CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2015 National Training Program

Medicare's Coverage of Hospice Services

For Those Who Counsel People With Medicare

July 2015

History of Modern Hospice

1948 — English physician Dame Cicely Saunders works with terminally ill

1963 — Saunders brings the concept to U.S. at Yale University

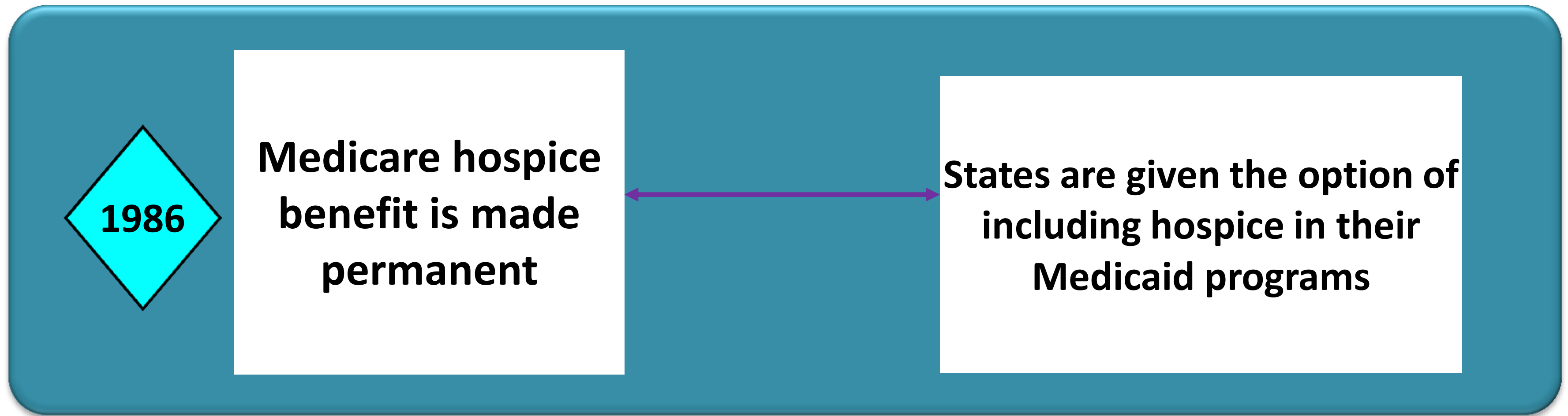
1967 — First modern hospice—St. Christopher's Hospice in UK

1969 — Dr. Elisabeth Kübler-Ross published her book "On Death and Dying"

1971 — Hospice, Inc. was founded in the U.S.

1974 — Connecticut Hospice was founded

Hospice Legislative History



- Most services take place in the patient's place of residence (67%)
- An interdisciplinary team approach to treatment and care planning
  - Attends to the physical, emotional, psychosocial, and spiritual aspects of dying and caregiving
- Focuses on quality of life and death, and views death as a natural process of living
- Affirms life and neither hastens nor postpones death
- Determines specific things that bring quality of life to you, including the right to die pain-free and with dignity
- You're encouraged to complete advance directives
  - Your choices regarding resuscitation measures and curative treatments are respected and honored

"All Hospice Care is Palliative but Not All Palliative Care is Hospice"

Palliative Care Programs

- May include curative care and treatments
- Can be received by patients at any time, at any stage of illness whether it be terminal or not
  - Often in an inpatient facility
  - No life expectancy of 6 months or less requirement
- Don't have to provide the same range of core services as required by the hospice benefit

Hospice Care Benefit

- A Medicare benefit for the terminal phase of life when a cure is no longer probable
  - 6 months or less life expectancy
- Addresses physical comfort symptoms and the emotional and spiritual concerns about dying for the patient and family, often at home

***Both provide "palliative care" which enhances comfort and promotes the quality of life for individuals and their families.**

Who is Electing Hospice? Top Hospice Claims Diagnoses 2004-2013

- Non-Alzheimer's dementia
- Congestive Heart Failure
- CVA/stroke
- Other Respiratory and Heart Disease
- Alzheimer's disease
- Parkinson's disease
- Chronic liver and kidney disease
- Debility and Adult Failure to Thrive
- ALS
- HIV/Aids

- Cancer (37%)
  - Breast, lung, colorectal, prostate, liver, pancreatic and bladder
  - Blood and lymph cancers such as leukemia, lymphomas and multiple myeloma

Lung cancer has been recognized as the most common diagnosis among Medicare hospice patients every year since 1998

Hospice Utilization Data

- According to claims data at the time of death, only 47% of people with Medicare were enrolled in hospice care
  - Only 25% of deaths occur at home
    - More than 70% of Americans would prefer to die at home (Robert Wood Johnson Foundation)
- The determination and/or decision to elect hospice is made extremely close to the end of life
  - The median (50th percentile) length of service in 2013 was 18.5 days
    - Most people are enrolled into hospice within one week of death
    - Half of hospice patients were enrolled for less than one month at the time of their death

When Should I Elect Hospice Services?

