HOSPICE PAYMENT SYSTEM

Target Audience: Medicare Fee-For-Service Providers

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BACKGROUND

Medicare Part A patients may elect the hospice care benefit. Patients must meet **all** listed requirements, including:

- Be eligible for Part A
- Be certified as terminally ill with a medical prognosis of 6 months or less to live if the illness runs its normal course
- Receive care from a Medicare-approved hospice program
- Sign a statement indicating they elect the hospice benefit and acknowledgment they waive all rights to Medicare payments for services related to the terminal illness and related conditions unless provided or arranged by the hospice

Medicare pays for covered benefits unrelated to the terminal prognosis.

HOSPICE SERVICES COVERAGE

The Medicare hospice benefit covers all items and services for the management and palliation of a terminal prognosis, including:

- Hospice-employed physician, nurse practitioner (NP), or beginning January 1, 2019, physician assistant (PA) services or services furnished by other physicians under arrangement with the patient

NOTE: Medicare pays attending physician services provided by a PA, when a patient selects a PA as their attending physician, **whether they are a hospice employee or not,** as long as the services are unrelated to the certification of terminal illness. If the PA is employed by the hospice, the hospice can bill Part A for physician services. If the PA is not employed by the hospice, the PA can bill Part B for physician services.

- 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
- Medical social services
- Dietary counseling
- Spiritual counseling
- Grief and loss counseling for the patient and their family before and after death
- Short-term inpatient care for pain control, symptom management, and respite care
- Other Medicare hospice benefits considered reasonable and necessary specified in the patient's plan of care (POC) and furnished or arranged by the hospice

When a patient elects hospice care, Medicare makes no payment for:

- Hospice care furnished by another hospice other than the hospice designated by the patient (unless furnished under arrangement by the designated hospice)
- Any Medicare hospice treatment services related to the terminal prognosis or any equivalent to hospice care, except:
  - Hospice care furnished by the designated provider
  - Hospice care furnished by another hospice under arrangements made by the designated provider
  - Hospice care provided by the individual's attending physician if that physician is not an employee of the designated hospice or getting compensation from the hospice for those services
- Room and board, unless it is for arranged short-term inpatient care
- Covered care in an emergency room, hospital, or other inpatient facility; outpatient services; or ambulance transportation, unless these services are arranged by the hospice provider or unrelated to the terminal prognosis

CERTIFICATION REQUIREMENTS

You must get a certification the patient is terminally ill from the medical director of the hospice or the physician member of the hospice interdisciplinary group, and from the patient's attending physician (if they have one), no later than 2 calendar days after initiating hospice care for the first 90-day hospice coverage period.

An attending physician (the most significant individual determining and delivering the medical care) is a doctor of medicine, a doctor of osteopathy, an NP, or a PA identified by the patient at the time they elect hospice care. Federal law only allows a medical doctor or a doctor of osteopathy to certify or recertify 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). The certification **must include:**

- A statement the patient is certified terminally ill with a prognosis of 6 months or less if the terminal illness runs its normal course
- Specific clinical findings and other documentation supports a life expectancy of 6 months or less
- A brief narrative explaining the clinical findings, composed by the certifying physician, that supports a life expectancy of 6 months or less
- Physician signature(s), certification signature date, and benefit period dates

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

- The third benefit period recertification
- Each subsequent recertification to determine continued hospice benefit eligibility

When a patient is newly admitted in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. Refer to Chapter 9 of the Medicare Benefit Policy Manual for more information about exceptional circumstances.

The hospice physician or NP who meets face-to-face with the patient must attest in writing they had the face-to-face encounter. The attestation must:

- Include the date of the face-to-face visit
- State the certifying physician received the clinical face-to-face findings to determine continued hospice care eligibility

ELECTION PERIODS AND STATEMENTS

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

The election statement must:

- Identify the designated hospice and attending physician furnishing the patient care. The individual or representative must acknowledge the identified attending physician was their choice.
- Include the patient's or their representative's acknowledgement the patient understands they receive palliative care rather than curative hospice services
- Include the patient's or their representative's acknowledgement the patient waives certain Medicare services by electing hospice benefits

- Include the effective election date, which may be the first day of hospice care or a later date but no earlier than the statement of election date
- Include the patient or representative signature

Hospices must also file a notice of election (NOE) with the MAC within 5 calendar days after the effective date of hospice election. Beginning January 1, 2018, you may submit the NOE via Electronic Data Interchange (EDI). Learn about submitting NOEs by referring to MLN Matters® Article SE18007, Recent and Upcoming Improvements In Hospice Billing and Claims Processing and Chapter 11 of the Medicare Claims Processing Manual. If the NOE is filed beyond this 5-day period, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing.

