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Medicare Hospice Benefit

We will cover information about Medicare hospice benefits:

- Who's eligible for hospice care
- What services are included in hospice care
- How to find a hospice provider
- Where you can find more information

Welcome

Choosing to start hospice care is a difficult decision. Support from a doctor and trained hospice care team can help you choose the most appropriate health care options for someone who's terminally ill. Whenever possible, include the person who may need hospice care in all health care decisions.



Hospice Care

Hospice is a program of care and support for people who are terminally ill (with a life expectancy of 6 months or less, if the illness runs its normal course) and their families.

Here are some important facts about hospice:

- Hospice helps people who are terminally ill live comfortably.
- Hospice isn't only for people with cancer.
- The focus is on comfort (palliative care), not on curing an illness.
- A specially trained team of professionals and caregivers provide care for the "whole person," including physical, emotional, social, and spiritual needs.
- Services typically include physical care, counseling, drugs, equipment, and supplies for the terminal illness and related conditions.
- Care is generally given in the home.
- Family caregivers can get support



Palliative Care

Palliative care is the part of hospice care that focuses on helping people who are terminally ill and their families maintain their quality of life. If you're terminally ill, palliative care can address your physical, intellectual, emotional, social, and spiritual needs. Palliative care supports your independence, access to information, and ability to make choices about your health care.

Care for a Condition Other than your Terminal Illness

Your hospice benefit covers care for your terminal illness and related conditions. Once you start getting hospice care, your hospice benefit should cover everything you need related to your terminal illness, even if you remain in a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan.

After your hospice benefit starts, you can still get covered services for conditions not related to your terminal illness. Original Medicare will pay for covered services for any health problems that aren't part of your terminal illness and related conditions. However, you must pay the deductible and coinsurance amounts for all Medicare-covered services you get to treat health problems that aren't part of your terminal illness and related conditions.



Care for a Condition Other than your Terminal Illness (Cont.)

Important: If you were in a Medicare Advantage Plan before starting hospice care, and decide to stay in that plan, you can get covered services for any health problems that aren't part of your terminal illness and related conditions. You can choose to get services not related to your terminal illness from either your plan or Medicare.

How your Hospice Benefit Works

If you qualify for hospice care, you and your family will work with your hospice provider to set up a plan of care that meets your needs

You and your family members are the most important part of a team that may also include:

- Doctors
- Nurses or nurse practitioners
- Counselors
- Social workers
- Pharmacists
- Physical and occupational therapists
- Speech-language pathologists
- Hospice aides
- Homemakers
- Volunteers

How your Hospice Benefit Works (Cont.)

In addition, a hospice nurse and doctor are on-call 24 hours a day, 7 days a week, to give you and your family support and care when you need it.

A hospice doctor is part of your medical team. You can also choose to include your regular doctor, a nurse practitioner, or a physician's assistant on your medical team as the attending medical professional who supervises your care.

The hospice benefit allows you and your family to stay together in the comfort of your home, unless you need care in an inpatient facility. If your hospice provider decides you need inpatient hospice care, your hospice provider will make the arrangements for your stay.

Who's Eligible for the Hospice Benefit

You can get hospice care if you have Medicare Part A (Hospital Insurance) AND meet all of these conditions:

Your hospice doctor and your regular doctor (if you have one) certify that you're terminally ill (you're expected to live 6 months or less).

You accept palliative care (for comfort) instead of care to cure your illness.

You sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions.

Note: Only your hospice doctor and your regular doctor (if you have one) can certify that you're terminally ill and have 6 months or less to live.

Finding a Hospice Provider

To find a hospice provider, talk to your doctor, or call California Hospice and Palliative Care Association (CHAPCA).

ASK Lots of Questions!

What Medicare Covers

You can get a one-time only hospice consultation with a hospice medical director or hospice doctor to discuss your care options and management of your pain and symptoms. You can get this one-time consultation even if you decide not to get hospice care.

Once your hospice benefit starts, Original Medicare will cover everything you need related to your terminal illness, but the care you get must be from a Medicare-approved hospice provider.

What Medicare Covers

Hospice care is usually given in your home, but it also may be covered in a hospice inpatient facility.

Depending on your terminal illness and related conditions, the plan of care your hospice team creates can include any or all of these services:

- Doctor services
- Nursing care
- Medical equipment (like wheelchairs or walkers)
- Medical supplies (like bandages and catheters)
- Prescription drugs
- Hospice aide and homemaker services
- Physical and occupational therapy
- Speech-language pathology services
- Social worker services
- Dietary counseling
- Grief and loss counseling for you and your family
- Short-term inpatient care (for pain and symptom management)
- Short-term respite care
- Any other Medicare-covered services needed to manage your terminal illness and related conditions, as recommended by your hospice team

Respite Care

If your usual caregiver (like a family member) needs rest, you can get inpatient respite care in a Medicare-approved facility (like a hospice inpatient facility, hospital, or nursing home). Your hospice provider will arrange this for you. You can stay up to 5 days each time you get respite care. You can get respite care more than once, but only on an occasional basis.