- According to external research, to allow you to get the full benefit of hospice services, it is preferred that hospice be on board for at least 2-3 months prior to death, in order to
  - Maximize comfort and decrease pain
  - Receive counseling
    - Attend to closure tasks which may include putting affairs in order, saying goodbye, letting go, finding meaning and value in life and death, and mending relationships
- Have a straightforward conversation with your doctor about end of life issues

If you have Medicare Part A (Hospital Insurance) **AND** meet these conditions, you can get hospice care

- Your doctor must certify that you're terminally ill (with a life expectancy of 6 months or less)
- You accept palliative care (for comfort) instead of care to cure your illness (except children in Medicaid)
- You sign a statement electing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions

Election of Hospice Care

- A valid hospice election statement signed by you or your representative is required
- You should be seen within 48 hours of the election
- Know what you are "electing" and that you are eligible
- The election statement must include the following information
  - Identification of the particular hospice and attending physician or nurse practitioner (if they have one) that will provide care to the individual
  - Acknowledgment that the individual understands hospice care particularly the palliative rather than curative nature of treatment
  - Acknowledgement that certain Medicare services are waived by the election
  - The effective date of the election
  - The signature of the individual or authorized representative

How Long Does Hospice Care Last?

- Care is given in “election periods”
- Doctor must certify each “election period”
  - Two 90-day periods (to equal 6 months)
  - Face-to-face encounter required prior to the third election period and each subsequent 60-day recertification
  - Then unlimited 60-day periods

Face-to-Face Encounter

- A face-to-face (FTF) encounter must
  - Occur within 30 calendar days prior to the start of the third election period (during your 5th month of care and each subsequent 60 day recertification)
  - Verify clinical findings supporting life expectancy of 6 months or less
  - Be documented with attestation
  - Be performed by a hospice physician or a hospice nurse practitioner (NP)
- If the FTF encounter requirements aren't met, the patient will no longer be eligible for the Medicare hospice benefit
  - The hospice should continue to care for the patient at its own expense and have them sign a new election when the FTF occurs

Hospice Team As Your Primary Provider Of Services

- Hospice should provide comprehensive and coordinated care
- Once you choose hospice care, your hospice benefit should cover most everything you need
- You shouldn't have to go outside of hospice to get care
  - Except in very rare situations unrelated to the terminal illness and related conditions
- 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
  - If unavailable, contact your state survey agency to file a complaint
- If the hospice team determines that you need inpatient care, they will make arrangements for your stay
  - Contact the hospice and document the direction they have provided
  - Ask them to communicate directly with non-hospice providers

Medicare Hospice Coverage

- Consulting hospice physician 100% covered
- Attending non-hospice affiliated physician
  - Is covered at 80% under Part B
- You must pay the deductible and coinsurance amounts for all Medicare-covered services to treat health problems that aren’t part of your terminal illness and related conditions*
  - You must continue to pay Medicare premiums
  - You must continue to pay Medicare Supplement Insurance (Medigap) premiums, if applicable

***Unrelated is determined case-by-case and must be coordinated by the hospice.**

Medicare Covered Hospice Services

- Includes physical care, counseling, equipment, and supplies for the terminal illness and related conditions
- Drugs for symptom control and pain relief
    - No more than $5 out-of-pocket cost per Rx to manage pain and symptoms while the patient is at home
- Short-term inpatient care in a Medicare/Medicaid participating facility for pain and symptom management that can't be managed in the home
- Respite care (caregiver relief) in a Medicare-certified facility, up to 5 days each time, no limit to how often
    - The patient is responsible for 5% inpatient respite care cost
- On a case-by-case basis, home respite may be available

Service Details That Must Be Provided by the Hospice

The hospice agency must provide directly*	Directly, contracted or under arrangements

Core Services

- Physician services
- Nursing care
- Social work and counseling services including pastoral care
- Bereavement services for up to one year

(*W2 employees of the hospice)

