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TO: All Part D Plan Sponsors and Medicare Hospice Providers

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SUBJECT: Part D Payment for Drugs for Beneficiaries Enrolled in Hospice—Request for Comments

DATE: December 6, 2013

Previous policy statements by CMS have addressed hospice and Part D sponsor requirements regarding responsibility for the payment of prescription drugs under the Part A hospice benefit and Part D. However, we have received questions indicating our policy statements are being misinterpreted by some parties. Therefore, in this memorandum, we seek to clarify the criteria for determining payment responsibility for drugs for hospice beneficiaries. The information included below is a summary, and clarification, of previous Medicare Part A regulatory and sub-regulatory guidance on eligibility and scope of benefits for Medicare hospice services. Based on these clarifications are new expectations for Part D sponsors to prevent duplicate payments for drugs covered under the hospice benefit or waived through the beneficiary's hospice election.

CMS continues to be concerned that drugs covered under the Part A Hospice Benefit are being billed to Part D inappropriately. Analysis completed by Abt Associates, on behalf of CMS, found that in 2010 there were 750,590 hospice beneficiaries enrolled in Part D. Of those hospice beneficiaries, 14.9% received 332,988 analgesics through Part D totaling $12.9 million. Analgesic billing appeared to be concentrated among certain types of hospices. Ten percent (350) of hospices accounted for approximately 51% of Part D analgesic claims. These hospices providers were typically for-profit, new, and/or rural. Furthermore, 50.3% of the analgesic claims were for hospice beneficiaries residing in nursing facilities.

We are issuing this guidance for review and seek comment on whether your questions have been addressed. Please submit your comments to the CMS Part D mailbox at: PartDBenefitImpl@cms.hhs.gov, using the subject "Request for Comments: Part D Payment for Drugs for Beneficiaries Enrolled in Hospice." Comments are due January 6, 2014 by noon EST.

Previous CMS Policy Statements

Medicare Part A Hospice Benefit

Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and symptoms), as opposed to curative care. Physical, emotional, psychosocial, and spiritual needs are addressed by a specially qualified interdisciplinary group of hospice employees or under arrangement, with an emphasis on keeping the hospice patient at home with family and friends as long as possible.

For an individual to be eligible for hospice services under the Medicare Hospice Benefit, the individual must be entitled to Medicare Part A, and must be certified as terminally ill. The individual's attending physician (if he or she has one) and the hospice medical director or physician member of the interdisciplinary group must certify that the individual is terminally ill.

Under the Medicare Hospice Benefit, "terminally ill" means that the individual has a medical prognosis of six months or less if the illness runs its normal course. The beneficiary (or his or her representative) must file and sign an election statement with the particular hospice. Additionally, the Social Security Act requires that the individual or representative electing hospice must acknowledge that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual's terminal prognosis; and, must acknowledge that he/she waives the right to payment of standard Medicare benefits for treatment of the terminal illness and related conditions.

In order for services to be covered under the Medicare hospice benefit, those services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. We have not made a regulatory specification of services that are unrelated to hospice care because of the wide variation of individual patient circumstances. These clinical decisions are to be made on a case-by-case basis.

To the extent that individuals seek and receive services outside of the hospice program, Medicare coverage is determined by whether or not the services are for treatment of a condition completely unrelated to the individual's terminal condition. It is our general view that the statutory waiver of the right to payment of standard Medicare benefits for treatment of the terminal illness and related conditions is a broad one, and hospices are required to provide virtually all the care that is needed by terminally ill individuals. The Statute does authorize the Secretary to establish guidelines to stipulate what services are waived that are related to the treatment of the individual's terminal condition or are the equivalent of hospice care. However, the regulations do not enumerate the specific services that the Secretary might consider related or equivalent to hospice care because it was recognized that there are many illnesses which may occur when an individual is terminally ill, which are brought on by the underlying condition(s) of the patient. As such, it was determined that the Medicare fiscal intermediaries and carriers would make determinations on individual cases as to whether the services received are covered hospice services, or are care among the services waived through the hospice election, or are unrelated services.

In Fiscal Year (FY) 2014 Medicare Hospice rulemaking ("Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform" proposed and final rules; 78 FR 27823, May 10, 2013; 78 FR 48234, August 7, 2013; respectively), we reiterated our view, as discussed in the 1983 implementing regulations, that when an individual is terminally ill, many health problems are brought on by underlying conditions, as bodily systems are interdependent. We also stated that the original intent of the Medicare Hospice Benefit was to have a Medicare benefit available that provided virtually all-inclusive care for terminally ill individuals, provided pain relief and symptom management, and offered the opportunity to die with dignity and comfort in one's own home rather than in an institutional setting.

