Hospice Governance Academy®

Hospice Industry Basics

HOSPICE REIMBURSEMENT BASICS

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SUMMARY

Since the Medicare Hospice Benefit was enacted in 1982, it has been the predominant form of reimbursement for hospice care. This article outlines key elements of traditional Medicare reimbursement for hospice.

Hospice Reimbursement Basics

The Medicare hospice benefit and its payment structure has been adopted by Medicaid and many commercial insurers. Hospice is a component of Medicare Part A services (inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care).

TABLE 2: FY 2022 Hospice RHC Payment Rates

Code	Description	FY 2021 payment rates	SIA Budget neutrality factor	Wage index standardization factor	Labor share standardization factor	FY 2022 hospice payment update	FY 2022 payment rates
651	Routine Home Care (days 1-60)	$199.25	1.0003	1.001	0.9995	1.02	$203.40
651	Routine Home Care (days 61+)	$157.49	1.0005	1.0009	0.9992	1.02	$160.74

TABLE 3: FY 2022 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2021 payment rates	Wage index standardization factor	Labor share standardization factor	FY 2022 hospice payment update	FY 2022 payment rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,432.41	1.0004	1.0006	1.02	$1,462.52 ($60.94 per hour)
655	Inpatient Respite Care	$461.09	1.0014	1.0059	1.02	$473.75
656	General Inpatient Care	$1,045.66	1.0019	0.9997	1.02	$1,068.28

Federal Register: Published *08/04/2021*, Effective Date: 10/01/2021, *https://www.federalregister.gov/d/2021-16311*

Except for the Continuous Home Care (CHC) level, Medicare pays hospices a daily rate based upon the level of care with an adjustment based upon the calculated wage index for a given geographic area. RHC is reimbursed at two rates: one for the first 60 days of care, and a slightly lower rate for day 61 and above. In addition, a Service Intensity Add-on is paid for nursing and social work visits in the last seven days of life. (This change, introduced in 2017, was intended to produce a "U-Shaped Curve" of reimbursement based upon the presumptions that intensity of care is highest early in the admission and close to death.)

CHC is paid in 15-minute increments as long as a minimum threshold of 8 hours of care is provided in a 24-hour period with greater than 50% of the care by an RN or LPN. These requirements make CHC a challenge for many hospices to staff given the need for high-intensity care of relatively short duration.

CHC and GIP rates are typically 5 to 7 times higher than RHC rates.

Wage Index Adjustments

A portion of the rate is adjusted based upon the wage index of the Core Based Statistical Area (defined by the Office of Management and Budget) in which the care is provided (not where the hospice is located).

Each level of care consists of two components:

- The Wage Component Subject to Index, and
- The Non-Weighted Amount

The Wage Index is a multiplier applied to the Wage Component Subject to Index, and can vary from 0.8 to 1.8. A hospice with a service area that covers more than one CBSA will be paid different rates depending upon the patient's location.

The percent of the base rate that equals the Wage Component Subject to Index varies from one level of care to another, so the impact of the wage index is not exactly uniform across all levels of care.

Caps

The total reimbursement to a hospice is subject to two caps:

- Inpatient Cap (no more than 20% of days at GIP or IRC),
- Aggregate Cap – a cap on the average payments per beneficiary imposed to justify the savings from the original hospice demonstration study adjusted for inflation. In 1984, the cap was $6,500, and with inflation adjustments has risen to about $31,298 in 2022. If a hospice has been paid more than the Aggregate cap, the difference is recouped retrospectively. In 2019, about 19% of hospices are estimated to have exceeded the aggregate cap.

The aggregate cap calculation can be complicated because the base number of beneficiaries changes over time if they are discharged live and a portion of their count is awarded to another hospice (this is known as "beneficiary erosion").

Exceeding cap is not common, but is most common in hospices with very long lengths of stay, high utilization of the GIP level of care, and/or high physician billing.

Benefit Periods

Medicare defines benefit periods (also known as certification periods) which entail either an initial certification or a re-certification of hospice eligibility. The first two benefit periods are 90 days each. Any additional benefit periods are 60 days.

For the third or later benefit period, a Face-to-Face (F2F) physician/NP visit is required (regardless of whether earlier benefit periods were with another hospice). If a F2F visit is not made within the mandated window, the patient must be readmitted with all admission paperwork, and no payment is allowed in the interim.

Billing for Physician and Nurse Practitioner (NP) Services

Some physician/NP services are billable through the hospice under Medicare Part A, although there are many scenarios in which these services are not separately billable (see Additional Resources for this course for more detail). In general, Medical Director services (IDT participation, F2F visits for assessment only, review of Plan of Care) are not billable. F2F visits by a physician may be billable if medically appropriate care is provided beyond just the assessment of hospice eligibility. Physician visits to patients on the General Inpatient level of care are also typically billable through the hospice, however NP visits are only billable if the NP is also the patient's attending physician.

These billable hospice physician and NP services are included in the calculation of the Aggregate Cap. Note: physician and NP visits for palliative care to non-hospice patients may be billable under their own Part B provider numbers, but Part B billing is not included in the Hospice Aggregate Cap calculation.

Medicare Cost Reports

Medicare requires that all hospices submit an annual cost report. While the cost report has no immediate bearing on reimbursement, the data is often used by federal agencies to make determinations about the adequacy of hospice payment levels in general. The historical inaccuracy of cost reports has brought on new edits that will reject cost reports that fail these common-sense tests. Many in the industry hope these edits, along with increased awareness of the impact of inaccurate cost report information, will help ensure that decisions being made by the government are based upon accurate information.

Requirements for Billing

Medicare has set out requirements that need to be met before a claim is submitted. For example, Certificates of Terminal Illness must be signed, dated and include required verbiage before a claim is submitted. For this reason, hospices look to a combination of EMR and human audit to review claims and their associated documentation prior to billing, and hold billing if all required elements are not in place. These steps are commonly called "Pre-Bill Review."

Non-Medicare Reimbursement

Currently, only a small percentage of hospice reimbursement comes from sources other than Medicare. Medicaid typically follows the Medicare benefit and payment, although there are some very slight differences in the base rates that result in slightly different rates between the two payors.

Commercial insurers who offer hospice benefits to people under 65, often follow the Medicare structure, but in some cases will contract on a per visit basis rather than a per diem basis.

Medicaid Managed Care introduces some variation from the Medicare hospice benefit, as these plans sometimes impose

pre-authorizations and may contract for lower rates.

Medicare Advantage, which is growing steadily, has a "carve out" for hospice services, which means that MA beneficiaries convert to traditional Medicare if they elect the hospice benefit (but may still receive supplemental benefits, such as dental or hearing, offered under their MA plan). A demonstration project known as the Value-Based Insurance Design (VBID) Model is underway to include hospice as a MA benefit. To date, only a small percentage of MA beneficiaries are in plans that "carve-in" hospice.

Those of you interested in more detail on this subject, will find handouts in the Course Supplement for this course.

A Glossary of Financial Terms is available in the Hospice Governance Academy Resource section.

See these Spotlight Interviews for further discussion of new payment models:

- *What Medicare Advantage and VBID Mean for Hospices*
- *What Hospice Boards Should Know About the Primary Care First Payment Model*