 21244-1850

DATE: April 20, 2000

FROM: Director
Chronic Care Policy Group
Center for Health Plans and Providers

Director
Survey and Certification Group
Center for Medicaid and State Operations

Director
Clinical Standards Group
Office of Clinical Standards and Quality

SUBJECT: **Advance Directives and Do Not Resuscitate (DNR) in Medicare Hospice - Clarification**

TO: All Regional Administrators
Regions I - X

The purpose of this memorandum is to provide clarification and/or additional information regarding Advance Directive and DNR requirements for Medicare hospice providers. This response comes as a result of several inquiries from hospice providers and State survey agencies regarding these issues.

On March 18, 1997, the Health Care Financing Administration (HCFA) distributed a memorandum (enclosed) entitled AClarification of Advance Directive Requirements@. This memorandum provided clarification on advance directive requirements for all Medicare providers, including hospices. HCFA has not changed the requirements for advance directives and/or DNR policies since the distribution of that memorandum, which is based on the law and implementing regulations found at 42 C.F.R. 489.100, 42 C.F.R. 489.102, and Section 1866 of the Social Security Act (the Act). Section 1866, among other things, requires that a provider of services under Medicare enter into a provider agreement with the Secretary and comply with the requirements specified in that section. It specifies that to participate in the Medicare program, hospitals, skilled nursing facilities (SNF), home health agencies (HHA), and hospice programs, as well as Apre-paid organizations and eligible organizations@ (HMOs and MCOs), must comply with advance directive requirements found in Section 1866(f). This requirement is implemented in 42 C.F.R. Part 489, Subpart I. In addition, Section 1902(w) of the Act mandates the same advance directive requirements for Medicaid providers. Implementation requirements for States and Medicaid providers are found in 42 C.F.R. Part 483, Subpart B.

Under these provisions, an advance directive means Aa written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated.@ This also includes Ado not resuscitate orders@. A living will generally states the kind of medical care that an individual wants, or does not want, if he or she is unable to make his or her own decision. A durable power of attorney for health care is a signed, dated and witnessed statement naming another person (spouse, significant other, child, parent or other person) to act for the individual on making decisions for that individual should he or she become unable to make those decisions.

As stated above, the law makes these rules explicitly applicable to hospices. Therefore, the hospice program is required to furnish advance directive information to patients at the time of initial receipt of hospice care by the individual from the program.

In certain circumstances as provided by the law, a facility or individual physician may conscientiously object (42 C. F. R. 489.102 (3)(4)) to carrying out certain advance directive requirements when permitted under State law, but this exception does not provide facilities with an exemption from the full advance directive requirements. Thus, while each patient has the right to formulate an advance directive, a facility or individual physician may conscientiously object to an advance directive, but only within certain limited circumstances and only if allowed by State law. For patients who are incapacitated and cannot make these decisions, the organization must defer to State law.

Based on the above referenced laws and regulations, Medicare certified hospice providers are bound by these requirements and may not refuse to have staff skilled in resuscitation or refuse to revive a patient who desires to be resuscitated. However, hospice providers may counsel patients at election as to the hospice=s philosophy, including its philosophy on this issue, and patients whose views are at odds with the hospice=s philosophy may elect to receive care from another source.

We would appreciate it if you would share this information with all RHHIs and States in your region.

Please contact Lynn Riley (CHPP/CCPG staff) at 410-786-1286 with any additional questions.

/s/ /s/ /s/

Thomas E. Hoyer Steven A. Pelovitz Rachael B. Weinstein

Enclosure:
HCFA Memorandum dated March 18, 1997