Medicare

HOSPICE BENEFITS

a special way of caring for the terminally ill

Health Care Financing Administration
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Medicare- Hospice Benefits

Medicare Hospice Benefit

Hospice is a special way of caring for a person whose disease cannot be cured. It is available as a benefit under Medicare Hospital Insurance (Part A) to beneficiaries with a very limited life expectancy.

A Medicare beneficiary who chooses hospice care receives non-curative medical and support services for his or her terminal illness. Home care is provided along with necessary inpatient care and a variety of services not otherwise covered by Medicare.

The focus is on care, not cure. Emphasis is on helping the person to make the most of each hour and each day of remaining life by providing comfort and relief from pain.

What Is Hospice Care?

Under Medicare, hospice is primarily a program of care delivered in the patient's home by a Medicare-approved hospice. Reasonable and necessary medical and support services for the management of a terminal illness are furnished under a plan-of-care established by the hospice and the patient's attending physician.

When all requirements are met, Medicare covers:

- ☑ Physician services.
- ☑ Nursing care.
- ☑ Medical appliances.
- ☑ Medical supplies.
- ☑ Outpatient drugs for symptom management and pain relief.
- ☑ Short-term inpatient care, including respite care.
- ☑ Home health aide and homemaker services.
- ☑ Physical and occupational therapy.
- ☑ Speech/language pathology services.
- ☑ Medical social services.
- ☑ Dietary and other counseling.

Medicare pays nearly the entire cost of those services. The only expense to the patient is limited cost-sharing for outpatient drugs and inpatient respite care.

Who Is Eligible?

Medicare coverage for hospice care is available only if:

- The patient is eligible for Medicare Part A;

- The patient's doctor and the hospice medical director certify that the patient is terminally ill with a life expectancy of six months or less;
- The patient signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness; and
- The patient receives care from a Medicare-approved hospice program.

Finding A Program

Hospice care can be provided by a public agency or private organization that is primarily engaged in furnishing services to terminally ill individuals and their families. To receive Medicare payment, the agency or organization must be approved by Medicare to provide hospice services.

Beneficiaries can find out whether a hospice program is approved by asking the organization offering the program, contacting any Social Security Administration office, or by calling **1-800-638-6833.** The TTY/TDD number for persons with hearing or speech impairments is **1-800-820-1202**.

How Is Care Provided?

Hospice uses a team of people to deliver care. The team usually consists of family, a nurse, physician, social worker, dietitian and clergy, all working together to plan and coordinate care. Speech pathologists, physical therapists, occupational therapists and other trained caregivers are available as needed.

While a family member or other caregiver attends to the patient on a daily basis, members of the team make regular home visits. In addition, a nurse and physician are on-call 24 hours a day, 7 days a week to provide advice over the telephone and to make visits whenever necessary.

If inpatient care is needed, the hospice team can arrange for care to be provided in another setting. In some cases, the care is provided in an inpatient hospice unit, hospital, or nursing home, depending on the needs of the patient.

Even though the hospice team includes a physician, patients can continue to use their personal physician. Medicare will help pay for covered services provided by

a physician not affliliated with the hospice if the patient is covered by Medicare Medical Insurance (Part B).

How Long Can Hospice Care Continue?

Special benefit periods apply to hospice care. A Medicare beneficiary may elect to receive hospice care for two 90-day benefit periods, followed by a 30-day period and, when necessary, an extension period of indefinite duration.

The benefit periods may be used consecutively or at intervals. Regardless of whether they are used one right after the other or at different times, the patient must be certified as terminally ill at the beginning of each period.

A patient has the right to cancel hospice care at any time and return to standard Medicare coverage, then later re-elect the hospice benefit if another benefit period is available. If a patient cancels during one of the first three benefit periods, any days left in that period are lost. For example, if a patient cancels at the end of 60 days in the first 90-day period, the remaining 30 days are forfeited. The patient is, however, still eligible

for the second 90-day period, the 30-day period, and the indefinite extension.

If the patient decides to cancel during the final period, the decision is irreversible. The patient must return to standard Medicare coverage and cannot use the hospice benefit again.

Besides having the right to discontinue hospice care at any time, patients also may change hospice programs once each benefit period.

How Is Payment Made?

Medicare pays the hospice directly at specified rates depending on the type of care given each day. The patient is responsible only for:

- Drugs or biologicals: The hospice can charge 5% of the reasonable cost, up to a maximum of $5, for each prescription for outpatient drugs or biologicals for pain relief and symptom management.
- Inpatient respite care: The hospice may periodically arrange for inpatient care for the patient to give temporary relief to the person who regularly provides care in the home. Respite care is limited each time to a stay of no more then 5 days.The patient can be charged about $5 per day for inpatient respite care. The charge, which is subject to change each year, varies slightly depending on the geographic area of the country.

What Is Not Covered?

All services required for treatment of the terminal illness must be provided by or through the hospice. When a Medicare beneficiary chooses hospice care, Medicare will not pay for:

- ☑ Treatment for the terminal illness which is not for symptom management and pain control;
- ☑ Care provided by another hospice that was not arranged by the patient's hospice; and
- ☑ Care from another provider which duplicates care the hospice is required to furnish.

Are Other Medicare Benefits Available?

When a Medicare beneficiary chooses hospice care, he or she gives up the right to standard Medicare benefits only for

treatment of the terminal illness. If the patient, who must have Part A in order to use the Medicare hospice benefit, also has Medicare Part B, he or she can use all appropriate Medicare Part A and Part B benefits for the treatment of health problems unrelated to the terminal illness. When standard benefits are used, the patient is responsible for Medicare's deductible and coinsurance amounts.

For Further Information

Other sources of information about hospice care include State health departments, State hospice organizations and The National Hospice Organization, 1901 North Moore Street, Suite 901, Arlington, VA 22209. The organization's toll-free number is **1-800-658-8898**.

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