Drugs and Biologicals Covered Under the Hospice Benefit

Under the Medicare Hospice Benefit, patients receive treatments and interventions to minimize symptoms, and maximize comfort and quality of life. By electing hospice, patients have chosen to move from a curative model of care to a holistic palliative model of care. Federal regulations at 42 CFR § 418.202(f) stipulate that the Medicare hospice benefit covers only drugs and biologicals used primarily for the relief of pain and symptom control for the terminal illness and related conditions (the term "drugs and biologicals" is defined in section 1861(t) of the Social Security Act). Patients may, in some cases, continue to receive the same treatment that they received prior to hospice elections, such as palliative chemotherapy, radiation, heart failure drugs, chronic obstructive pulmonary disease (COPD) drugs, etc. if those medications or treatments are for palliative purposes. Reimbursement for drugs and biologicals that are necessary for the palliation and management of the terminal illness and related conditions is included in the Medicare hospice per diem payment made under Medicare Part A. The Medicare hospice benefit does not pay for services that are curative in nature or for care by another hospice or provider that is not arranged for by the patient's hospice.

As noted above, a key component of hospice care is symptom control. These symptoms can be physical, emotional, psychosocial, and/or spiritual. Thus, when we refer to "pain and symptom relief", or "palliation and management of the terminal illness and related conditions", this encompasses all medical supplies and drugs needed to manage all the patient's health conditions related to the terminal prognosis, to minimize symptoms and maximize comfort and quality of life. The focus is not limited to pain medications or a narrow definition of palliative care, but is broad and holistic.

Use of Hospice Formularies

Hospices typically have a formulary of the drugs they frequently use for palliation and management of the terminal illness and related conditions. The hospice decides which medications it will carry on its formulary. Hospices work from their formulary first in finding medications to provide pain and symptom relief for their patients. All medications prescribed for a beneficiary must meet the needs of the beneficiary. If the drugs on the formulary are not providing the relief needed, then the hospice must provide an alternative(s) in order to relieve pain and symptoms, even if it means providing a drug(s) that is not on their formulary. We

expect hospices to provide non-formulary drugs when they are necessary to meet the patient's needs and desired outcomes.

However, sometimes a patient requests a specific drug which is not on the hospice formulary. The hospice does not have to provide that specific drug if the hospice interdisciplinary group determines that a medication on its formulary would work as well. If a patient insists on medication A that the hospice does not believe is reasonable and necessary, and the hospice has an alternative medication B that could meet the patient's needs, the patient could still receive medication A, but the hospice would not be liable for its cost. Part D cannot cover medication A since medication A or its equivalent is for palliation and management of the terminal illness and related conditions. The beneficiary assumes financial liability for medication(s) beyond what is considered reasonable and necessary. (See the section entitled "Implications for Beneficiaries" for further detail regarding beneficiary claims filing and appeals.) If the patient or his/her representative does not agree with the hospice plan of care and refuses to accept medications prescribed to meet the assessed needs, then the hospice is required to document this in the clinical record.

Hospice Policy- Notice of Election (NOE) Filing

The individual (or authorized representative) electing to receive hospice care must file an election statement with a particular hospice. When a Medicare beneficiary elects hospice services, hospices must complete an election notice (Form CMS-1450). CMS' hospice policy addresses both the required timing of NOE filing and the methods by which NOEs are filed. Section 20.1.1 of the Hospice Claims Processing Manual (IOM 100-04, chapter 11) states,

> "Hospices must send the Form CMS-1450 Election Notice to the Medicare contractor by mail, messenger, or direct data entry (DDE) depending upon the arrangements with the Medicare contractor. The NOE should be filed as soon as possible after a patient elects the hospice benefit."

Filing the NOE as soon as possible after election has been longstanding hospice policy. We reiterated this policy in the hospice section of the CY 2011 Home Health Final Rule, repeating the manual language above ("Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices"; 75 FR 70442, November 17, 2010), and have reiterated it in other settings as well, such as through Open Door Forums. The overwhelming majority of NOEs are filed electronically using direct data entry, which is the most efficient way to transfer the information from the hospice to the contractor. CMS expects hospices to comply with the requirement to submit the NOE as soon as possible after a patient elects the hospice benefit.

