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MEDICARE HOSPICE BENEFIT

Se habla español

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WHAT IS HOSPICE CARE?

- Hospice care is compassionate end-of-life care that includes medical and supportive services intended to provide comfort to individuals who are terminally ill.
- Often referred to as "palliative care," hospice care aims to manage the patient's illness and pain, but does not try to cure the underlying terminal illness.
- Hospice care may include spiritual and emotional services for the patient, and respite care for the family.
- Hospice care is provided by a team of appropriate professionals.
- Many hospitals and skilled nursing facilities have hospice units, but most hospice care is provided at home.

Hospice Care Goals include ensuring the patient will:

- Be as comfortable and pain-free as possible.
- Be independent for as long as possible.
- Receive care from family and friends.
- Receive support through the stages of dying.
- Die with dignity.

WHAT CARE AND SERVICES DOES THE HOSPICE BENEFIT COVER?

Hospice care includes all the care necessary for management of the patient's terminal illness and related conditions and to ensure the patient's comfort, independence, and dignity. The individual services must be provided pursuant to a specific hospice plan of care created in collaboration with the patient's attending physician and the patient and caregivers. The services may include: physician and nursing care; physical, occupation, and speech therapy; medical social services; hospice aide and homemaker services; medical supplies, medications, and durable medical equipment; and dietary, spiritual, and bereavement counseling.

HOW LONG CAN HOSPICE COVERAGE LAST?

- Hospice coverage is not time limited. Initially the beneficiary must be certified as hospice eligible for a ninety day period. When this period is exhausted, the beneficiary must be certified for a second ninety day period, there are then an unlimited number of sixty day certification periods.

- Hospice beneficiaries may revoke the benefit. Upon doing this, they are immediately eligible for their traditional Medicare benefits.

- The beneficiary may re-elect the hospice benefit at any time. Upon re-election, the beneficiary begins the next certification period.

- Within a certification period, the beneficiary may change his or her designated hospice program one time without the need for revocation.

LEVELS OF HOSPICE CARE

Generally, Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled. This daily payment is made regardless of the amount of services provided on a given day. Payments are made according to a fee schedule based on four categories of care.

1. **Routine Home Care:** Most hospice care is provided at the routine home care level, provided where the person resides. This can be a home, a skilled nursing facility, or an assisted living facility. It is the level of care provided when the person is not in crisis. Covered services can include, scheduled visits from nurses, aides, and social workers, payment for palliative medications related to the terminal illness, and coverage of durable medical equipment, such as hospital beds and wheelchairs. It also includes 24 hour access to "on-call" hospice registered nurses. It does not include room and board while a beneficiary resides in a skilled nursing facility. While on routine home care, beneficiaries may be charged a 5% coinsurance for each drug furnished, not to exceed $5.00 per medication.

2. **Continuous Home Care:** This care is provided where a person resides when there is a medical crisis. During such periods, the hospice team can provide up to around-the-clock care. During continuous home care, hospices bill Medicare per hour rather than per day. Coinsurance responsibility for the beneficiary is the same as under routine home care.

3. **General Inpatient Care:** This care is provided in an inpatient facility until the patient is stabilized if the needed care cannot be managed where the patient resides. This coverage does include room and board and the patient is not responsible for any coinsurance while is at a general inpatient level of care.

4. **Inpatient Respite Care:** Is provided in an inpatient facility. Because it is acknowledged that caring for a dying person can be difficult, this level of care is available to give the caregiver a rest. It is available for periods of up to five consecutive days. This level of care does include room and board costs. Hospices, however, may charge beneficiaries five percent of Medicare's respite care per diem.

HOW DOES SOMEONE BEGIN AND CONTINUE MEDICARE COVERED HOSPICE CARE?

- A hospice physician must certify that the beneficiary is terminally ill. This means that in the physician's judgment the individual has 6 months or less to live if the illness runs its normal course.

- The beneficiary or his/her representative must elect the Medicare hospice benefit by signing and filing a hospice benefit election form with the hospice of choice.

- After having been certified by a hospice physician, the beneficiary is eligible for two 90 day hospice election periods and an unlimited number of subsequent 60 day periods.

- Prior to the start of the beneficiary's third benefit period and again prior to each subsequent benefit period, the beneficiary must have a "face-to-face" encounter with a hospice physician or nurse practitioner to determine continued eligibility.

HOSPICE PATIENTS' RIGHTS AND RESPONSIBILITIES

- To exercise his or her rights as a patient of the hospice;
- To have his or her property and person treated with respect;
- To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice;
- To not be subjected to discrimination or reprisal for exercising his or her rights;
- To receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;
- To be involved in developing the hospice plan of care;
- To refuse care or treatment;
- To choose his or her attending physician;
- To have a confidential clinical record (and access to that record);
- To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injury of unknown source, and misappropriation of property;
- To receive information about the services covered under the Medicare hospice benefit; and
- To receive information about the scope of services that the hospice will provide and specific limitations on those services.

ADVOCACY TIPS

- If you think you might qualify for Medicare coverage of hospice care, ask your physician.
- Any treating physician can make a hospice referral.
- Ask your physician to act as your attending physician for hospice care. Ask that he or she participate in care planning activities with the hospice interdisciplinary team.
- The patient need not be actively dying to receive Medicare covered hospice care. He or she must have a limited life-expectancy of six months or less if the terminal illness runs its normal course.
- Medicare covers hospice care based on the patient's life-expectancy, not on his or her illness.
- A "do not resuscitate order" is not a prerequisite for Medicare coverage of hospice care.
- Prior to discharging a patient from Medicare covered hospice care, the provider must give the patient a written notice. If you disagree with the discharge, call the telephone number provided on the notice for the Beneficiary Family Centered Care Quality Improvement Organization. (BFCC-QIO). After receipt of the notice, you must make this phone call by noon of the following day.
- Quality of Care complaints should also be made by calling the BFCC-QIO.
- In Connecticut, the telephone number for the BFCC-QIO is:
  1-866-815-5440

CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy, founded in 1986, is a national non-profit law organization that works to ensure fair access to Medicare and quality health care. The Center is based in Connecticut and Washington, DC, with offices around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of health care coverage and services.

Staffed by attorneys, legal assistants, nurses, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State health insurance program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

- We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.

- We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

The Center for Medicare Advocacy is the most experienced organization for Medicare beneficiaries and their families.

Visit our website:
www.MedicareAdvocacy.org

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