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# Hospice Payment System

PAYMENT SYSTEM SERIES



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**Please note:** The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

**T**his publication provides the following information about the Medicare hospice benefit:

- ❖ Background;
- ❖ Coverage of hospice services;
- ❖ Certification requirements;
- ❖ Election periods and election statements;
- ❖ How payment rates are set;
- ❖ Payment updates;
- ❖ Patient coinsurance payments;
- ❖ Caps on hospice payments;
- ❖ Hospice option for Medicare Advantage (MA) enrollees;
- ❖ Hospice Quality Reporting Program (HQRP); and
- ❖ Resources.

When “you” is used in this publication, we are referring to Medicare hospice providers.

## Background

Hospice care is an elected benefit covered under Medicare Part A for a patient who meets all of the following requirements:

- ❖ The individual is eligible for Part A;
- ❖ The individual is certified as having a terminal illness with a medical prognosis of 6 months or less to live if the illness runs its normal course;
- ❖ The individual receives care from a Medicare-approved hospice program; and

- ❖ The individual signs a statement indicating that he or she elects the hospice benefit and waives all other rights to Medicare payment for services related to the treatment of the terminal prognosis.

Medicare will continue to pay for covered benefits for services unrelated to the terminal prognosis.

## Coverage of Hospice Services

The Medicare hospice benefit includes the following hospice services for the palliation and management of the terminal prognosis:

- ❖ Physician services furnished by hospice-employed physicians and nurse practitioners (NP) or by other physicians under arrangement with you;
- ❖ Nursing care;
- ❖ Medical equipment;
- ❖ Medical supplies;
- ❖ Drugs for pain and symptom management;
- ❖ Hospice aide and homemaker services;
- ❖ Physical therapy;
- ❖ Occupational therapy;
- ❖ Speech-language pathology services;
- ❖ Social worker services;
- ❖ Dietary counseling;
- ❖ Spiritual counseling;
- ❖ Grief and loss counseling for the individual and his or her family before and after death;
- ❖ Short-term inpatient care for pain control and symptom management and for respite care; and
- ❖ Any other hospice services, as specified in the patient’s plan of care (POC) and furnished or arranged by you, as reasonable and necessary, and for which payment may otherwise be made under Medicare.

Medicare will not pay for the following services when hospice care is chosen:

- ❖ Hospice care furnished by a hospice other than the hospice designated by the individual (unless furnished under arrangement by the designated hospice);
- ❖ Any Medicare services related to treatment of the terminal prognosis for which hospice care was elected or are equivalent to hospice care, with the exception of the following:

- Care furnished by the designated hospice;
  - Care furnished by another hospice under arrangements made by the designated hospice; or
  - Care furnished by the individual's attending physician who is not an employee of the designated hospice or receiving compensation from the hospice under arrangement for those services;
- ❖ Room and board, unless it is for short-term inpatient care that you arrange; and
  - ❖ Covered care in an emergency room, hospital, or other inpatient facility; outpatient services; or ambulance transportation, unless these services are either arranged by you or are unrelated to the terminal prognosis.

## Certification Requirements

For the first 90-day period of hospice coverage, you must obtain a certification that the patient is terminally ill from both the medical director of the hospice or the physician member of the hospice interdisciplinary group, and from the individual's attending physician (if he or she has an attending physician), no later than 2 calendar days after hospice care is initiated. An attending physician is a doctor of medicine, a doctor of osteopathy, or an NP who is identified by the patient, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of his or her medical care. The statute only allows a medical doctor or a doctor of osteopathy to certify or recertify that the patient is terminally ill.

Written certification must be on file in the patient's clinical record before you submit a claim to the Medicare Administrative Contractor (MAC). It must include:

- ❖ A statement that the individual is certified as being terminally ill with a prognosis of 6 months or less if the terminal illness runs its normal course; and
- ❖ Specific clinical findings and other documentation that support a life expectancy of 6 months or less; and
- ❖ A brief narrative explanation of the clinical findings, composed by the certifying physician, that supports a life expectancy of 6 months or less; and

- ❖ Signature(s) of the physician(s), the date the certification was signed, and the benefit period dates to which it applies.