Previous Part D Guidance

As a result of concerns that Part D sponsors may have been paying for drugs that should have been the responsibility of a Medicare hospice, we issued a memorandum (October 22, 2010 entitled "Preventing Part D Payment for Hospice Drugs") specifying the statutory and regulatory requirements for hospices to provide drugs and biologicals related to the palliation and

management of the terminal illness and related conditions and indicating that, because hospice is a Part A benefit, drugs covered under the Medicare payment to the hospice are not covered under Part D. That memorandum directed Part D sponsors to communicate with their network pharmacies regarding ensuring that hospice drugs are not billed to Part D.

In the 2012 Final Call Letter (Attachment VII of the Announcement of Calendar Year 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter dated April 4, 2011), we noted that Part D sponsors receive beneficiary-level hospice data on the daily transaction reply report (DTRR). How promptly hospice data is reported on the DTRR following the hospice election is dependent upon the filing of the NOE and the flow of data through CMS systems. We directed sponsors to ensure their claims processor is notified of an enrollee's hospice election and that processes are in place to prevent Part D payment for hospice drugs. In response to requests for further guidance regarding how sponsors should identify hospice drugs, we suggested that unless the plan has information available at point-of-sale to determine payment responsibility, sponsors should pay the claims for drugs furnished to members enrolled in a hospice program that may be covered under the hospice benefit and retrospectively determine payment responsibility.

The most recent Part D hospice guidance (Attachment VIII of the Announcement of Calendar Year 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter published on April 1, 2013) in the 2014 Final Call Letter reiterated that drugs and biologicals when used primarily for the relief of pain and symptom control related to the terminal condition and related conditions are covered under the Medicare Part A per-diem payment to a hospice program and, therefore, are not covered under Part D. We noted our previous guidance had been to pay for drugs that may be covered under the hospice per-diem payment and retrospectively determine payment responsibility. However, the hospice industry expressed uncertainty with the definitions of terminal condition and related conditions, and Part D sponsors were thus uncertain about whether payment should be the responsibility of either the hospice or Part D. Therefore, we stated that when a sponsor receives a DTRR showing a beneficiary has elected hospice, the sponsor must have controls in place to comply with the requirement that Part D does not pay for drugs and biologicals that should be covered under the Medicare Part A per-diem payment to a hospice. Although we strongly encouraged sponsors to place beneficiary-level prior authorization (PA) requirements on four categories of prescription drugs, including: analgesics, antinauseants (antiemetics), laxatives, and antianxiety drugs, we permitted sponsors to use other approaches, such as pay-and-chase, to resolve payment responsibility in these scenarios. However, beneficiaries should only very rarely be taking drugs that are not covered under the hospice per diem. Drugs may also be discontinued following the assessment of services necessary for palliation and management of the terminal prognosis. Therefore, the number of drugs to be paid under Part D for hospice beneficiaries should be very minimal.

New Clarification for Part D

<u>Determination of Payment Responsibility for Drugs for Hospice Beneficiaries</u>

Subsequent to the release of the 2014 final Call Letter, two points have become clear. First, we have become aware that the duplicative payment issue for Part D sponsors was broader than the four classes of drugs specified in the Call Letter. Second, in reviewing the comments received on the May 2013 Hospice Proposed Rule (discussion at 78 FR 48245), we have recognized that a number of hospices are not viewing the benefit as holistically as CMS has defined it since implementation of the Medicare Hospice Benefit. Therefore, we provide the following clarifications to guide Part D sponsors in making decisions regarding their payment responsibilities for drugs for hospice beneficiaries.

The hospice plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. As such, there may be some medications that were used prior to the hospice election that will continue as part of the hospice plan of care, and would be covered under the Medicare hospice benefit, if those drugs are necessary for the palliation and management of the terminal illness and related conditions.

There may also be some drugs that were for the treatment of the terminal illness and/or related conditions prior to the hospice election that will be discontinued as it has been determined by the hospice interdisciplinary group, after discussions with the hospice patient and family that those medications may no longer be effective in the intended treatment, and/or may be causing additional negative symptoms in the individual. These medications would not be covered under the Medicare hospice benefit as they would not be reasonable and necessary for the palliation of pain and/or symptom management. If a beneficiary still chooses to have these medications filled through his or her pharmacy, the costs of these medications would then become a beneficiary liability for payment and not covered by Part D. These medications would not be covered by Part D because their further coverage is waived under Medicare.