NOTE: In certain circumstances, filing the NOE within 5 calendar days may be beyond a hospice's control. Regulations allow for four exceptions. Refer to Chapter 11 of the Medicare Claims Processing Manual (Section 20.1.1) to learn about the four exceptions.

If the patient wants to change attending physicians, they must file a signed statement with the hospice indicating the change.

A patient or representative may revoke the hospice election at any time. It is the patient's or representative's choice to revoke the hospice care election without undue influence from the hospice provider. To revoke the election, the patient must file a document with the hospice (a verbal declaration is unacceptable) that includes:

- A signed statement saying they revoke the hospice care election for the remainder of that election period
- The effective revocation date

The patient forfeits any remaining days in that election period, and their Medicare coverage of benefits previously waived resumes. If a MA enrollee revokes their hospice, they can resume services through their MA plan or through Medicare Fee-For-Service (FFS) providers, subject to the FFS Medicare deductible until the beginning of the next month when they must exclusively get services through their MA plan.

A patient can change the hospice election designation once in each election period. This is considered a transfer (not a revocation). To change the designated hospice, the patient must file a signed statement with the hospice where they were receiving care and with the newly designated hospice. The statement **must** include:

- The previous hospice provider's name
- The name of the newly chosen hospice provider
- The effective date change

Unless submitting a final claim, hospices must file a notice of termination/revocation with the MAC within 5 calendar days after a patient or representative revokes the hospice election or the patient discharges.

SETTING PAYMENT RATES

Medicare pays hospices a daily rate for each patient-enrolled day. It pays daily regardless of services furnished each day. The payments cover the costs of services identified in the patient's POC, including services provided directly or arranged by the hospice. Medicare bases payments on the level of care needed to meet the patient's and family's needs. The levels of care are:

- Routine home care (RHC) – Effective January 1, 2016, RHC payments are:
  1. A higher payment rate for the first 60 days of hospice care
  2. A reduced payment rate for hospice care days 61 and over
- Continuous home care
- Inpatient respite care
- General inpatient care

Effective January 1, 2016, Medicare pays a service intensity add-on (SIA) to the per diem RHC rate for services furnished during the patient's last 7 days of life. These criteria must be met:

1. The day is an RHC-level-of-care day
2. The day occurs during the patient's last 7 days of life, and the patient is discharged expired
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) that day

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

The Centers for Medicare & Medicaid Services (CMS) adjusts the daily hospice payment rates to account for different wage rates among markets. Each level of care's base rate has a labor share and a non-labor share. Medicare adjusts the labor share of the base payment rate by the hospice wage index, and annually updates the base rates established on the hospital market basket update. The Act requires a productivity adjustment reduction of the hospital market basket. For fiscal years (FYs) 2013 through 2019, the Hospice Payment System market basket update is also 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 by Section 1814(i)(1)(C)(v) of the Act).

PAYMENT UPDATES

Refer to FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements for more information.

PATIENT COINSURANCE PAYMENTS

Prescription drugs or biologicals – When a patient is not a hospice inpatient, the hospice may bill them a coinsurance amount for each palliative drug or biological prescription (if the patient is receiving routine or continuous home care). The coinsurance for each prescription is about 5 percent of its cost to the hospice. The hospice determines and establishes the drug copayment schedule. However, 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 – Hospices may bill patients a coinsurance amount for each respite care day equal to 5 percent of the payment by Medicare for a respite care day. The amount of a patient's respite care coinsurance liability during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year the hospice coinsurance period began.

HOSPICE PAYMENT CAPS

Two caps affect Medicare payments under the hospice benefit:

1. Medicare limits the number of days of inpatient care hospices may furnish to no more than 20 percent of total patient care days (the inpatient cap).
2. Hospices may receive an aggregate Medicare payment for services provided. The cap year is limited to the cap amount times the number of Medicare patients served (the aggregate cap). There are two methods used for counting the number of Medicare patients. Refer to the FY 2012 Medicare Hospice Wage Index Final Rule for more aggregate cap information.

Additionally, the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule aligned the cap accounting year for the inpatient cap and the hospice aggregate cap with FYs 2017 and later. This allows timely initiation of changes from the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) while better aligning the cap accounting year with the timeframes described in the IMPACT Act. The IMPACT Act mandates updating the hospice aggregate cap by the hospice payment update percentage, rather than using the Consumer Price Index – Urban (CPI-U), for a specified time. The timeframe for counting the number of beneficiaries with the FY is aligned for FYs 2017 and later.

MEDICARE ADVANTAGE (MA) ENROLLEES HOSPICE OPTION

MA plans must cover all services FFS covers, except hospice care. An MA plan enrollee receives hospice benefits under Medicare FFS, and may choose to receive care from providers outside the MA plan for treatment unrelated to the terminal prognosis (including care from an attending physician). When MA enrollees get services unrelated to their terminal prognosis from Medicare FFS providers, they are subject to the Original Medicare 20 percent coinsurance.