A hospice physician or hospice NP must have a face-to-face encounter with a hospice patient prior to, but not more than 30 days prior to:

- ❖ The third benefit period recertification; and
- ❖ Each recertification thereafter to determine continued eligibility for the hospice benefit.

When you newly admit a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For more information about the exceptional circumstances, please refer to Chapter 9 of the "Medicare Benefit Policy Manual" (Publication 100-02) located at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

The hospice physician or NP who performs the face-to-face encounter with the patient must attest in writing that he or she had a face-to-face encounter with the patient. The attestation must:

- ❖ Include the date of the face-to-face visit; and
- ❖ State that the clinical findings of the face-to-face visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

## Election Periods and Election Statements

Hospice care is available for 2 periods of 90 days and an unlimited number of subsequent 60-day periods.

The election statement must:

- ❖ Identify the hospice that will furnish care to the individual;
- ❖ Include the individual's or representative's (if applicable) acknowledgement that the patient has a full understanding of the palliative rather than curative nature of hospice services;
- ❖ Include the individual's or representative's (if applicable) acknowledgement of his or her understanding that certain Medicare services are waived by the election;
- ❖ Include the effective date of the election, which may be the first day of hospice care or a later date but no earlier than the date of the election statement;

- ❖ Include the signature of the individual or representative;
- ❖ Include the name of the individual's attending physician; and
- ❖ Be filed with the MAC within 5 calendar days after the effective date of hospice election.

If the individual chooses to change attending physicians, he or she must file a signed statement with the hospice indicating the change.

An individual or representative may revoke the election of hospice care at any time. It is the individual's or representative's choice to revoke the election of hospice care without undue influence from you. To revoke the election, the individual must file a document with you that includes:

- ❖ A signed statement that he or she revokes the election of hospice care for the remainder of that election period; and
- ❖ The effective date of that revocation.

The individual forfeits any remaining days in that election period, and his or her Medicare coverage of the benefits previously waived is resumed.

An individual may change the designation of the hospice from which he or she elects to receive hospice care one time in each election period. This designation is considered a transfer (not a revocation). To change the designated hospice, the individual must file a signed statement with both the hospice from which he or she has received care and with the newly designated hospice. The statement must include:

- ❖ The name of the hospice from which he or she has received care; and
- ❖ The name of the hospice from which he or she plans to receive care; and
- ❖ The date the change is to be effective.

Unless you have filed a final claim, you must file a notice of termination/revocation with the MAC within 5 calendar days after an individual or representative revokes the election of hospice or the individual is discharged.

## How Payment Rates Are Set

Medicare pays hospices a daily rate for each day a patient is enrolled in the hospice benefit. Daily payments are made regardless of the amount of services furnished on a given day. The payments are

intended to cover the costs you incur in furnishing services identified in the patient's POC, including services provided directly or arranged by you. Payments are made based on the level of care required to meet the patient's and family's needs. The levels of care are:

- ❖ Routine home care (RHC) – Hospices will be paid a single RHC rate updated for fiscal year (FY) 2016 from October 1, 2015, through December 31, 2015. Effective January 1, 2016, RHC payments will be made at:
  1. A higher payment rate for the first 60 days of hospice care; and
  2. A reduced payment rate for hospice care for 61 days and over;
- ❖ Continuous home care;
- ❖ Inpatient respite care; and
- ❖ General inpatient care.

Effective January 1, 2016, a service intensity add-on (SIA) payment, which is in addition to the per diem RHC rate, will be made for services furnished during the last 7 days of a patient's life. The following criteria must be met:

1. The day is a RHC level of care day;
2. The day occurs during the last 7 days of the patient's life, and the patient is discharged expired; and
3. Direct patient care is furnished by a registered nurse (RN) or social worker as defined by Sections 418.114(c) and 418.114(b)(3) of the Social Security Act (the Act), respectively, that day.