Similarly, if a beneficiary requests a drug for his or her terminal illness or related conditions that is not on the hospice formulary and the beneficiary refuses to try a formulary equivalent first; or is determined by the hospice to be unreasonable or unnecessary for the palliation of pain and/or symptom management, the beneficiary may opt to assume financial responsibility for the drug. However, no payment for the drug will be available under Part D.

For prescription drugs to be covered under Part D when the enrollee has elected hospice, the drug must be for treatment of a condition that is completely unrelated to the terminal condition(s) or related conditions; in other words, the drug is unrelated to the terminal prognosis of the individual. We expect drugs covered under Part D for hospice beneficiaries will be extremely rare. **Therefore, the sponsor should place beneficiary-level PA requirements on <u>all</u> drugs for hospice beneficiaries to determine whether the drugs are coverable under Part D.** Because these PAs are necessary to establish whether the drug may be covered under Part D at all, a Part D enrollee's transition benefit has no impact on relaxing these edits.

As a general rule, hospice providers are expected to cover virtually *all* drugs for hospice beneficiaries during the hospice election. The hospice provider will be responsible for coordinating with Part D plan sponsors for those drugs they believe are completely unrelated to the terminal illness and/or related conditions to determine payment responsibility.

Although we expect it is extremely rare, beneficiaries who have elected hospice may be prescribed a medication for a condition that is completely unrelated to the terminal illness or related conditions. In such instances, we expect that the hospice provider or prescriber will immediately provide, to the Part D sponsor, the written documentation necessary to satisfy the PA. We expect the sponsor to accept the documentation that the drug is unrelated and not waived through the hospice election. Therefore, the drug is reimbursable under Part D and the claim should be processed. However, once an independent review process (see section below entitled "CMS' Independent Reviewer") is implemented, the sponsor may subsequently seek a determination from CMS' independent reviewer to confirm Part D coverage.

If the Part D sponsor pays for drug claims prior to receiving notification of the beneficiary's hospice election, the sponsor must perform a subsequent review of claims paid within the hospice election period and should conduct outreach to the hospice provider to make retrospective determinations of payment responsibility for the drugs. In order to determine whether the drug is for treatment of a completely unrelated condition, CMS expects the hospice provider to coordinate with the plan sponsor regarding these claims and provide the necessary written information, as requested by the sponsor. If the drug is determined to be the responsibility of the hospice or the beneficiary, the Part D sponsor must recover payment from the responsible party and delete the Prescription Drug Event (PDE) record, if applicable. Thus, the payment recovery will be handled without involving the pharmacy, that is, without recouping funds from the pharmacy or requiring the pharmacy to reverse the original claim. We have provided payment reconciliation guidance (see discussion below) to address this scenario.

For these scenarios, if the plan sponsor believes that the drug is <u>not</u> for a completely unrelated condition, once the appeals process is implemented, the sponsor should subsequently seek a determination from CMS' independent reviewer to confirm coverage under Part D. If the beneficiary desires to continue taking drugs that are not covered by Medicare Part A or Part D, then the hospice must fully inform the beneficiary of his or her financial liability.

If the hospice provider and Part D sponsor disagree, then once an independent review process is implemented, either may contact the CMS independent reviewer for a determination of drug payment responsibility. A medical review process would be initiated to determine whether the drug is reasonable and necessary, related to the terminal illness and/or related conditions, and therefore the hospice provider's payment responsibility; or was an item waived through the hospice election, and is the beneficiary's responsibility; or is unrelated, and can be paid through Part D. CMS expects Part D sponsors and hospice providers to accept the independent reviewer determination as final. Beneficiaries who disagree with such determinations may continue raising these issues through the Medicare fee-for-service appeals process if the determination relates to Part A or B coverage and the Part D appeals process if the determination relates to Part D coverage.

<u>Hospice Data and Data Flow</u>

Hospice Election, Certification, and Benefit Periods

To receive hospice care, an individual (or an authorized representative) must elect the hospice benefit and must be certified by a physician as terminally ill. A hospice election continues until the beneficiary revokes the benefit, is discharged, or passes away. As noted previously, a NOE is completed by the hospice and filed with the Medicare contractor, to transmit the data to CMS' Common Working File (CWF) in electronic format. The data are reported by the CWF to other CMS systems (see Attachment 1 for a chart of the data flow). An election is comprised of one or more benefit periods. The initial certification and benefit period is for 90 days. After the initial period, subsequent periods consist of another 90-day period and an unlimited number of 60-day periods.

