Hospice Care: Comfort and Compassion When It's Needed Most

Coping with a terminal illness can be a daunting experience — not only for the dying patient, but also for his or her loved ones. Every day, we are faced with tough decisions on end-of-life care. Questions we are asking may include:

"What kind of end-of-life care will I need or want?"
"Where will I receive this care?"
"How will I pay for it?"

This situation will only intensify as Baby Boomers become Senior Boomers. Surprisingly, many people do not realize that there is an all-inclusive hospice care benefit available to Americans through the Medicare program. Since 1983, the Medicare Hospice Benefit has enabled millions of terminally ill Americans and their families to receive quality end-of-life care that provides comfort, compassion, and dignity.

This brochure helps patients and loved ones understand more about hospice care, as well as learn about the eligibility requirements and services covered under the Medicare Hospice Benefit.

What is hospice care?

Considered to be the model for quality, compassionate care at the end-of-life, hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is extended to the patient's loved ones, as well. At the center of hospice is the belief that each of us has the right to die pain-free and with dignity, and that our loved ones will receive the necessary

support to allow us to do so. The focus is on caring, not curing and, in most cases, care is provided in the patient's home. Hospice care is also provided in free-standing hospice facilities, hospitals, and nursing homes and other long- term care facilities. Hospice services are available to patients of any age, religion, race, or illness.

How does hospice care work?

Typically, a loved one serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Members of the hospice staff

make regular visits to assess the patient and provide additional care or other services. Hospice staff are on-call 24 hours a day, seven days a week.

The hospice team develops a care plan that focuses on the patient's well-being and the need for pain management and symptom control. The plan outlines the medical and support services required such as nursing care, personal care (dressing, bathing, etc.), social services, physician visits, counseling, and homemaker services. It also identifies the medical equipment, tests, procedures, medication and treatments necessary to provide high-quality comfort care.

The hospice team usually consists of:

- The patient's family/caregiver;
- The patient's personal physician;
- Hospice physician (or medical director);
- Nurses;
- Home health aides;
- Social workers;
- Clergy or other counselors;
- Trained volunteers; and
- Speech, physical, and occupational therapists, if needed.

For more information on how to select a hospice program, see the National Hospice Foundation's brochure, *"Hospice Care: A Consumer's Guide to Selecting a Hospice Program."*

What is the Medicare Hospice Benefit?

As you may know, the Medicare program consists primarily of two parts:

Part A — often described as "Hospital Insurance"

Part B — known as "Supplementary Medical Insurance."

Learn what services are covered under the Medicare Hospice Benefit.

Hospice care is available as a benefit under Medicare Part A. The Medicare Hospice Benefit is designed to meet the unique needs of those who have a terminal illness, providing them and their loved ones with special support and services not otherwise covered by Medicare. Under the Medicare Hospice Benefit, beneficiaries elect to receive non-curative treatment and services for their terminal illness by waiving the standard Medicare benefits for treatment of a terminal illness. However, the beneficiary may continue to access standard Medicare benefits for treatment of conditions unrelated to the terminal illness. For more information about Medicare health plans or to receive a Medicare handbook, call 1-800-MEDICARE (1-800-633-4227).

Who is eligible for hospice benefits under Medicare?

Hospice benefits are available to Medicare beneficiaries who:

- Are certified by their doctor and the hospice medical director as terminally ill and have a life expectancy of six months or less;
- Sign a statement choosing hospice care using the Medicare Hospice Benefit, rather than curative treatment and standard Medicare covered benefits for their terminal illness; and
- Enroll in a Medicare-approved hospice program.

It is important to note that Medicare will continue to pay for covered benefits for any health problems that are not related to the terminal illness.

What services are covered under the Medicare Hospice Benefit?

The Medicare Hospice Benefit (the Benefit) covers the following services as long as they relate to the terminal diagnosis and are outlined in the patient's care plan:

- Physician services for the medical direction of the patient's care, provided by either the patient's personal physician or a physician affiliated with a hospice program;
- Regular home care visits by registered nurses and licensed practical nurses to monitor the patient's condition and to provide appropriate care and maintain patient comfort;

- Home health aide and homemaker services such as dressing and bathing that address the patient's personal needs;
- Chaplain services for the patient and/or loved ones, if desired;
- Social work and counseling services;
- Bereavement counseling to help patients and their loved ones with grief and loss;
- Medical equipment (i.e., hospital beds);
- Medical supplies (i.e., bandages and catheters);
- Drugs for symptom control and pain relief;
- Volunteer support to assist the patient and loved ones;
- Physical, speech, and occupational therapy; and
- Dietary counseling.

Will the Benefit pay for hospice care in a place other than a personal residence?

