Making the decision to place a loved one in hospice care in the United States can be an overwhelming one particularly if family members are not aware of how hospice could potentially be covered by the government program, Medicare.

Medicare Hospice Conditions of Participation

Those patients coping with a life-limiting illness may qualify for hospice, but this can present many problems and questions for family members who are curious about next steps. After speaking with the patient’s medical team, doctors and other professionals may recommend that it is time to consider hospice. While this is never an easy decision, it is often one
that may be in the best interests of a loved one when doctors believe it is the best way to provide comfort care.

Getting answers to critical questions about hospice as soon as possible can benefit everyone involved. When family members understand how the hospice benefit works with Medicare, those family members are able to make an informed decision that has the best interests of the patient in mind.

**Basics of the Medicare Hospice Benefit**

Established in 1983, Medicare beneficiaries were allowed to have access to end of life care under the Medicare hospice benefit. Hospice provides a cost-effective and patient-centered care philosophy that brings together a team of professionals to provide essential and compassionate pain management, medical care, spiritual support and emotional support in line with the patient’s wishes and needs.

As a loved one of someone who may be suffering from a life-limiting illness, knowing that hospice can bring comfort and ease during this challenging time can make this process much easier for everyone. This is why many family members begin the process of evaluating determining the appropriate hospice location or firm to partner with.

**Where Can Patients Receive Care for Hospice?**

Patients may be eligible to receive hospice care at an acute care hospital, their own residence, a residential facility or nursing home, or a hospice inpatient facility, although the majority of hospice care is provided to patients in their own home or the home of a loved one.
Depending on the aggressiveness or nature of a patient’s current disease, and his or her medical needs, that location of care can also be shifted as necessary. This is one of the best reasons to consider hospice care when it has been recommended by a doctor.

A patient can be allowed to receive comfort care in a location that works best for him or her, and family members can feel more comfortable in certain locations.

Many family members opt to have a loved one receive hospice care in his or her home. This allows the loved one to have his or her familiar surroundings while receiving comfort care.

While this decision is never easy, it is one that can be made easier by walking through all of the options with the hospice staff. Family members often play a crucial role in hospice care, working with the hospice staff to ensure that the loved one is as comfortable as possible.

Critical to the hospice benefit is a team of professionals working together to provide comprehensive care in terms of pain management, emotional support and medical care for the patient in question. While the vast majority of hospice patients were able to receive benefits, many hospice programs can be flexible based on the patient’s individual needs and the wishes of the family members as well.

Who Is Eligible to Receive Hospice Care?

If two or more physicians have determined that the patient has a prognosis of six months or fewer to live, a patient may be eligible for hospice care. Of course, patients will be reassessed regularly, but there is no time limit for how long a patient is eligible to receive hospice care. One research study identified that up to 1.7 million patients received
Many family members start thinking about hospice care for a loved one when a doctor recommends it. If other treatment options have been explored, a doctor might recommend that hospice is the best way for the loved one to receive pain management services and comfort care in a facility or at home. The decision to go this route is never an easy one, but it can also be in the best interests of a loved one.

Program Conditions of Participations for Facilities Providing Hospice Care

In order for a hospice program to partner with Medicare, the hospice program must implement, develop and maintain an ongoing hospice program. This not only qualifies the hospice program to be able to partner with Medicare but it also gives family members a greater sense of peace and comfort knowing that the hospice program has to comply with these high-quality standards. Data is collected regarding patient care and other critical factors that could influence the hospice program’s participation with Medicare.

How Often is Hospice Care Covered by Medicare?

Hospice care may include any or all of the following services:

- Nursing care
- Dietary counseling
- Doctor services
- Short term respite care
- Social work services
- Occupational and physical therapy
- Prescription drugs for pain relief or symptom control
- Medical supplies
- Nursing care
- Medical equipment
- Speech-language pathology services
- Loss and grief counseling for family members
- Short term inpatient care

When a loved one has selected hospice care, there are some services that are usually not covered. These include:

- Prescription drugs designed to eliminate the illness as opposed to pain relief or symptom control
- Room and board. Medicare is not responsible for covering room and board in the event that you receive hospice care in your home, in a hospice inpatient facility or a nursing home
- Care from a physician that has not been approved or set up by the hospice medical team
- Care received as a hospital outpatient or care a patient receives as a hospital in-patient

What About Respite Care?

One of the most common types of care within hospice is called respite care. If the traditional caregiver, such as one member of the family, needs a break, the patient might also be approved for inpatient respite care so long as this is provided in a Medicare-approved facility. The hospice provider currently helping the patient can set this up. That family member is eligible to receive up to 5 days each time that he or she gets respite care. It is also possible to get respite care several times.

What Patient Costs Are Associated with Hospice Care?

Patients may be responsible for a copayment of no more than $5 for every prescription drug or other pain relief options. The patient is also responsible for paying up to 5% of any
approved amount for respite care on an inpatient basis. As an example, if Medicare has approved that someone is eligible to have up to $100 of per-day respite care, then Medicare will pay $95 of that, but the patient would retain responsibility for $5 of that on a daily basis. Bear in mind that respite care charges like this can change on an annual basis, so make sure to find out what this covered amount is before initiating a respite care benefit.

One of the most important aspects of identifying the appropriate hospice provider is to find out whether or not that provider is Medicare approved. This information can be obtained by speaking to the hospice provider, the state health department, state hospice organization or a physician.

**What if the Patient Has a Medicare Advantage Plan?**

A Medicare Advantage plan is similar to a PPO or HMO and is a Medicare program administered by a private company to cover all of a patient’s Medicare Part A and Medicare Part B benefits. All Medicare-covered services are provided by basic Medicare when it comes to hospice, even in the event that the patient also had another Medicare program or was enrolled in a Medicare Advantage Program.

Usually, for a patient entering hospice care, all of the hospice benefits under that umbrella should cover the patient’s needs. So long as a patient continues to pay his or her premium, however, then the Medicare Advantage Plan can help with additional benefits, like vision or dental.

**What If the Patient Lives Longer**
than Expected?

If a patient in hospice lives longer than six months, he or she may still qualify for hospice care. as long as the hospice provider re-evaluates and determines that the patient is afflicted with life-limiting illness with a life expectancy of six months or less. Hospice care has various periods of care. The initial benefit periods are two periods of 90 days each followed by 60-day periods. The physician or hospice care provider must recertify that the patient still meets the qualifications in order for care to be continuously covered under Medicare.

What About Stopping Hospice Care?

In the event that the patient’s illness goes into remission, he or she may no longer require hospice care. It is important to remember that the patient has the right to stop hospice care at any point in time. No patient should be forced to sign forms about stopping hospice care at the time that the hospice care is initiated.

sources:
https://www.medicare.gov/Pubs/pdf/02154.pdf