

Medicare
Learning
Network

**PAYMENT
SYSTEM
FACT SHEET
SERIES**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES



**Hospice
Payment System**



Hospice Care is an elected benefit covered under Medicare Part A for a beneficiary who meets all of the following conditions:

- The individual is eligible for Part A;
- The individual is certified as having a terminal illness with a prognosis of six months or less 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 payments for services for the terminal illness and related conditions. In addition to covered hospice services, Medicare will continue to pay for covered benefits that are not related to the terminal illness.

Hospice is not a basic benefit under the Medicare Advantage (MA) Program and MA Plans are not required to provide a hospice benefit.



Enrollees in MA Plans receive the hospice benefit under Original Medicare. Upon enrollment, and annually thereafter, MA Plans must inform enrollees of the availability of the Medicare hospice option and any approved hospices in the MA Plan's service area including those that the MA organization owns, controls, or in which it has a financial interest.

COVERAGE OF HOSPICE SERVICES

The Medicare hospice benefit includes the following hospice services for the terminal illness and related conditions:

- Physician services;
- Nursing care;

- Medical equipment;
- Medical supplies;
- Drugs for symptom control and pain relief;
- 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;
- Short-term inpatient care for pain control and symptom management and for respite care; and
- Any other services as identified by the hospice interdisciplinary group.

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

- Hospice care furnished by a hospice other than the hospice designed by the individual (unless furnished under arrangement by the designated hospice); and
- Any Medicare services that are related to treatment of the terminal illness or a related condition for which hospice care was elected or that 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 for those services.

CERTIFICATION REQUIREMENTS

For the first 90-day period of hospice coverage, the hospice must obtain a certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician

(if he or she has an attending physician) no later than two calendar days after hospice care is initiated.

Only a medical doctor or a doctor of osteopathy can certify or recertify a terminal illness. An attending physician is a doctor of medicine or osteopathy or a nurse practitioner (NP) who is identified by the beneficiary, 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. However, a NP may not certify the terminal illness pursuant to Section 1814(a)(7)(A)(i)(I) of the Social Security Act.



Written certification must be on file in the beneficiary's clinical record prior to submission of a claim to the Fiscal Intermediary or A/B Medicare Administrative Contractor and must include:

- A statement that the individual is certified as having a terminal illness with a prognosis of six months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation that support a life expectancy of six months or less; and
- Signature(s) of the physician(s).

ELECTION PERIODS

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

The election statement includes the following information:

- Identification of the particular hospice that will furnish care to the individual;
- The individual or representative's (if applicable) acknowledgement that he or she has been given a full understanding of hospice care;
- The individual or representative's (if applicable) acknowledgement that he or she understands that certain Medicare services are waived by the election;

- Effective date of the election; and
- Signature of the individual or representative.

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 the hospice. In order to revoke the election, the individual must file a document with the hospice 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 waived is resumed.

An individual may change the designation of the hospice from which he or she elects to receive hospice care once in each election period. In order 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 includes the following information:

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



HOW PAYMENT RATES ARE SET

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit. The daily payments are made regardless of the amount of services furnished on a given day and are intended to cover costs that the hospice incurs in furnishing services identified in the beneficiary's plan of care. Payments are made based on the level of care required to meet beneficiary and family needs:

- Routine home care;
- Continuous home care;
- Inpatient respite care; and
- General inpatient care.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each category of care's base rate has a labor share and a nonlabor share. The labor share of the base payment amount is adjusted by the hospice wage index. Base rates are updated annually based on the hospital market basket index.

The fiscal year 2009 payment rates for the period October 1, 2008 through September 30, 2009 increased by 3.6 percentage points of the 2008 payment rates, as depicted in the chart below.

Fiscal Year 2009 Hospice Payment Rates

Code	Description	Rate	Wage Component Subject to Index	Non-Weighted Amount
651	Routine Home Care	\$139.97	\$96.17	\$43.80
652	Continuous Home Care Full Rate = 24 hours of care \$34.04 hourly rate	\$816.94	\$561.32	\$255.62
655	Inpatient Respite Care	\$144.79	\$78.37	\$66.42
656	General Inpatient Care	\$622.66	\$398.56	\$224.10

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS website.

Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.hhs.gov/MedicareContractingReform> on the CMS website.

There are two caps that apply to the hospice benefit:

- 1) The number of days of inpatient care the hospice may furnish is limited to not more than 20 percent of total patient care days; and
- 2) An aggregate payment amount that a Medicare hospice provider may receive per Medicare beneficiary.

The hospice aggregate cap is adjusted annually by the medical expenditure category of the Consumer Price Index for all Urban Consumers. For the cap year ending October 31, 2008, the cap is \$22,386.15.

For claims with dates of service on or after January 1, 2008, hospices must report on claims the Core Based Statistical Area for the location where services are furnished for all levels of hospice care.

To find additional information about the hospice benefit, see the Hospice Center Web Page located at <http://www.cms.hhs.gov/center/hospice.asp>. This web page also contains a link to hospice program transmittals and hospice manual information (Chapter 9 of the *Medicare Benefit Policy Manual*, Pub. 100-02, and Chapter 11 of the *Medicare Claims Processing Manual*, Pub. 100-04).