The SIA payment is equal to the Continuous Home Care hourly payment rate multiplied by the amount of direct patient care furnished by a RN or social worker during the 7-day period for a minimum of 15 minutes and up to 4 hours total per day.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each level of care's base rate has a labor share and a nonlabor share. The labor share of the base payment rate is adjusted by the hospice wage index. Base rates are updated annually based on the hospital market basket update. The Act requires a reduction of the hospital market basket by a productivity adjustment. For FYs 2013 through 2019, the market basket update under the Hospice Payment System will also be reduced by a 0.3 percentage point (although for

FYs 2014 through 2019, the potential 0.3 percentage point reduction is subject to suspension under conditions set out under Section 1814(i)(1)(C)(v) of the Act).

## Payment Updates

For more information about Hospice Payment System payment updates, refer to the “[FY 2016 Hospice Payment Rate Update](#)” Fact Sheet on the CMS website and the [FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule](#) on the Office of the Federal Register (OFR) website.

## Patient Coinsurance Payments

Prescription drugs or biologicals – You may bill the patient a coinsurance amount for each palliative drug or biological prescription when he or she is not an inpatient (when the patient is receiving routine or continuous home care). The coinsurance for each prescription is about 5 percent of its cost to the hospice, determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed \$5.00. When a patient is receiving general inpatient care or respite care, there is no coinsurance for covered prescriptions.

Respite care – You may bill the patient a coinsurance amount for each respite care day equal to 5 percent of the payment made by Medicare for a respite care day. The amount of an individual’s coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

## Caps on Hospice Payments

Two caps affect Medicare payments under the hospice benefit:

- ❖ The number of days of inpatient care you may furnish is limited to not more than 20 percent of total patient care days (the inpatient cap); and
- ❖ An aggregate payment amount you may receive in Medicare payments for services provided in the cap year is limited to the cap amount times the number of Medicare patients served (the aggregate cap). There are two different methods for counting the number of Medicare patients.

For more information about the aggregate cap, please refer to the August 4, 2011, [FY 2012 Medicare Hospice Wage Index Final Rule](#) on the Government Publishing Office (GPO) website.

In addition, the [FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule](#) on the OFR website aligned the cap accounting year for both the inpatient cap and the hospice aggregate cap with the FY for FYs 2017 and later. This allows for the timely implementation of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act changes while better aligning the cap accounting year with the timeframes described in the IMPACT Act. The IMPACT Act mandates that the hospice aggregate cap is updated by the hospice payment update percentage, rather than using the CPI-U, for a specified time. The timeframe for counting the number of beneficiaries with the FY will also be aligned for FYs 2017 and later.

## Hospice Option for MA Enrollees

MA Plans must cover all services Fee-For-Service (FFS) Medicare covers, except hospice care. An enrollee in a MA Plan receives the hospice benefit under FFS Medicare, and may also choose to receive care from providers outside the MA Plan for treatment unrelated to the terminal prognosis (including care from an attending physician). Alternatively, an MA enrollee who requires treatment unrelated to the terminal prognosis may elect to receive services through their MA plan at the plan cost sharing level. Upon enrollment, and annually thereafter, MA Plans must inform enrollees about Medicare hospice option availability and any approved hospices in the MA Plan’s service area, including those the MA organization owns, controls, or in which it has a financial interest.



Under Section 1814(i)(5)(C) of the Act, you must submit data to the Secretary of the Department of Health & Human Services on quality measures specified by the Secretary. Under Section 1814(i)(5)(A)(i) of the Act, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with quality data submission requirements with respect to that FY.

## Measures for the FY 2015 Annual Payment Update (APU)

The measures required for the FY 2015 APU were the same two measures required for the FY 2014 cycle except that, for the structural measure, hospices were not required to list the subject matter (topics) of all patient care indicators. The data collection period for both measures was January 1, 2013, through December 31, 2013. The data submission deadline for both measures was April 1, 2014. If you did not report quality data in 2014, you were subject to a 2 percentage point reduction in your applicable market basket update for FY 2015.

