CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Hospice Benefits

This official government booklet includes 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. The information in this booklet and 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.

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

This product was produced at U.S. taxpayer expense.

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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 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.

Words in blue are defined on pages 15–16.

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, Original Medicare will cover everything you need related to your terminal illness, even if you remain in a Medicare Advantage Plan 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.

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 these from either your plan or Original Medicare. If you follow the plan's rules in getting these services, you're only responsible for paying your deductible and coinsurance. For more information on hospice care if you're in a Medicare Advantage Plan or other Medicare health plan, see page 10.

Note: If you started hospice care on or after October 1, 2020, you can ask your hospice provider for a list of items, services, and drugs that they've determined aren't related to your terminal illness and related conditions. This list must include why they made that determination. Your hospice provider is also required to give this list to your non-hospice providers or Medicare if requested.

Words in blue are defined on pages 15–16.

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. For more specific information on a hospice plan of care, call your state hospice organization. Visit Medicare.gov/talk-to-someone, or call 1-800-MEDICARE (1-800-633-4227) to find the number for your state hospice organization. TTY users can call 1-877-486-2048.

You and your family members are 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

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 choose to include your regular doctor, a nurse practitioner, or a physician's assistant on your medical team as the attending medical professional.

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.

Words in blue are defined on pages 15–16.

Who's eligible for the hospice benefit

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

- 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 comfort care (palliative care) 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 your state hospice organization. Visit Medicare.gov/talk-to-someone, or call 1-800-MEDICARE (1-800-633-4227) to find the number for your state hospice organization.

Medicare only covers your hospice care if the hospice provider is Medicare approved. Visit Medicare.gov/care-compare to find Medicare-approved hospice providers in your area.

If you belong to a Medicare Advantage Plan and want to start hospice care, ask your plan to help you find a hospice provider in your area. Your plan must help you locate a Medicare-approved hospice provider in your area.

Words in blue are defined on pages 15–16.

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 managing 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.

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

Note: If you pay out-of-pocket for an item or service your doctor ordered, but your hospice provider refuses to give it to you, you can file an appeal with Medicare. Contact your State Health Insurance Assistance Program (SHIP) if you need help filing or understanding an appeal. For more information on filing a claim or an appeal, visit Medicare.gov/claims-appeals or call 1-800-MEDICARE.

Words in blue are defined on pages 15–16.

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 that **aren't** for your terminal illness or related conditions.
- **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. The hospice team must give or arrange all care that you get for your terminal illness and related conditions. 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, nurse practitioner, or physician's assistant, if you've chosen him or her to be the attending medical professional.
- **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 your hospice team arranges it or it's unrelated to your terminal illness and related conditions.

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

Words in blue are defined on pages 15–16.

Hospice care if you're in a Medicare Advantage Plan or other Medicare health plan

Once you start getting hospice care, Original Medicare will cover everything you need related to your terminal illness, even if you choose to remain in a Medicare Advantage Plan or other Medicare health plan.

If you were in a Medicare Advantage Plan before starting hospice care, **you can stay in that plan as long as you pay your plan's premiums**. If you choose to stay in your plan, your plan will still cover:

- Any extra services that are medically necessary (like dental and vision benefits).
- Covered services for health problems not related to your terminal illness. You must follow the plan's rules when getting these services (like if your plan requires you to see in-network providers). You also have to pay your plan's deductible and coinsurance for these services.

If your plan doesn't cover services from out-of-network providers, Original Medicare may cover services that aren't related to your terminal illness.

For more information about Original Medicare, Medicare Advantage Plans, and other Medicare health plans, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Information about Medicare Supplement Insurance (Medigap) policies

If you have a Medigap policy, it will cover your hospice costs for drugs and respite care. Your Medigap policy will also help cover health care costs for problems that aren't part of your terminal illness and related conditions. Call your Medigap policy or your State Health Insurance Assistance Program (SHIP) for more information.

To get more information about Medigap policies, visit Medicare.gov or call 1-800-MEDICARE.