Alternatively, an MA enrollee who needs treatment unrelated to the terminal prognosis may choose 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 has a financial interest.

HOSPICE QUALITY REPORTING PROGRAM (HQRP)

Under Section 1814(i)(5)(C) of the Act, hospices must submit data on specified quality measures to the Secretary of the U.S. Department of Health & Human Services. The Secretary shall reduce the market basket update by 2 percentage points for any hospice noncompliant with quality data submission requirements for that FY.

FY 2016 Annual Payment Update (APU) Measures

In the Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements and Survey and Enforcement Requirements for Home Health Agencies Final Rule, CMS established the HQRP with the set of Hospice Item Set (HIS) quality measures hospices must report in calendar year (CY) 2014 that impacts FY 2016 APU. This chart provides the measures (six National Quality Forum [NQF]-endorsed measures and one modified NQF-endorsed measure) required for the FY 2016 APU and subsequent years.

Measures Required for FY 2016 APU and Subsequent Years

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)

For each patient admission and discharge, complete and submit with acceptance the HIS, a standardized patient-level data collection instrument. It collects the data elements used to calculate the seven quality measures. Hospices that fail to submit with acceptance the quality data in the applicable reporting year are subject to a 2-percentage point reduction in their market basket update. For more information, visit the HIS webpage.

FY 2017 APU Measures

CMS introduced no new HIS or Consumer Assessment of Healthcare Providers and Systems (CAHPS®) quality measures for the FY 2017 APU.

However, CMS introduced the CAHPS® Hospice Survey measures nationally in January 2015 with a 3-month dry run (January 2015 through April 2015), followed by continuous monthly surveys. Compliance with the CAHPS® Hospice Survey impacts the FY 2017 APU and subsequent years.

Beginning FY 2017 APU and subsequent years, the HQRP includes quality measures derived from the HIS data submission and CAHPS® Hospice Survey measures; HQRP = HIS + CAHPS® Hospice data.

CAHPS® Hospice Measures Required for FY 2017 APU and Subsequent Years

Number	Required Measure
1	Hospice Team Communication NQF #2651
2	Getting Timely Care NQF #2651
3	Treating Family Member with Respect NQF #2651
4	Providing Emotional and Religious Support NQF #2651
5	Getting Help for Symptoms NQF #2651
6	Getting Hospice Care Training NQF #2651
7	Overall Rating of Hospice Care NQF #2651
8	Willingness to Recommend Hospice NQF #2651

Refer to the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule and the FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice; Final Rule for more information about the CAHPS® Hospice Survey.

FY 2018 APU Measures

CMS introduced no new FY 2018 HIS or CAHPS® Hospice Survey quality measures. CMS finalized HIS submission with acceptance timeliness requirements and thresholds beginning with the FY 2018 APU to meet HQRP requirements.

Refer to the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule for more information.

FY 2019 APU Measures

CMS established the set of HIS quality measures hospices must report beginning with FY 2019 APU in the FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule. Hospices that fail to timely report HIS and CAHPS® Hospice quality data and meet the HIS threshold in 2019 are subject to a 2 percentage point reduction in their market basket update for FY 2020. The following table provides the additional HIS measures required for FY 2019 APU.

Additional HIS Measures Required for FY 2019 APU

Number	Required Measure
1	Hospice Visits when Death is Imminent Measure Pair
2	Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

RESOURCES

Hospice Payment System Resources

For More Information About…	Resource
Fiscal Year 2019 Payment and Policy Changes for the Medicare Hospice Benefit	FederalRegister.gov/d/2018-16539
Hospice Benefit	CMS.gov/Center/Provider-Type/Hospice-Center.html CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf
Hospice Quality Reporting	HIS Requirements CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting CAHPS® Requirements HospiceCAHPSSurvey.org
Hospice Regulations	eCFR.gov/cgi-bin/text-idx?rgn=div5;node=42%3A3.0.1.1.5
Manual Updates Related to Payment Policy Changes Affecting the Hospice Aggregate Cap Calculation and the Designation of Hospice Attending Physicians	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10517.pdf

Hyperlink Table

Embedded Hyperlink	Complete URL
Chapter 9 of the Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf
Chapter 11 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf
FY 2012 Medicare Hospice Wage Index Final Rule	https://www.federalregister.gov/d/2011-19488

Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice; Final Rule	https://www.federalregister.gov/d/2014-18506
FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule	https://www.federalregister.gov/d/2015-19033
FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule	https://www.federalregister.gov/d/2016-18221
FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements	https://www.federalregister.gov/d/2018-16539
HIS	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html
Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements and Survey and Enforcement Requirements for Home Health Agencies Final Rule	https://www.federalregister.gov/d/2012-26904
Recent and Upcoming Improvements In Hospice Billing and Claims Processing	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18007.pdf