Non-Core Services

- Therapy services
- Hospice aide services
- Home health aide/homemaker services
- Volunteer services

Other services may be provided under arrangement

- Short-term inpatient or respite care
- Medical equipment/ supplies
- Medications for symptom management and pain relief

Medicare Reimburses 4 Levels of Hospice Care

- **Routine Home Care**—is most common; patient is at home under care of the hospice and not receiving any other category of care
- **Continuous Home Care**—patient is at home and in a period of crisis requiring a high level of care to maintain them in the home setting. (A minimum of 8 total hours a day must be provided, of which, more than half must be provided by an RN or LPN in addition to aide or homemaker care)
- **Inpatient Respite Care**—patient is in an approved inpatient facility* and receiving respite care (caregiver relief); 5 days maximum in a single period at a *Medicare or Medicaid certified hospital, SNF, hospice facility, or NF
- **General Inpatient Care**—patient is inpatient at a Medicare certified hospice facility, hospital or skilled nursing facility

The needs of the patient determine the level of care.

Services Covered—Limited Room and Board

- Room and board are covered in some instances
  - During short-term respite care
  - During short-term inpatient stays for pain/symptom management
- Room and board aren’t covered by Medicare if
  - You receive routine home care hospice services while a resident of a nursing home, or at a freestanding hospice residential facility
- But if you have Medicaid and live in nursing facility
  - Room and board are covered by Medicaid

Hospice and Nursing Home/Facility

- Medicare covers hospice at a skilled nursing facility (SNF) for general inpatient care and inpatient respite care
  - **Only** if the SNF has a contract with the hospice to provide you care
- Short term inpatient care
  - To manage crisis symptoms and control pain
    - In a hospice freestanding facility, hospital or nursing facility
  - Provide caregiver relief (respite care)
    - Inpatient hospital or nursing facility care

***If already a resident in a SNF and approached to "elect" this benefit, ask for details so that your consent is informed.**

Hospice and Medicare Advantage (MA)

- MA Plans must inform enrollees about all of the hospice options that are available in the area they live
- MA enrollees may elect hospice
  - With any Medicare certified hospice provider and your hospice services are covered by Original Medicare
    - From the effective date of election to the date of discharge or revocation through **the end of the month** when you revoke or are discharged from hospice alive
- If you need health care services that are not covered by your hospice you can receive those services through Original Medicare
  - With 20% cost sharing or through your MA plan at the plan cost sharing rate

Coordination Between Part D Sponsors, Hospices, and Prescribers

- The Code of Federal Regulations §418.106 and §418.202(f) require hospice programs to provide individuals under hospice care with drugs and biologicals
  - Related to the palliation and management of the terminal illness and related conditions as defined in the hospice plan of care
- For prescription drugs to be covered under Part D when the enrollee has elected hospice
  - The drug must be for treatment of a condition that's unrelated to the terminal condition which will be determined by the hospice interdisciplinary group

Communication Between Medicare Part D Plans and Hospice Providers

- Optional standardized form "Hospice Information for Medicare Part D Plans CMS-10538" and its instructions are available on CMS' website
  - CMS.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/index.html
- Part D sponsors and hospice organizations are strongly encouraged to begin using the optional form as soon as possible
- Prior authorization is recommended for the following drugs frequently used in hospice settings
  - Analgesics, antinauseants (antiemetics), laxatives, and antianxiety drugs (anxiolytics)

Revocation of Hospice

- You or your representative may revoke (end) the election of hospice care in writing at any time for any reason
- If an election has been revoked by you or a representative, you may at any time
  - Resume Medicare coverage of the benefits waived while under hospice
    - May then seek medical care outside the parameters of the defined hospice benefit
    - If you have a Medicare Advantage Plan, the plan starts covering you the first day of the next month
  - Elect to receive hospice coverage for any other future hospice election periods for which you're eligible

Signed Written Statement of Revocation

- The written statement must contain the effective date of the revocation
  - A verbal revocation of hospice election is NOT acceptable
- You forfeit hospice coverage for any remaining days in that election period
- You may not designate a revocation effective date earlier than the date the revocation is made – do not sign this form in advance of actual revocation
- The day of revocation is a billable day
- The hospice can’t revoke the beneficiary’s election, nor can the hospice demand the beneficiary revoke his/her election
- There is not a standardized hospice revocation form

Acceptable Reasons for Discharge from Hospice Care

Medicare regulations Title 42 Code of Federal Regulations 418.26 define 3 reasons for discharge from hospice care.

