

FAST FACTS AND CONCEPTS #82
MEDICARE HOSPICE BENEFIT – PART I: ELIGIBILITY AND TREATMENT PLAN

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Background In the United States, the Medicare Hospice Benefit (MHB) pays for 80% of all hospice care. Established in 1983, the MHB pays for medical, nursing, counseling, and bereavement services to terminally ill patients and their families. The original goal of the MHB was to support families caring for a dying relative at home. Under certain circumstances, hospice services under the MHB can also be provided in a nursing home or the acute care hospital. Referral for hospice care is appropriate when the overall plan of care is directed toward comfort rather than reversing the underlying disease process. *Fast Facts #87, 90, 139, and 140* further discuss the MHB.

Eligibility—Medicare Hospice Benefit

1. The patient must be entitled to Medicare Part A (hospital payments); once the patient decides to enter hospice care, they sign off Part A and sign on (elect) the MHB. Note: this process is reversible—patients may at a future time elect to return to Medicare Part A.
2. The patient must be *certified* by the Hospice Medical Director and primary physician to have a life expectancy < 6 months “*if the patient's disease runs its natural course.*” Patients can continue to be eligible if they live beyond 6 months as long as the physicians believe death is likely within 6 months.
3. Under the MHB, DNR status **cannot** be used as a requirement for admission.

Covered Services (100% coverage with no co-pay)

- Case oversight by the physician Hospice Medical Director
- Nursing care: symptom assessment, skilled services/treatments and case management. The nurse visits routinely; 24-hour/7-day per week emergency contact is also provided.
- Social work: counseling and planning (living will, DPOA).
- Counseling services including chaplaincy.
- All medications and supplies *related* to the terminal illness. The hospice can charge a \$5 copay per medication, but most choose not to charge this. Medications for conditions not related to the terminal condition are not covered.
- Durable medical equipment: hospital bed, commode, wheelchair, etc.
- Home health aid and homemaker services.
- Speech, nutrition, physical, and occupational therapy services as determined by the plan of care (see below).
- Bereavement support to the family after the death of the patient.
- Short term *General Inpatient Care* for problems that cannot be managed at home—most commonly intractable pain, delirium, or caregiver breakdown.
- Short term *Respite Care*—up to 5 days to permit family caregivers to take a break.
- *Continuous care* at home for short episodes of acute need.

Not Covered: Continuous nursing assistance (i.e. extended supervisory care) or nursing home room and board charges.

Plan of Care (POC): The hospice team and the patient’s physician work together to maximize quality of life by jointly developing the *Plan of Care*. The POC is based on the patient’s diagnosis, symptoms, and other needs. The hospice program and the patient’s physician must together approve any proposed tests, treatments, and services. In general, only those treatments that are necessary for palliation and/or management of the terminal illness will be approved.

Physician Role: At the time of enrollment the patient indicates the primary physician who will direct care; the patient may select a hospice physician for this role or may select their usual primary doctor. The primary physician is responsible for working with the hospice team to determine appropriate care.

Non-Medicare Hospice Plans: Medicaid hospice benefits closely mirror the MHB. Private insurance plans generally emulate the MHB but occasionally depart from it dramatically (e.g. capping the total number of days a patient may receive hospice care).

References:

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