## Measures for the FY 2016 APU

In the [CY 2013 Home Health Prospective Payment System Final Rule](#) on the GPO website, we implemented the set of quality measures you were required to report beginning with the FY 2016 APU. The chart below provides the measures (six National Quality Forum [NQF]-endorsed measures and one modified NQF-endorsed measure) required for the FY 2016 APU. NQF measure number 0209 and the structural measure were no longer required.

### Measures Required for FY 2016 APU

Number	Required Measure
1	NQF #1617 – Patients treated with an opioid who are given a bowel regimen
2	NQF #1634 – Pain screening
3	NQF #1637 – Pain assessment
4	NQF #1638 – Dyspnea treatment
5	NQF #1639 – Dyspnea screening
6	NQF #1641 – Treatment preferences
7	Modified NQF #1647 – Beliefs/values addressed (if desired by the patient)

Beginning July 1, 2014, for each patient admission and discharge, you completed and submitted a standardized patient-level data collection instrument, the Hospice Item Set (HIS), which collects the data elements used to calculate the seven quality measures. If you did not submit the quality data using the HIS as required beginning July 1, 2014, you are subject to a 2 percentage point reduction in your applicable market basket update for FY 2016. For more information about the HIS, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html> on the CMS website.

## Measures for the FY 2017 APU

We did not introduce any new quality measures for the FY 2017 APU. You must continue ongoing submission of the HIS for each patient admission and discharge. If you do not submit the required HIS data during 2015, you will be subject to a 2 percentage point reduction in your applicable market basket update for FY 2017.

In the [FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule](#) on the OFR website, we provide the quality measures under consideration for future implementation in the HQRP. These measures complement the existing measure set and address important processes of care as well as patient experience of care. The HQRP will include quality measures derived from the HIS data submission and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. In addition, we finalized requirements for HIS submission timeliness requirements and thresholds beginning with the FY 2018 annual payment determination.

National implementation of the Hospice CAHPS Survey began in January 2015 with a 3-month dry run (January 2015 through April 2015), followed by continuous monthly implementation. Compliance with the Hospice CAHPS survey will impact the FY 2017 APU.


## Measures for the FY 2018 APU

For the FY 2018 payment update, hospices will be required to submit HIS data and CAHPS data to fulfill the requirements for the annual payment determination. For more information about these requirements, refer to the [FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule](#) on the OFR website.

## Resources

The chart below provides Hospice Payment System resource information.

### Hospice Payment System Resources

For More Information About...	Resource
Hospice Benefit	<p><a href="https://www.cms.gov/Center/Provider-Type/Hospice-Center.html">https://www.cms.gov/Center/Provider-Type/Hospice-Center.html</a> on the CMS website</p> <p>Chapter 9 of the “Medicare Benefit Policy Manual” (Publication 100-02) located at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf</a> on the CMS website</p> <p>Chapter 11 of the “Medicare Claims Processing Manual” (Publication 100-04) located at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf</a> on the CMS website</p>
Hospice Regulations	Title 42, Part 418 of the electronic “Code of Federal Regulations” located at <a href="http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5">http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5</a> on the GPO website
Compilation of Social Security Laws	<a href="https://www.ssa.gov/OP_Home/ssact/title18/1800.htm">https://www.ssa.gov/OP_Home/ssact/title18/1800.htm</a> on the U.S. Social Security Administration website
Hospice Quality Reporting	<p>HIS requirements and information <a href="https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting">https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting</a> on the CMS website</p> <p>CAHPS requirements and information <a href="http://www.hospicecahpsurvey.org">http://www.hospicecahpsurvey.org</a> on the CAHPS Hospice Survey website</p>
All Available Medicare Learning Network® (MLN) Products	<p>“<a href="#">MLN Catalog</a>” on the CMS website or scan the Quick Response (QR) code</p> 
Provider-Specific Medicare Information	MLN publication titled “ <a href="#">MLN Guided Pathways: Provider Specific Medicare Resources</a> ” booklet on the CMS website
Medicare Information for Patients	<a href="https://www.medicare.gov">https://www.medicare.gov</a> on the CMS website



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