

Helping Clients with Hospice Care – Frequently Asked Questions

1. What is hospice?

Hospice is a program of end-of-life pain management and comfort care for those with a terminal illness. Medicare's hospice benefit is primarily home-based and offers end-of-life palliative treatment, including support for a beneficiary's physical, emotional, and other needs. The goal of hospice is to help beneficiaries to be as comfortable as possible, not to cure a terminal illness.

2. How does a Medicare beneficiary elect hospice?

To elect hospice, a beneficiary must:

- Be enrolled in Medicare Part A
- Have a doctor certify that they have a terminal illness. This means they have a life expectancy of six months or less
- Sign a statement electing to have Medicare pay for palliative care (pain management), rather than curative care (unless their hospice is participating in the Medicare Care Choices Model (MCCM) program through the Centers for Medicare and Medicaid Innovation (CMMI))
 - The MCCM program lets hospice patients receive both hospice care and curative care for their terminal condition at the same time
- Receive care from a Medicare-certified hospice agency

Currently, once a person chooses hospice, all their hospice-related services will be covered under Original Medicare, even if they are enrolled in a Medicare Advantage (MA) Plan. For more information on beneficiaries with Medicare Advantage and the hospice benefit, see question 5.

The hospice benefit is structured with two 90-day hospice benefit periods, followed by an unlimited number of 60-day benefit periods, which each require certification by a doctor.

If a beneficiary is interested in Medicare's hospice benefit, they should:

- Ask their doctor whether they meet the eligibility criteria for Medicare-covered hospice care.
- Ask their doctor to contact a Medicare-certified hospice provider on their behalf.
 - The beneficiary should be persistent. There may be several Medicare-certified hospice agencies in their area. If the first one they contact is unable to help them, they should contact another.

Once the beneficiary has found a Medicare-certified hospice:

- The hospice medical director (and/or the beneficiary's regular doctor if they have one) will certify that they are eligible for hospice care. Afterwards, they must sign a statement electing hospice care and waiving curative treatments for their terminal illness.
- Their hospice team must consult with the beneficiary (and their primary care provider, if they wish) to develop a plan of care. Their team may include a hospice doctor, a registered nurse, a social worker, and a counselor.

3. What services are covered under Medicare's hospice benefit?

If a beneficiary qualifies for the hospice benefit, Medicare covers the following:

- **Skilled nursing services**, which are services performed by or under the supervision of a licensed or certified nurse to treat their injury or illness. Services they may receive include injections (and teaching them to self-inject), tube feedings, catheter changes, observation and assessment of their condition, management and evaluation of their care plan, and wound care
- **Skilled therapy services**, which are physical, speech, and occupational therapy services that are reasonable and necessary to manage their symptoms or help maintain their ability to function and carry out activities of daily living (eating, dressing, toileting). These services are performed by or under the supervision of a licensed therapist
- **Hospice aides and homemaker services**, including full coverage of a hospice aide to provide personal care services, including help with bathing, toileting, and dressing, as well as some homemaker services (changing the bed, light cleaning, and laundry)
- **Medical supplies**, including full coverage of certain medical supplies, such as wound dressings and catheters
- **Durable medical equipment (DME)**, including full coverage of equipment needed to relieve pain or manage their terminal condition
- **Respite care**, which means short-term inpatient stays for the beneficiary that allow their caregiver to rest. This coverage includes up to five consecutive inpatient days at a time. The beneficiary will pay a copayment of no more than 5% of the Medicare-approved amount for each day. Their total copays for respite care should be no more than the inpatient hospital deductible amount for the year they first elected hospice care
- **Short-term inpatient care**, which is care at a hospital, skilled nursing facility, or hospice inpatient facility if their medical condition calls for a short-term stay for pain control or acute or chronic symptom management. This is only covered if care cannot feasibly be provided in another setting
- **Medical social services**, including full coverage of services ordered by a doctor to help the beneficiary with social and emotional concerns they have related to their illness. This may include counseling and/or help finding resources in their community.
- **Prescription drugs** related to pain relief and symptom control. They will pay a \$5 copay
- **Spiritual or religious counseling**
- **Nutrition and dietary counseling**

The hospice benefit does not cover care for unrelated conditions. This care is still paid for by Original Medicare or the person’s MA Plan, depending on the coverage they had before they elected hospice. While a beneficiary cannot generally receive curative care for symptoms related to their terminal illness while receiving hospice care, they can access treatment for unrelated conditions.