What your Hospice Benefit Won't Cover

When you start hospice care, you've decided that you no longer want care to cure your terminal illness and related conditions, and/or your doctor has determined that efforts to cure your illness aren't working. Medicare won't cover any of these once your hospice benefit starts:

- **Treatment intended to cure your terminal illness and/or related conditions.** Talk with your doctor if you're thinking about getting treatment to cure your illness. You always have the right to stop hospice care at any time.
- **Prescription drugs** (except for symptom control or pain relief).
- **Care from any provider that wasn't set up by the hospice medical team.** You must get hospice care from the hospice provider you chose. All care that you get for your terminal illness and related conditions must be given by or arranged by the hospice team. You can't get the same type of hospice care from a different hospice, unless you change your hospice provider. However, you can still see your regular doctor or nurse practitioner if you've chosen him or her to be the attending medical professional who helps supervise your hospice care.
- **Room and board.** Medicare doesn't cover room and board. However, if the hospice team determines that you need short-term inpatient or respite care services that they arrange, Medicare will cover your stay in the facility. You may have to pay a small copayment for the respite stay.
- **Care you get as a hospital outpatient (like in an emergency room), care you get as a hospital inpatient, or ambulance transportation,** unless it's either arranged by your hospice team or is unrelated to your terminal illness and related conditions.

What you Pay for Hospice Care

Medicare pays the hospice provider for your hospice care. There's no deductible. You'll pay:

- Your monthly Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) premiums.
- A copayment of up to \$5 per prescription for outpatient prescription drugs for pain and symptom management. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan (if you have one) to see if it's covered by Medicare prescription drug coverage (Part D).
- 5% of the Medicare-approved amount for inpatient respite care.

For example, if Medicare approves \$100 per day for inpatient respite care, you'll pay \$5 per day and Medicare will pay \$95 per day. The amount you pay for respite care can change each year.

What you Pay for Hospice Care (Cont.)

Important: Once your hospice benefit starts, Original Medicare will cover everything you need related to your terminal illness. Original Medicare will also pay for covered services for any health problems that aren't part of your terminal illness and related conditions.

Note: If you need to get inpatient care at a hospital for your terminal illness and/or related conditions, your hospice provider must make the arrangements. The cost of your inpatient hospital care is covered by your hospice benefit, but paid to your hospice provider. They have a contract with the hospital and they work out the payment between them. However, if you go to the hospital and your hospice provider didn't make the arrangements, you might be responsible for the entire cost of your hospital care.

How Long you can get Hospice Care

Hospice care is for people with a life expectancy of 6 months or less (if the illness runs its normal course). If you live longer than 6 months, you can still get hospice care, as long as the hospice medical director or other hospice doctor recertifies that you're terminally ill.

Hospice care is given in benefit periods. You can get hospice care for two 90-day benefit periods followed by an unlimited number of 60-day benefit periods. At the start of the first 90-day benefit period, your hospice doctor and your regular doctor (if you have one) must certify that you're terminally ill (with a life expectancy of 6 months or less).

How Long you can get Hospice Care (Cont.)

Important: At the start of each benefit period after the first 90-day benefit period, the hospice medical director or other hospice doctor must recertify that you're terminally ill, so you can continue to get hospice care. A benefit period starts the day you begin to get hospice care and it ends when your 90-day or 60-day benefit period ends.

Note: You have the right to change your hospice provider once during each benefit period.

Stopping Hospice Care

If your health improves or your illness goes into remission, you may no longer need hospice care.

You always have the right to stop hospice care at any time. If you choose to stop hospice care, you'll be asked to sign a form that includes the date your care will end.

You shouldn't be asked to sign any forms about stopping your hospice care at the time you start hospice. Stopping hospice care is a choice only you can make, and you shouldn't sign or date any forms until the actual date that you want your hospice care to stop.

Your Medicare Rights

As a person with Medicare, you have certain guaranteed rights, including:

- The right to get care that meets professionally recognized standards. If you believe that the care you're getting is below this standard, and you're dissatisfied with the way your hospice provider has responded to your concern, you have the right to contact a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Visit [Medicare.gov/contacts](https://www.Medicare.gov/contacts), or call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your BFCC-QIO. TTY users can call 1-877-486-2048.
- The right to ask for a review of your case. If your hospice provider or doctor believes that you're no longer eligible for hospice care because your condition has improved, and you don't agree, you have the right to ask for a review of your case. Your hospice provider should give you a notice that explains your right to an expedited (fast) review by a BFCC-QIO. If you don't get this notice, ask for it. This notice lists your BFCC-QIO's contact information and explains your rights.

Your Medicare Rights (Cont.)