Sometimes a patient does not or cannot reside in a private home. The Benefit reimburses for hospice services that are delivered in freestanding hospice facilities, hospitals, and nursing homes and other long-term care facilities. However, the Benefit does not cover expenses for room and board. In some instances, Medicaid may cover these expenses for eligible patients. For benefits available under Medicaid, consult your state Medicaid office.

Does the Benefit cover continuous care (a special level of hospice care) at home?

Yes. If there is a brief, acute episode that requires additional care to manage pain or acute medical symptoms, nursing care may be covered on a continuous basis to maintain the patient at home. Skilled nursing or home health aide services — or a combination of both — may be covered on a 24-hour basis during periods of crisis, but care during these periods must be predominantly nursing care.

Does the Benefit cover general inpatient care that may be needed as a result of a crisis or an acute episode that cannot be handled in a patient's primary residence?

If a hospice inpatient admission is necessary for the patient, the hospice team will arrange for the patient's stay in a freestanding hospice facility, a hospital, a nursing home, or other long-term care facility, which is covered by Medicare.

Is there any relief for loved ones whose responsibility it is to care for the hospice patient?

Caregivers, who are family members or other loved ones responsible for taking care of the hospice patient, may, on occasion, need a break, or "respite," from daily

caregiving. To give the caregiver relief, respite care may be provided in a Medicare-approved facility such as a freestanding hospice facility, a hospital, a nursing home or other long-term care facility, which is covered by Medicare for up to five days at a time.

What is not covered?

The following services are not covered under the Medicare Hospice Benefit:

- Services for conditions unrelated to the terminal illness, or
- Services for the terminal diagnosis that are not called for in the hospice care plan or arranged for by the hospice program.

Care that patients receive under the Medicare Hospice Benefit for their terminal illness must be from a Medicare-approved hospice program.

What costs are covered and what are the "out-of-pockets" to be paid by the patient?

Medicare pays the hospice directly for the patient's hospice care. Patients may have to pay no more than 5 percent — up to $5 for each prescription — for outpatient drugs for pain relief and symptom control. The hospice patient may also be responsible for 5 percent of the Medicare payment amount for inpatient respite care.

Is a patient's Medicare coverage forfeited if hospice care is chosen?

Not at all. A patient retains full Medicare coverage for any health care needs not related to the terminal diagnosis, even if the patient elects hospice care. The patient must continue to pay the applicable deductible and coinsurance amounts under the standard Medicare Plan or the copayment under a Medicare managed care (HMO) plan.

How long can a patient receive hospice care?

For as long as the physicians continue to recertify the terminal illness, patients can receive hospice care. Two 90-day periods of care are followed by an unlimited number of 60-day periods, as long as the patient remains eligible. Hospice care is provided only to patients who have been certified by their doctor and the hospice medical director as terminally ill with a life expectancy of six months or less.

What if a patient is enrolled in a Medicare managed care (HMO) plan?

A hospice-eligible patient who is enrolled in a Medicare managed care plan may choose any Medicare-certified hospice provider. *Authorization from the managed care plan is not required.*

Can a patient change his or her hospice provider?

Yes. A hospice patient has the right to change hospice providers at any point, as long as the newly-chosen hospice program is Medicare-approved.

Ask about Medicare-certified hospice programs in your area.

Why would a patient stop receiving hospice care?

A hospice patient has the right to stop receiving hospice care at any time, for any reason. If the patient chooses to stop hospice care, health care benefits from the standard or managed care Medicare program continue. On occasion, a terminally ill patient's health improves or the patient's illness goes into remission while receiving hospice care. A patient's condition may become stable to the point that the hospice team and physician(s) believe the patient cannot be certified as terminally ill (having a life expectancy of six months or less), and, therefore, is no longer eligible for the Benefit. At any point in time, a patient can return to hospice care, as long as the eligibility criteria is met and certification by physician(s) and hospice team is received.

How can someone find a Medicare-certified hospice program?

The National Hospice and Palliative Care Organization (NHPCO) is committed to improving end-of-life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones. This organization, which represents most hospice programs in the United States, has a hospice locator program of its members. To find an NHPCO member hospice, call NHPCO's HelpLine at 1-800-658-8898 or log on to their web site at www.nhpco.org/database.htm. Other ways to find Medicare-certified hospice programs are through state hospice associations, state health departments, or health care professionals and clergy.

National Hospice Foundation

The National Hospice Foundation, a 501 (C) (3) charitable organization, was created in 1992 to broaden America's understanding of hospice through education and research. Its mission is to expand America's vision for end-of-life care. In doing so, it engages and informs the public about the quality end-of-life care that hospice provides.

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