Hospice Information Reported on the TRR

Hospice election information is sent to sponsors on the DTRR. As specified in the Plan Communications User Guide, the DTRR includes a hospice indicator, a hospice start date and a hospice termination date (see Attachment 2 for the hospice-related fields). Hospice data are reported on the DTRR at the time of the beneficiary's enrollment in a Part D plan, or hospice election if that election is made later. Updated data are reported when the hospice start dates change to reflect a new benefit period or a termination date is added due to death, discharge, or revocation of the election by the beneficiary.

Only one hospice benefit period can be reported on the DTRR. Thus, the hospice start date will be the date the current benefit period started. When the current benefit period ends, a new start date will be reported reflecting the start date of the new benefit period. Termination dates are reported on the DTRR only when the hospice benefit has terminated due to death, discharge, or revocation of the beneficiary's election. Thus, if no hospice termination date is reported on the DTRR, the new start date is the beginning of a new benefit period. Therefore, a new start date should not be viewed as an indication that the beneficiary revoked his/her hospice election and then re-elected the benefit, or was discharged and re-elected, creating an entirely new election. When a beneficiary revokes a hospice election or is discharged, the effective date of the revocation or discharge will be reported as the hospice termination date on the DTRR. If the beneficiary revoked the election, a hospice revocation indicator will be included in the MARx system. Please note that when a beneficiary revokes his/her hospice election or is discharged from hospice care, the beneficiary immediately resumes Medicare coverage of the benefits waived when hospice care was elected.

Since only a single hospice benefit period can be reported on the DTRR, sponsors must store the hospice data in their systems so historical data are available when needed for claims adjudication and adjustments. Sponsors can also access additional hospice data via MARx User Interface, including prior benefit period start and end dates and the hospice revocation indicator (see Attachment 3 for a sample of the MARx hospice data screen).

We will continue to explore approaches for expediting the reporting of the hospice data to make it more timely, thereby reducing the need for retroactive claims adjustments and PDE deletions. However, we are unable to comply with requests to expand the DTRR to include fields for the name, address and phone number of the hospice. Instead, we will be posting hospice information on the CMS website; thus, once hospice is identified by a pharmacy, prescriber or beneficiary, the contact information will be available to sponsors when needed.

Part D Payment Reconciliation with the Medicare Hospice or the Beneficiary

CMS Part D policy regarding payer-to-payer reconciliation is addressed in Chapter 14 of the Medicare Prescription Drug Benefit Manual section 50.14.4 entitled, "Resolution Directly with Other Payers." Although this guidance describes scenarios in which Part D sponsors must work with other payers who either pay when they should not have paid at all, or pay more than they should have, because they paid out of the correct payer order, we believe the inverse of this guidance also applies. That is, in scenarios in which Part D sponsors pay and should not have, because payments were the responsibility of other payers, the payers should work together to reconcile the payment issues.

This is applicable in scenarios involving drugs for hospice beneficiaries. In such scenarios, the other payer is the hospice, and CMS expects sponsors and hospices to work directly with each other to resolve payment responsibility and recover amounts paid. In those scenarios in which the beneficiary requests a nonformulary drug and refuses to try a formulary equivalent, or it was determined by the hospice to be unreasonable or unnecessary, but the beneficiary agreed to assume financial responsibility for it, recovery should be sought from the beneficiary. Thus, sponsors should delete the PDE and implement processes to handle payment resolution directly with hospices and beneficiaries without having the pharmacy reverse and rebill the original claim.

CMS' Independent Reviewer

We recognize a mechanism is necessary for handling disputes between the hospice and Part D sponsors regarding payment responsibility when the drug should be paid for and the question at issue is whether it should be paid for by the hospice or Part D sponsor. As a result, we are exploring incorporating an independent reviewer function as part of the appeals process under a CMS contract. The independent reviewer's decisions will be binding on the hospice and the Part D sponsor. We will outline the details of the independent review process in future guidance providing adequate notice to all affected parties.