To see a full list of your rights and for information about how to file a complaint about the hospice providing your care, visit [Medicare.gov/claims-and-appeals](https://www.Medicare.gov/claims-and-appeals), or call 1-800-MEDICARE.

Definitions

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)—A type of QIO (an organization of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Definitions

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

Deductible—The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Definitions

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/ Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part A (Hospital Insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Definitions

Medicare prescription drug coverage (Part D)—Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medigap policy—Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage.

Original Medicare—Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Definitions

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Respite care—Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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California Law Effective 1/1/2023

AB 2673

This bill would require the department, by January 1, 2024, to adopt emergency regulations to implement the recommendations in a specified report of the California State Auditor. The bill would require the department to maintain the general moratorium on new hospice agency licenses until the department adopts the regulations. The bill would require the regulations, among other things, to establish guidelines for assessing the appropriateness of a hospice agency's ratio of patients to nurses, require hospice agency management personnel to meet minimum standards of training and experience, and to establish timelines for reporting changes to application information, as specified. The bill would require the moratorium to end on the earlier of 2 years from the date that the California State Auditor publishes a report on hospice agency licensure, or the date the emergency regulations are adopted. The bill would exempt licensed hospice facilities, as defined, from the moratorium.

California Law Effective 1/1/2022

Effective January 1, 2022, AB 1280 makes various changes to the referral and election of hospice care.

AB 1280 prohibits a hospice provider, employed hospice staff, or agent for the hospice from giving payment to referral sources for referring patients to the hospice. Payment means anything of value, including cash, giftcards, prepaid cards, or remuneration of any kind. A referral source is a medical or nonmedical entity or medical or nonmedical provider that refers a patient, patient's family, or patient's representative to a hospice provider for a consultation or any other reason. A patient's representative is either a person designated by the patient or a person acting on the patient's behalf under the authority of the Long-Term Care Patient Representative Program, established by Chapter 3.6 of Division 8.5 of the Welfare & Institutions Code.

A hospice salesperson, recruiter, agent, or employee who receives any form of compensation or remuneration for hospice referrals or admissions is prohibited from providing consultation on hospice services, hospice election, or informed consent to a patient, patient's family, or patient's representative.

The election of hospice, informed consent, completed signatures, and counsel on the election of hospice to a patient, patient's family, or patient's representative must be completed by a registered nurse, licensed vocational nurse, medical social worker, chaplain, or counselor employed by the hospice.

A hospice must provide a patient or the patient's representative with verbal and written notice of the patient's rights and responsibilities in a language and manner that the person understands during the initial visit before furnishing care.

California Law Effective 1/1/2022

Effective January 1, 2022, SB 664 institutes a moratorium on new hospice licensure that will remain in place until 365 days from the date the CSA publishes a report on hospice licensure. During the moratorium, CDPH will be prohibited from issuing a new license to begin operation of a new hospice. The moratorium prohibits CDPH from issuing a new initial license or approving another location to an existing license. CDPH may grant an exception during the moratorium upon making a written finding that an applicant has shown a demonstrable need for hospice services in the applicant's proposed service area based on the concentration of all existing hospice services in that area. SB 664's provisions sunset on January 1, 2027.

Applications Received Prior to January 1, 2022

Until the initiation of the moratorium, CDPH will continue to review applications for new hospice licensure under the current process **in the order they are received**. Currently, CDPH's Centralized Applications Branch (CAB) continues to review initial hospice licensure applications. However, due to the volume there is approximately a six-month delay.

CDPH must cease processing applications for hospice licensure that have not been issued a license as of December 31, 2021. CDPH will send a letter to all applicants with pending applications asking that they either indicate their intent to withdraw their applications or submit a justification and any supporting documentation to demonstrate need based on geographic concentration to CAB by January 31, 2021. For those applicants seeking to withdraw their application due to the moratorium, CDPH will begin processing and issuing fee refunds to those applicants that previously submitted fees. If an applicant decides to continue with the application process and submits a justification to demonstrate need based on geographic concentration, the application will be subject to the licensing fee even if the exception request is denied. Due to the large number of licensure applications, applicants may experience some delay in receiving their refunds.

Applications After January 1, 2022

Individuals or entities interested in applying for hospice licensure after January 1, 2022, should begin by submitting an exception request. This consists of submitting a written justification and supporting documentation to demonstrate need based on geographic concentration to CAB. If CAB determines there is a need based on geographic concentration, CAB will notify the applicant that they may submit an application.

How to Report a Medicare Complaint

CMS developed a [video](#) to share with your patients if they need to file a complaint, such as poor quality treatment or abuse.

2 Ways to File:

[State Survey Agency \(PDF\)](#)

[CMS Beneficiary and Family Centered Care Quality Improvement Organization](#)

More Information:

[Medicare.gov: filing complaints](#) & [your rights](#)

[Immediate Advocacy process](#)

Thank You | Questions

www.calhospice.org

916-925-3770 Monday-Friday
9:00 am to 4:00 pm

