

HOSPICE & PALLIATIVE CARE OF GREATER WAYNE COUNTY
HOSPICE BENEFITS UNDER MEDICARE and/or MEDICAID*

Hospice care is a special way of caring for a patient whose disease cannot be cured. It is available as a benefit under Medicare Hospital Insurance (Part A) and Ohio Medicaid. A Medicare/ Medicaid beneficiary who chooses hospice care receives non-curative medical and support services for his/her terminal illness. To be eligible, the person must, among other things, be certified by a physician to be terminally ill with a life expectancy of approximately six months or less. While the individual no longer receives treatment toward a cure, he/she requires close medical and supportive care which a hospice can provide. Hospice care under Medicare/Medicaid includes both home care and inpatient (hospital) care, when needed, and a variety of services not otherwise covered by standard Medicare coverage. The focus is on comfort care, not cure. **Emphasis is on helping the person to make the most of each hour and each day of remaining life.**

The following explains the special rules that govern Medicare's/Medicaid's coverage of, and payment for hospice care:

WHAT IS THE HOSPICE MEDICARE/MEDICAID BENEFIT?

Under Medicare/Medicaid, hospice is a comprehensive program of care delivered in a person's home. The Hospice Medicare and/or Medicaid Benefit provides all the reasonable and necessary medical and support services for the management of a terminal illness.

THE HOSPICE MEDICARE/MEDICAID BENEFIT COVERS:

- physician services provided by Hospice & Palliative Care of Greater Wayne County Medical Directors
- nursing care from the Hospice & Palliative Care of Greater Wayne County nurses
- medical equipment and supplies
- medicines for symptom management and pain relief
- short-term (hospitalization) inpatient care for symptom management
- home health aide services
- specialized therapies such as physical therapy, speech therapy, etc.
- medical social services
- counseling, including dietary and bereavement counseling
- respite care: up to 5 days stay in a contract facility
- continuous care is utilized on a short-term basis to maintain a person's comfort in the home.

WHO IS ELIGIBLE? Hospice care is available under this Benefit only if:

- the patient is eligible for Medicare Hospital Insurance (Part A), or Medicaid.
- the patient's doctor and the hospice medical director certify that the patient is terminally ill, with a life expectancy of six months or less.
- the patient signs a statement choosing The Hospice Medicare and/or Medicaid Benefit.
- the patient receives care from a Medicare-approved hospice program.

HOW LONG CAN HOSPICE CARE CONTINUE?

Medicare/Medicaid Benefit Periods: Special benefit periods apply to hospice care. These periods are as follows:

First Benefit Period -- **90-days**
Second Period -- **90-days**
unlimited number of subsequent 60-day periods

The benefit periods may be used consecutively or at intervals. Regardless of whether they are used one right after the other or at different times, the patient must be recertified with a life expectancy of six months or less, before the beginning of each benefit period.

HOW DOES RECERTIFICATION HAPPEN?

To assure compliance with Medicare/Medicaid rules and regulations, all patients receiving the Hospice Medicare/Medicaid Benefit must be evaluated near the end of each benefit period.

Recertification is a decision process which is completed by the Medical Director with physician, patient/family, and Hospice Team input. The outcome determines a patient's eligibility for continued hospice services into the next benefit period. The same rules apply during recertification that were followed at the time of admission.

As a part of the recertification process, your attending physician may request that certain diagnostic tests be completed or repeated. This will assist the Medical Director and your physician in making their decision about your case.

If, at recertification, the patient has improved – Medicare/Medicaid rules state that the Hospice is required to suspend hospice care. If hospice care is suspended and in the future the patient declines, hospice care may be started again.

Should you have questions or concerns about the recertification process, please feel free to contact your Nurse Case Manager, or the Patient Care Coordinator. Should you disagree with the Medical Director's decision, you may appeal to Medicare by filing a Demand Bill. Please call the Patient Care Coordinator for information, should you wish to appeal.

OTHER RULES:

- A patient who chooses hospice care may change hospice programs once each benefit period. To change programs, you must inform Hospice & Palliative Care of Greater Wayne County so arrangements can be made for the transfer of your care.
- A patient also has the right to cancel hospice care at any time and return to standard Medicare/Medicaid coverage, then later re-elect the hospice benefit. If a patient cancels the Hospice Medicare/Medicaid Benefit, any days left in that period are lost, but the patient is still eligible for the remaining benefit period(s). For example, if a patient cancels at the end of 60 days in the first 90-day period, the remaining 30 days in the period are forfeited. The patient is, however, still eligible for the second 90-day period and the subsequent benefit periods.

HOW IS PAYMENT MADE?

Medicare and Medicaid pay the hospice directly at a specified rate for each day the patient is served. The amount depends on the type or level of care given each day.

ARE OTHER MEDICARE/MEDICAID BENEFITS AVAILABLE?

When a Medicare/Medicaid beneficiary chooses hospice care, he/she gives up the right to standard Medicare/Medicaid benefits for treatment of the terminal illness. Medicare/Medicaid pays the entire costs of the covered services required to manage the illness. A hospice patient can, however, qualify for standard Medicare/Medicaid benefits if:

- the patient has Medicare Supplementary Medical Insurance (Part B) and the patient's attending physician is not working for the hospice. In that case, Medicare Part B will help pay for the physician's services. Medicare pays 80 percent of the approved amount for covered services after the patient meets the Part B annual deductible
- the patient requires covered Medicare/Medicaid services for the treatment of a condition unrelated to the terminal illness.

WHAT IS NOT COVERED?

All services required for treatment of the terminal illness must be provided by or authorized by/arranged through the hospice. **If a patient seeks health care without involving the hospice, Medicare/Medicaid will not cover the bill. The patient is then responsible for the bill.**

Medicare/Medicaid will not pay for:

- treatment for the terminal illness which is not for symptom management and pain control
- care provided by another hospice that was not arranged for by the patient's hospice, and
- care from another provider which duplicates care the hospice is required to provide.