In the interim, CMS expects:

- The hospice and Part D sponsor to coordinate their benefits;
- The hospice/prescriber to immediately provide written documentation to satisfy the Part D PA;
- The Part D sponsor to accept and maintain the documentation that the drug is unrelated and not waived through the hospice election and is, therefore, reimbursable under Part D and process the claim; and
- If the sponsor disagrees with the hospice/prescriber decision, the sponsor to flag the claim and request a retrospective determination of drug payment responsibility by the independent reviewer once the process is implemented.

Effective Date of Clarified Part D Guidance

The effective date of this policy clarification will be March 1, 2014. Part D sponsors, however, must follow prior CMS instructions concerning the denial of Part D payments for pain medications for hospice beneficiaries.

Implications for Beneficiaries

Beneficiary Fee-for-Service Claims and Appeals

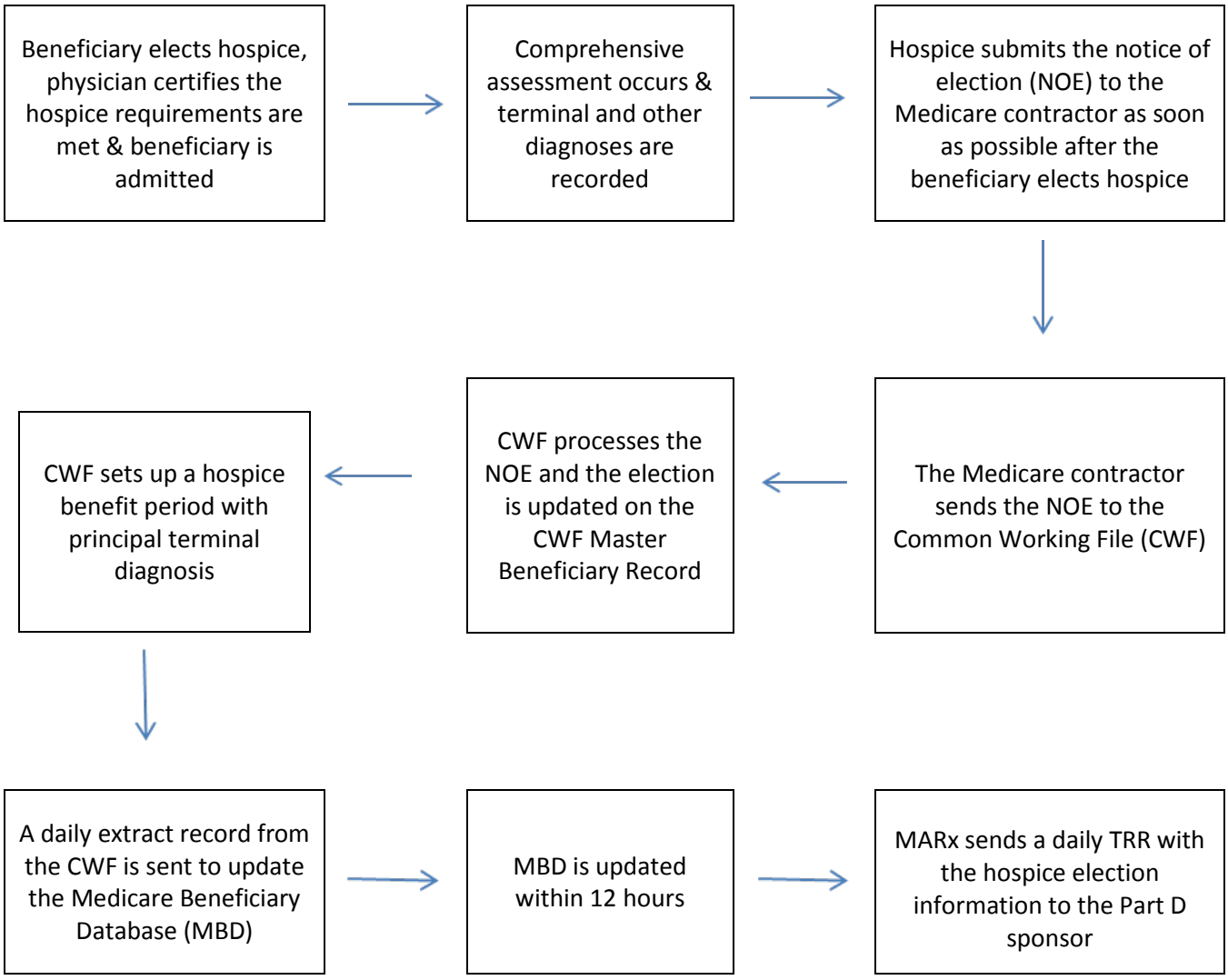
Sometimes a beneficiary requests a certain medication that a hospice can't or won't provide because it's not reasonable and necessary for the palliation and management of the terminal illness and related conditions. The cost of such a medication, which is not reasonable and necessary for the management of the terminal illness or related conditions, would be a beneficiary liability. If the hospice does not provide the medication, the hospice is not obligated to provide any notice of non-coverage (including the Advance Beneficiary Notice of Non-coverage or ABN). If the hospice provides the medication even though it is not reasonable and necessary, it must issue an ABN in order to charge the beneficiary for the medication. Regardless of whether or not the hospice furnishes the drug, if the beneficiary feels that the Medicare hospice should cover the cost of the drug, the beneficiary may submit a claim for the medication directly to Medicare on Form CMS-1490S. If the claim is denied, the beneficiary may file an appeal of that determination under the appeals process set forth in part 405, subpart I.