Words in blue are defined on pages 15–16.

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 the hospice benefit doesn't cover your drug, your hospice provider should contact your Medicare drug plan (if you have one) to see if your plan covers it.
- **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.

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. See page 5 for more information.

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. Your hospice benefit will cover the cost of your inpatient hospital care and pay your hospice provider. Since the hospice provider and the hospital have a contract, 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.

Words in blue are defined on pages 15–16.

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. 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. 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).

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. Once your hospice benefit starts, you don't need to "re-choose" hospice care for each new benefit period.

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, the hospice provider will ask you to sign a form that includes the date your care will end.

No one should ask you 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.

Words in blue are defined on pages 15–16.

Stopping hospice care (continued)

If you were in a Medicare Advantage Plan when you started hospice, you can stay in that plan while getting hospice care, by continuing to pay your plan's premiums. If you stop your hospice care, you're still a member of your plan and can continue to get Medicare coverage from your plan after you stop hospice care. See page 10 for more information.

If you weren't in a Medicare Advantage Plan when you started hospice care, and you decide to stop hospice care, you can continue in Original Medicare. If you're eligible, you can go back to hospice care at any time.

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/talk-to-someone, 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.

To see a full list of your rights, visit Medicare.gov/claims-appeals/your-medicare-rights, or call 1-800-MEDICARE.

How to submit a quality of care complaint

If you or your caregiver has a complaint about the quality of care you get from your hospice provider, you can file a complaint with your hospice provider directly. If you are uncomfortable filing a complaint with your hospice provider, or if you're dissatisfied with how your hospice provider has responded to your complaint, you can file a complaint with your BFCC-QIO by visiting Medicare.gov/claims-appeals/file-a-complaint-grievance/filing-a-complaint-about-your-quality-of-care or calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

For more information

To learn more about Medicare eligibility, coverage, and costs and get official Medicare publications and resources, visit Medicare.gov or call 1-800-MEDICARE.

To get help finding a hospice provider:

- Visit Medicare.gov/care-compare.
- Talk to your doctor.
- Call your state hospice organization.

Visit Medicare.gov/talk-to-someone, or call 1-800-MEDICARE to find the number for your state hospice organization.

For free health insurance counseling and personalized help with insurance questions, call your State Health Insurance Assistance Program (SHIP). To find the contact information for your SHIP, visit shiphelp.org or call 1-800-MEDICARE.

For more information about hospice, contact these organizations:

- **National Hospice & Palliative Care Organization (NHPCO)**
  Visit nhpco.org, or call 703-837-1500.
- **National Association of Home Care & Hospice**
  Visit nahc.org, or call 202-547-7424.
- **Family Caregiver Alliance**
  Visit www.caregiver.org, or call 202-508-9498.
- **Hospice Foundation of America (HFA)**
  Visit hospicefoundation.org, or call 1-800-854-3402.

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%).

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.

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage

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.

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).

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

Notes

CMS Accessible Communications

The Centers for Medicare & Medicaid Services (CMS) provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format from CMS, you won't be disadvantaged by any additional time necessary to provide it. This means you'll get extra time to take any action if there's a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. **Call us:**
   For Medicare: 1-800-MEDICARE (1-800-633-4227)
   TTY: 1-877-486-2048
2. **Send us a fax:** 1-844-530-3676
3. **Send us a letter:**

   Centers for Medicare & Medicaid Services Offices of Hearings and Inquiries (OHI)
   7500 Security Boulevard, Mail Stop S1-13-25
   Baltimore, MD 21244-1850
   Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you're enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State or local Medicaid office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. **Online:**
   www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.
2. **By phone:**
   Call 1-800-368-1019. TDD user can call 1-800-537-7697.
3. In writing: Send information about your complaint to:

   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Room 509F, HHH Building
   Washington, D.C. 20201

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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This isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

This booklet is available in Spanish. To get a free copy, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia gratis, visite Medicare.gov o llame al 1-800MEDICARE (18006334227). Los usuarios de TTY pueden llamar al 18774862048.