Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-040 **Date: MARCH 28, 2003**

CHANGE REQUEST 2570

SUBJECT: Provider Education Article: "Hospice Care Enhances Dignity and Peace As Life Nears Its End"

The attached article is for publication in your next regularly scheduled bulletin, and for posting on your provider education Web site, within two weeks of receiving this Program Memorandum (PM). In addition, if you have a list-serv that targets the affected provider community (i.e., physicians, skilled nursing facilities and hospitals), you should use your list-serv to notify subscribers that important information about the Medicare Hospice Benefit is available on your Web site. This article addresses the issue of the Medicare hospice benefit and emphasizes the benefits of hospice care for beneficiaries. It advises physicians that they need not be concerned about CMS penalties when certifying an individual for hospice care. The article notes that CMS is aware that terminal illness does not always have a predictable course and can be extended beyond the initial six month certification.

The article is a reminder to physicians, skilled nursing facilities, and hospitals that this benefit is available to Medicare beneficiaries, and it serves as a notice that a Medicare beneficiary may independently request the hospice benefit if he/she feels it is warranted. However, in all instances, a physician must certify that the hospice care is appropriate and the beneficiary meets all qualifying conditions of the benefit. The beneficiary's physician must certify the hospice care if the decision is made by the beneficiary to receive the benefit. Physicians, hospitals and skilled nursing facilities are urged to recommend hospice care to beneficiaries whom they determine may benefit from it.

The *effective date* for this PM is March 28, 2003.

The *implementation date* for this PM is April 11, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after March 31, 2004.

If you have any questions concerning provider education activities addressed in this PM, contact Mary Loane at (410) 786-1405.

Attachment

Attachment

Hospice Care Enhances Dignity and Peace As Life Nears Its End

---

Much of the pain and sense of hopelessness that may accompany terminal illness can be eased by services specifically designed to address these needs. Hospice care, a fully reimbursable Medicare Part A benefits option for beneficiaries and providers since 1983, offers the services designed to address the physical and emotional pain through effective palliative treatment when cure is not possible. In the event that a beneficiary has been advised by his/her physician, that a cure for his/her illness is no longer possible, Medicare beneficiaries may discuss hospice care as an option. Physicians and other health care practitioners can be encouraged that the Medicare program includes a hospice benefit that provides coverage for a variety of services and products designed for those with terminal diagnoses. When properly certified and appropriately managed, hospice care is a supportive and valuable covered treatment option.

Physicians and health care providers in the community, skilled nursing facilities, and hospitals are urged to raise awareness among their patients about the hospice benefit and its availability. Further, a beneficiary may independently elect hospice care. The beneficiary may discuss this option in the event that he or she has a terminal diagnosis; however, in all such cases, a physician must certify that the beneficiary has a terminal diagnosis with a six month prognosis, if the illness runs its usual course.

Hospice care that is covered by Medicare is chosen for specified amounts of time known as "election periods." Essentially, a physician may certify a patient for hospice care coverage for two initial 90-day election periods, followed by an unlimited number of 60-day election periods. Each election period requires that the physician certify a terminal illness. Payment is made for each day of the election period based on one of four per diem rates set by Medicare, commensurate with the level of care.

Generally speaking, the hospice benefit is intended primarily for use by patients whose prognosis is terminal, with six months or less of life expectancy. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses, therefore, the benefit is available for extended periods of time beyond six months provided that proper certification is made at the start of each coverage period.

Recognizing that prognoses can be uncertain and may change, Medicare's benefit is not limited in terms of time. Hospice care is available as long as the patient's prognosis meets the law's six month test.

This test is a general one. As the governing statute says: "The certification of terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

CMS recognizes that making medical prognostication of life expectancy is not always an exact science. Thus, physicians need not be concerned. There is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill.

Many physicians appreciate the fact that hospice care enables family and loved ones to participate in the experience and to get help from the hospice in managing their own feelings and reactions to the illness. The value of hospice care is recognized and advanced by many physicians and other health professionals. One professional organization, the American Academy of Hospice and Palliative Medicine (formerly the Academy of Hospice Physicians) focuses its efforts on the "prevention and relief of suffering among patients and families" through palliative therapy, education and counseling. Among the Academy's objectives are to "bring the hospice approach into mainstream medicine and eliminate the dichotomy whereby patients receive either curative or palliative care."

This distinction is important because despite a growing appreciation for hospice care both as a philosophy and as a fully covered Medicare benefit, there appears to be two perceived barriers to its broader acceptance.

First is an understandable reticence to contemplate the end of life. A 1999 survey conducted by the National Hospice and Palliative Care Organization (NHPCO) found that Americans generally are reticent to discuss hospice care with their elderly parents. According to the survey, less than one in four of us have put into writing how we wish to be cared for at life's end. About one in five have not contemplated the subject at all, and a slightly smaller number told the surveyors they have thought about it but have not shared their thoughts with others.

The second perceived barrier is a lack of knowledge on the part of both patients and practitioners that the covered hospice benefits are both broad and readily available virtually everywhere in the country. As with other covered services, payments for hospice care generally are made to providers based on prospectively-set rates that are updated every year for inflation. Hospice care is primarily a specialized type of home health care, and as is the case with the home health care benefit, hospices are served by regional intermediaries for Medicare billings, payments, cost reports and audits.

Hospice care also is covered by Medicaid in many states. Medicare covers a number of specific services as defined in regulation and in the Medicare Hospice Program Manual. Most of these services are familiar to health care professionals and other practitioners who have worked with skilled nursing facilities (SNFs) and home health services. Covered services include:

- Medical and nursing care
- Medical equipment (such as wheelchairs or walkers)
- Pharmaceutical therapy for pain relief and symptom control
- Home health aide and homemaker services
- Social work services
- Physical and occupational therapy
- Speech therapy
- Diet counseling
- Bereavement and other counseling services
- Case management

Hospice care also is covered by Medicaid in many states.

In 1999, 474,270 individuals received hospice care at 2,281 certified hospice programs in the United States. In 2000 there were 2,266 certified hospices. In 2001, approximately 580,000 individuals received hospice care at 2, 277 (as of August 2001) certified hospice programs. The hospice setting also is appropriate for patients who suffer from terminal illnesses such as lung disease or end-stage heart ailments, cancer, Alzheimer's disease, and terminally ill AIDS patients. Hospice is not about death, but rather about the quality of life as it nears its end, for all concerned – the patient, family and friends, and the health professional community.

For more hospice information: *go online to* www.cms.gov/medlearn *and* www.medicare.gov/Publications/home.asp