Part D Transition for Changes in Level of Care

Existing transition guidance in Chapter 6 of the Medicare Prescription Drug Benefit Manual §30.4.7 discusses level of care changes and transition. The guidance states that circumstances exist in which unplanned transitions for current enrollees could arise and in which prescribed drug regimens may not be on sponsor formularies. These level of care changes involve a beneficiary changing from one treatment setting to another, and include beneficiaries who revoke hospice to revert to standard Medicare benefits.

For these unplanned transitions, beneficiaries and providers must avail themselves of sponsor exceptions and appeals processes. CMS has streamlined the grievance, coverage determination, and appeals process requirements in order to ensure that beneficiaries receive quick determinations regarding the medications they need. In all cases, CMS makes it clear that a Part D sponsor is required to make coverage determinations and redeterminations as expeditiously as the enrollee's health condition requires.

Attachment 1- Hospice Data Flow



Attachment 2- Daily Transaction Reply Report (DTRR) (excerpted from PCUG)

F.14.1 DTRR Data File Detailed Record Layout

Item	Field	Size	Position	Description
12	Hospice Indicator	1	54	'1' = Hospice; '0' = No Hospice; Space = not applicable.
15	Transaction Reply Code (TRC)	3	57-59	TRC, see TRC list on page I-2 for values
18	Effective Date	8	63-70	YYYYMMDD Format; Effective date is present for all TRCs.
24	Positions 85 – 96 are dependent upon the TRC value. There are spaces for all codes except where indicated below.	8	85-92	This field value depends on the TRC that is returned on the reply. See the TRC-related values below:
	e. Hospice Start Date	8	85-92	YYYYMMDD Format; Present only when TRC is 71
	f. Hospice End Date	8	85-92	YYYYMMDD Format; Present only when TRC is 72

Table I-2: Transaction Reply Codes

Code	Type	Title	Short Definition	Definition
071	M	Hospice Status Set	HOSPICE ON	This TRC is returned on a reply with Transaction Type 01 and occasionally with Transaction Type 51, and Transaction Type 61. When returned with Transaction Type 01, the TRC is in response to a change in beneficiary Hospice status. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. In the case of Transaction Type 01, a notification has been received that this beneficiary is in Hospice status. The date on which Hospice Status became effective is reported in DTRR data file fields 18 and 24. The effective date for Hospice Status is not restricted to the first or last day of the month. It may be any day of the month. When this TRC is returned with Transaction Type 61 the TRC is in response to a retroactive enrollment and is identifying the fact that an enrollment end date has been established due to the beneficiary's hospice status. The enrollment start date is in DTRR data file field 18 and the enrollment end date is in field 24. In this circumstance it is accompanied by TRC 018, Automatic Disenrollment, as well.
072	M	Hospice Status Terminated	HOSPICE OFF	This TRC is returned on a reply with Transaction Type 01. It is not a reply to a submitted transaction but is intended to supply the Plan with additional information about the beneficiary. A notification has been received that this beneficiary's Hospice Status has been terminated. The end date for the Hospice Status is reported in DTRR data file fields 18 and 24. The date for termination of Hospice Status is not restricted to the first or last day of the month. It may be any day of the month.

Attachment 3- Hospice Data in the MARx System