1. The patient moves out of the hospice's service area or transfers to another hospice.
2. The hospice determines that the patient is no longer terminally ill.
3. The hospice determines the patient meets its internal policy regarding discharge for cause.

Summary of What the Medicare Hospice Benefit Doesn’t Cover

- Treatment intended to cure your terminal illness and/or related conditions
- Prescription drugs that aren’t related to the terminal illness and related conditions
  - Except for symptom control or pain relief
- Care from any provider that wasn’t set up by the hospice medical team
- Room and board except short term general inpatient level of care or inpatient respite level of care if the hospice team determines you need it
- Care in an emergency room, inpatient facility care, or ambulance transportation
  - Unless arranged by the hospice related to the terminal illness and related conditions

Note: Contact your hospice team **before** you get any get any of these services, or you might have to pay the entire cost

Hospice Scenario—Anton

Anton has Original Medicare with Part D. He has had insulin-dependent diabetes for 10 years.

He has taken Ativan (lorazepam) for anxiety since his diagnosis 10 years ago.

He now has terminal pancreatic cancer and elects the hospice benefit.

Is the hospice or Part D responsible for his insulin and/or Ativan?

Hospice Scenario 1 Review—Anton
Hospice vs. Part D Medication

Is his need for insulin related to his terminal diagnosis (pancreatic cancer)?

Who makes the determination?

Is his need for antianxiety medication related to his terminal diagnosis ?

What should be done if the hospice believes either of these drugs should be covered by Anton's Part D plan?

Hospice Scenario 2—Jermaine

Jermaine experienced new onset seizures, his wife Mabel called the hospice and a hospice nurse arrived at 10 AM.

The nurse provided skilled care and remained with him until 2 PM (4 total hours) when his symptoms were better controlled. She also provided training to Mabel.

Mabel is exhausted and says she can't provide any more care for her husband.

A hospice aide is assigned to monitor him for 24 hours, beginning at 2 PM, with a total of 8 hours of direct care the first day.

The nurse returned intermittently to administer medications to control his symptoms, assess Jermaine, and relieve the aide for breaks for an additional 5 hours the same day.

The hospice's social worker spent 3 hours counselling Mabel and identifying alternative methods to care for Jermaine.

Hospice Scenario 2— Continuous Home Care Review

Let's look at parts of this scenario that could guide if it qualifies for Continuous Home Care (CHC).

Was this a medical crisis?

What happened to his family support system?

Did he need frequent medication adjustments to control his symptoms?

What is the minimum number of hours of services provided to be considered CHC?

How many hours of nursing care (LPN or RN) was provided?

How many hours of aide services were provided?

Do all the hours of services have to be continuous?

Does this scenario qualify for CHC?

You matter because you are...

"You matter because you are you;
and you matter to the last
moment of your life"

"...if we can come together,
not only in our professional capacity,
but also in our common vulnerable humanity,

there may be no need of words on our part,
only of respect and concerned listening..."

Dame Cicely Saunders

CMS National Training Program (NTP)

To view all available NTP training materials, or to subscribe to our email list, visit

CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html

For questions about training products email training@cms.hhs.gov

Hospice Scenario 3—Betty

Dan is caring for his wife Betty. Although her breast cancer had been in remission, 6 months ago it returned.

- The decision was made to elect hospice and Dan continued caring for his wife at home
- On Sunday morning about 2 AM, Betty's condition deteriorated and her pain was no longer managed
  - Dan called 911 and Betty was taken to the local hospital Emergency Room
  - Dan gave the hospital his Medicare Advantage Plan card on admission
  - Betty was stabilized, admitted, and agreed to re-start chemotherapy treatments
  - Betty passed away later that week

Hospice Scenario 3—Betty (Continued)

Six months after Betty's passing, Dan received a bill from the hospital for $16,500.

- Dan called you and was distraught and confused because he thought everything was supposed to be covered by Medicare.
- What would you ask next?

Hospice Scenario 3—Betty Additional Questions

- What other information do you need to know in order to clarify this situation?
- Who would you contact and why?
- Where could you look for more information?

Hospice Scenario 3 Review—Betty

Was the hospital made aware Betty had elected hospice prior to billing the Medicare Advantage Plan?

Did Betty revoke (in writing) her election of hospice when agreeing to re-start treatments for cure?

Did the hospice arrange the admission?

Were the services related to the terminal illness?

Is Dan responsible for the hospital bill? What about the cost of the ambulance ride?

