PAYING FOR HOSPICE CARE

For most hospice patients, the cost of hospice care is fully covered by the Medicare Hospice Benefit (under Medicare Part A, or hospital insurance). The Medicare Hospice Benefit provides a daily allowance to the hospice organization. In turn, the hospice organization pays for all medical services, medications, durable medical equipment, supplies and treatments **related to managing the serious illness and approved as part of the individual plan of care**. The hospice plan of care focuses on **comfort, rather than curative**, measures.

Like Medicare, Medicaid and most private insurance companies also provide coverage for hospice care and services. Private insurance benefits, deductibles and co-insurance requirements may vary by plan and are therefore reviewed and communicated on an individual basis

Common Questions about the Medicare Hospice Benefit:

Who is eligible for the Medicare Hospice Benefit?
Medicare beneficiaries must meet the following criteria to qualify:

- You must have Medicare Part A.
- You must enroll in a Medicare-approved hospice program such as Lincoln Medical Home Health and Hospice.
- Your doctor and/ or the hospice medical director must certify that you have a life-limiting illness with a probable prognosis of six months or less if the disease runs its normal course.
- You must sign a form indicating that you are electing your Medicare Hospice Benefit to cover the costs of services related to managing your life-limiting illness (Hospice Benefit Election Form) and that you are no longer seeking aggressive treatment.

Will I lose my Medicare coverage if I elect the Medicare Hospice Benefit?
Standard Medicare coverage for services unrelated to your life-limiting illness does not change and is not affected by electing the Medicare Hospice Benefit. Services related to your life-limiting illness and included in the hospice plan of care are covered by the Medicare Hospice Benefit in the form of a daily allowance issued to the hospice organization who then pays for the cost of these services.

Where can hospice care be delivered?
Most hospice care is provided in your residence. This is called “routine level hospice”. If your home is a nursing home or assisted living facility, routine hospice care can be provided there as well. The hospice benefit DOES NOT pay for room and board for routine level hospice. Therefore, a patient in an assisted living facility or nursing home will be responsible for continued room and board payment. If a patient has Medicaid that pays for nursing home room and board, that coverage will continue, with the patient responsible for the liability payment. If a patient is too unstable or has needs that cannot be managed in the home setting, hospice can be provided in a skilled nursing facility or hospital until symptoms can be managed in a less aggressive setting.

What costs are covered?
When deemed directly-related to your serious illness, the following services are generally included in your hospice plan of care and are covered by the Medicare Hospice Benefit:

- Registered Nurses who are specially trained in pain and symptom management who make routine visits as needed
- Regular visits by Licensed Practical Nurses and Hospice Aides to provide personal care
- Social work and counseling services to provide emotional support for you and your family
- Chaplain services for you and your family
- Visits by trained volunteers as needed
- Short-term inpatient care at Hamilton Medical Center if needed for symptom management.
- Temporary respite care at Hamilton Medical Center or a skilled nursing facility.
- 24-hour on-call medical services
- Dietary counseling
- Durable medical equipment (for example: oxygen, hospital bed, walker, wheelchair, overbed table, shower chair) related to your illness and included in your plan of care.
- Medical supplies (for example: wound care supplies)
- Prescription medications (specified in your Plan of Care)
- Other treatments and services related to managing your illness

What are some treatments that are not included in the hospice plan of care and therefore, not covered?
Some treatments are considered aggressive and therefore are not paid for by hospice:

- Total parenteral nutrition (TPN)
- Radiation therapy
- Chemotherapy
- Blood transfusions
- Hemodialysis or peritoneal dialysis
- BiPAP machines

If I elect the Hospice Benefit, am I locked in to this decision forever?
No, if you decide that you would like to pursue aggressive treatment again then the Hospice Benefit can be revoked, with no penalty or loss of days. The benefit can be re-elected at a later time if you continue to meet eligibility criteria.