4. How are drugs covered under the hospice benefit?

Medicare’s hospice benefit should include coverage for any prescription drugs a beneficiary needs for pain and symptom management related to their terminal condition.

- They will pay a \$5 copayment for outpatient pain and symptom management drugs.
- They will pay nothing for drugs they receive as an inpatient during a short-term hospital or skilled nursing facility (SNF) stay.

The hospice benefit will not cover medications that are not related to the beneficiary’s terminal condition. Their stand-alone Part D plan or Medicare Advantage drug coverage is responsible for medications that are unrelated to their terminal condition, and their plan’s coverage rules and cost-sharing will apply.

After a beneficiary elects hospice, Medicare assumes that medications prescribed to treat symptoms of pain, nausea, constipation, and/or anxiety are related to their terminal condition and should be covered by their hospice provider, not their Part D plan. If a beneficiary does not need these kinds of drugs to treat their terminal condition—but does need them to treat other conditions—they should ask their hospice provider to send information to their Part D plan indicating that the prescriptions are unrelated to their terminal condition. After receiving this information, the beneficiary’s Part D plan must cover the medication.

If a beneficiary is denied at the pharmacy counter for anti-nausea, anti-anxiety, pain, or laxative medication unrelated to their terminal condition, they should receive a Medicare Prescription Drug Coverage and Your Rights notice. They should contact their plan and file an appeal. The beneficiary’s plan must contact their hospice provider to confirm that the medication is unrelated to hospice. Beneficiaries should check with their hospice provider that their plan received this information. Afterwards, the plan must provide coverage within three days or within 24 hours if waiting longer could put the beneficiary’s health at risk. If a beneficiary needs their medication sooner, they should ask their hospice provider to cover a temporary supply under the hospice benefit.

5. How does hospice work for beneficiaries with Medicare Advantage Plans?

Hospice care is currently covered under Original Medicare, even if a beneficiary has a Medicare Advantage Plan. After electing hospice, care related to their terminal illness will follow Original Medicare’s cost and coverage rules.

If a beneficiary has a Medicare Advantage Plan when they elect hospice, the plan will continue to pay for any care that is unrelated to their terminal condition. For example, if a

beneficiary has elected hospice because they have terminal lung cancer and they fall and break their leg and that break is unrelated to their cancer, their Medicare Advantage Plan would cover the x-rays and other care needed to address the broken leg.

If a person has a Medicare Advantage Plan and need care unrelated to their terminal condition, they can choose to either see providers in their plan's network or see Original Medicare providers.

- When seeing Medicare Advantage providers, the beneficiary should follow their plan's coverage rules, including getting prior approval or referrals, if needed. They should owe their usual Medicare Advantage cost-sharing.
- If the beneficiary sees Original Medicare providers that are not in their plan's network, they will pay the Original Medicare cost-sharing.

A beneficiary's Medicare Advantage Plan or Part D plan will also cover prescription drugs unrelated to their terminal condition, and the plan's cost and coverage rules will apply.

A beneficiary's Medicare Advantage Plan will also continue to cover any additional benefits it provides, such as vision or dental services.

Note: Starting in 2021, some MA Plans may offer coverage of hospice care under the Value-Based Insurance Design (VBID) model program. For the first two years, hospice rules and rates must remain the same as they currently exist under Original Medicare, except that an MA Plan can offer one month of concurrent care (hospice and curative treatment together).

6. Does Medicare cover hospice care in a skilled nursing facility (SNF)?

Medicare covers hospice at a skilled nursing facility (SNF) only if the SNF has a contract with a Medicare-certified hospice that can provide hospice care. The hospice benefit will not pay for room and board at the SNF, so the beneficiary will be responsible for that cost.

If a beneficiary has skilled care needs for a condition unrelated to their terminal illness, and they meet Medicare's coverage requirements for a SNF stay, Medicare should cover room and board and skilled care related to that other condition. For example, if a beneficiary has elected hospice because they have terminal cancer and they fall and break their knee, as long as they meet other requirements for the Medicare SNF benefit, Medicare will cover their stay in a SNF for the daily physical therapy they need for the broken knee.