Hospice Resources

- Electronic Code of Federal Regulations
  - § 418—Hospice Care
- Medicare Benefit Policy Manual
  - Chapter 9 - Coverage of Hospice Services Under Hospital Insurance
- Medicare Claims Processing Manual
  - Chapter 11 - Processing Hospice Claims
    - Section 30.4 addresses Managed Care
- Medicare.gov Publication
  - "Medicare Hospice Benefits"
- Hospice Center
  - CMS.gov/Center/Provider-Type/Hospice-Center.html

Finding Your State Hospice Organization

- Medicare.gov/contacts/

A field with an asterisk (*) is required.

1. *Choose your location for contact information

Select your state:

Maryland

2. *Choose an organization OR topic of interest

Select an organization:

State Hospice Organization

Select a topic of interest:

Learn more about topics of interest

- Help with my Medicare options & issues
- Other insurance programs
- Complaints about my care or services
- General health & health conditions
- Claims & billing
- Health care facilities & services in my area

Select all topics

Find contact information

Other helpful websites

State Health Insurance Assistance Programs (SHIPs)
Find links to state-specific SHIP websites with information about local, personalized counseling and assistance to people with Medicare and their families.

Medicare Savings Programs (MSPs)
Find links to state-specific websites with information about Medicare Savings Programs.

State Insurance Departments
Find links to State Insurance Department websites with information about Medicare Supplement Insurance (Medigap) plans sold in the state.

Senior websites
Find links to websites with information for older adults.

Other government websites
Find links to other government websites.

Other health care resources
Find links to websites that can help you make health care decisions, like choosing a hospital or nursing home.

Other ways to find helpful information

Download the Helpful Contacts database
You can download the data used by the Helpful Contacts tool onto your computer as a zipped CSV file. To find contacts in a specific location, search by organization or topic of interest instead of downloading the data.

Appendix–Page 1 Hospice/Part D Form

HOSPICE INFORMATION FOR MEDICARE PART D PLANS

SECTION I -HOSPICE INFORMATION TO OVERRIDE AN "HOSPICE A3 REJECT" OR TO UPDATE HOSPICE STATUS

A. Purpose of the form (please check all appropriate boxes) :

Admission ☐ Proactive Rx Communication ☐ A3 Reject Override ☐ Termination ☐

To: Medicare Part D Plan		From: Hospice Provider	
Plan Name		Hospice Name	
PBM Name		Address	
Phone #	( ) -	Phone #	( ) -
Fax #	( ) -	Fax #	( ) -
Secure E-Mail		NPI	
Contact Name		Contact Name	
Plan Sponsor Website Link:			

B. Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Practice Name	
Hospice Admit Date		Practice Address	
Hospice Discharge Date		Contact Name	
Principal Diagnosis Code		Practice Phone Number	( ) -
Other Diagnosis Code (s)		Practice Fax #	( ) -
Unrelated Diagnosis Code (s)		Hospice Affiliated	☐ YES ☐ NO

For change in hospice status update documentation is required. Please check to indicate which document is attached.

Notice of Election ☐ Notice of Termination /Revocation ☐

C. Hospice Pharmacy Benefit Manager (PBM) Information

PBM Name		BIN		Cardholder ID	
PBM Phone #	( ) -	PCN		Group ID	

D. Prior Authorization Process: Enter a separate line for each Analgesic, Antinauseant (antiemetic), Laxative, and Antianxiety drug (anxiolytic) Medication that is Unrelated to Terminal Prognosis . Drugs outside of these four classes do not require prior authorization.

Medication Name and Strength	Dosing Schedule	Quantity/ Month	Rationale to Support the Medication is Unrelated to Terminal Prognosis (Optional)

E. Signature of Hospice Representative or Prescriber (Required).

Representative ________________________________ Date____/_____/_______
Title ________________________________

Prescriber* ________________________________ Date____/_____/_______
*If the prescriber of the medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal prognosis? Yes ☐ No ☐

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Appendix–Page 2 Hospice/Part D Form

HOSPICE INFORMATION for MEDICARE PART D PLANS

SECTION II – PLAN OF CARE (Optional)

Hospice Name		Hospice NPI	

Patient Name		Patient ID# (HICN)		Patient DOB	/ /

Additional Medications Under Hospice Plan of Care and Designation of Financial Responsibility					
Medication Name and Strength	Hospice	Patient	Medication Name and Strength	Hospice	Patient
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
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Signature of Hospice Representative

Representative ______________________ Date___/____/______

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative ______________________ Date___/____/______