7. How does a beneficiary continue their hospice care past their initial prognosis?

Medicare covers hospice care for two initial 90-day benefit periods, or a total of six months. After this, it will cover an unlimited amount of 60-day (two-month) benefit periods. At the start of each benefit period, a beneficiary's hospice doctor or a related provider must recertify that they have a life expectancy of six months or less.

If a beneficiary continues hospice past their two initial benefit periods, they are required to have a face-to-face meeting with a hospice doctor or nurse practitioner before the start of

each additional 60-day benefit period. Meetings should take place before the end of their current benefit period but no earlier than 30 days before the new benefit period.

Beneficiaries have the right to ask for a review of their case if a hospice provider has declared them no longer eligible for hospice care. The provider is required to give them a notice explaining their right to an expedited appeal. Instructions for appealing should be provided on this notice.

Beneficiaries also have the right to change their hospice provider once per benefit period. To change hospice providers, a beneficiary must sign a statement naming the new hospice provider they plan to receive care from, their previous hospice provider, and the effective date of the change. This statement must be filed at both hospice agencies.

8. How does a beneficiary end their hospice benefit?

If a beneficiary decides they want curative treatment and wish to leave hospice care, they have the right to stop hospice at any time. They should speak with their hospice doctor if they are interested in stopping. If the beneficiary chooses to end their hospice care, they will be asked to sign a form that includes the date such care will end. Afterwards, they will again receive Medicare coverage the way they did before choosing hospice, either through Original Medicare or a Medicare Advantage Plan.

If a beneficiary chooses to end hospice care, they should make sure to provide their Part D plan with written proof of the change so that it can update their status. If they do not give their plan this information, they may encounter medication denials.

A beneficiary can elect hospice again later if they continue to meet the eligibility requirements.

9. How can beneficiaries protect themselves from hospice fraud?

Beneficiaries should look out for suspicious behavior from health care providers that might indicate Medicare fraud or abuse. For example, providers should not be providing or billing for hospice services for patients who are not terminally ill, billing for a higher level of care than they provide, or falsifying records related to hospice care eligibility.

If a beneficiary suspects that a provider is committing hospice care fraud, they should contact their Senior Medicare Patrol (SMP). Their SMP can help them identify possible fraud, errors, and abuse, and report concerns. If a beneficiary does not know how to reach their SMP, they can call 877-808-2468 or visit www.smpresource.org.

10. Does Medicare cover palliative care outside of hospice?

Outside of hospice coverage, Medicare doesn't cover palliative care explicitly, but it does cover services that are included in palliative care. Medicare Part B covers some treatments that provide palliative care, including visits from doctors, nurse practitioners, and social workers, while Part D covers certain types of pain medication.

If the patient wishes to receive care at home and not in hospice care, then they may be eligible for coverage of that care under the home health benefit. Beneficiaries must meet certain conditions in order to have Medicare cover home health care. They must*:

- Be homebound, meaning it is extremely difficult for them to leave their home and they need help doing so
- Need skilled nursing services and/or skilled therapy care on an intermittent basis.
 - Intermittent means they need care at least once every 60 days and at most once a day for up to three weeks. This period can be longer if they need more care, but their care needs must be predictable and finite.
 - Medicare defines skilled care as care that must be performed by a skilled professional, or under their supervision.
 - Skilled therapy services refer to physical, speech, and occupational therapy.
- Have a face-to-face meeting with a doctor within the 90 days before they start home health care, or the 30 days after the first day they receive care. This can be an office visit, hospital visit, or in certain circumstances a face-to-face visit facilitated by technology (such as video conferencing).
- Have their doctor sign a home health certification confirming that they are homebound and need intermittent skilled care. The certification must also state that their doctor has approved a plan of care for them and that the face-to-face meeting requirement was met.
- Receive care from a Medicare-certified home health agency (HHA).

If the care is medication—even IV—it is covered under Part D, rather than the home health benefit.

*Note: Some of the usual requirements for home care have been suspended or modified during the COVID-19 Public Health Emergency. The listed requirements are the generally applicable rules. Some of the changes may become permanent with future action from CMS or congress.