

# HOSPICE SERVICES PAYMENT SYSTEM

payment**basics**

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The Medicare hospice benefit covers a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician. Beneficiaries who elect the Medicare hospice benefit agree to forgo curative treatment for their terminal condition. For conditions unrelated to their terminal illness, Medicare continues to cover items and services outside of hospice. Typically, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities and other inpatient settings. Hospice providers can be freestanding entities or based in hospitals, skilled nursing facilities, or home health agencies.

CMS data show rapid growth in use of the hospice benefit among Medicare beneficiaries and associated program spending. The number of beneficiaries using hospice more than doubled between 2000 and 2009, reaching nearly 1.1 million in 2009. The total number of providers has also increased. The number of hospice agencies participating in the Medicare program rose 54 percent from 2001 to 2010. In addition, as of April 2011, just over half of hospice agencies were for profit, compared to about one-third in 2001. Medicare payment for hospice grew from almost \$3 billion in 2000 to \$12 billion in 2009.

## The hospice product and Medicare payment

The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. To provide this type of care, the benefit covers an array of services, such as:

- skilled nursing services;
- drugs and biologicals for pain control and symptom management;

- physical, occupational, and speech therapy;
- counseling (dietary, spiritual, family bereavement, and other counseling services);
- home health aide and homemaker services;
- short-term inpatient care;
- inpatient respite care; and
- other services necessary for the palliation and management of the terminal illness.

## Setting the payment rates

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit (Figure 1). Medicare makes a daily payment, regardless of the amount of services provided on a given day and on days when no services are provided. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans. Payments are made according to a fee schedule that has four base payment amounts for the four different categories of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Table 1). The base rates are updated annually based on the hospital market basket index.

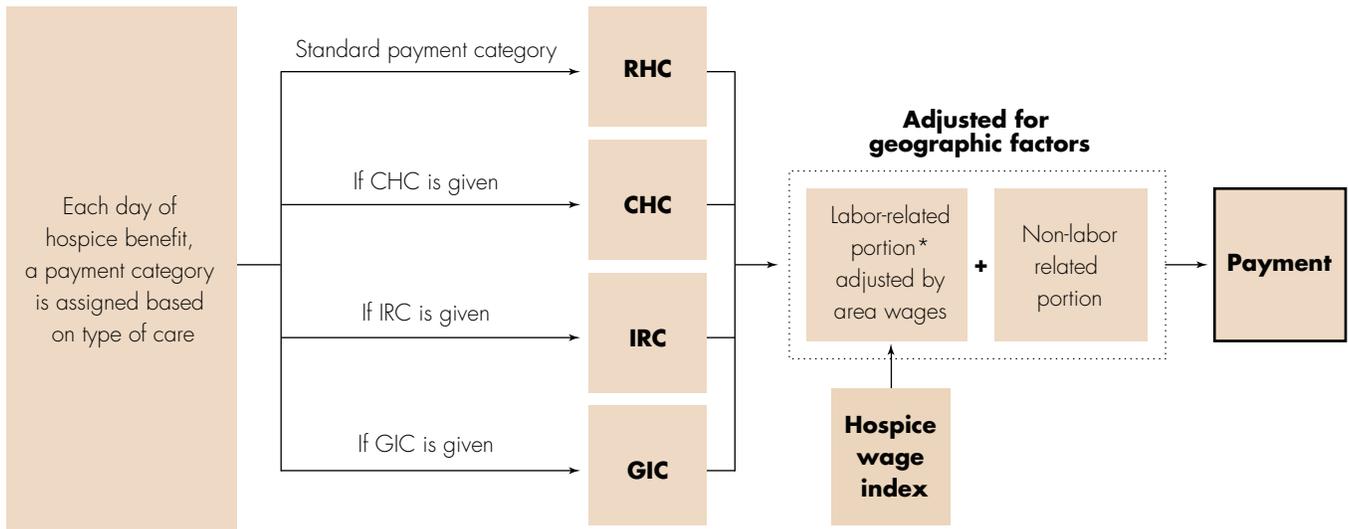
The four categories are distinguished by the location and intensity of the services provided, and the base payments for each category reflect variation in expected input cost differences. Unless a hospice provides CHC, IRC, or GIC on any given day, it is paid at the RHC rate. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change. More than 95 percent of days of hospice care provided are at the routine home care level.

*This document does not reflect proposed legislation or regulatory actions.*

**MEDPAC**

601 New Jersey Ave., NW  
Suite 9000  
Washington, DC 20001  
ph: 202-220-3700  
fax: 202-220-3759  
www.medpac.gov

**Figure 1 Hospice prospective payment system**



Note: RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care).

\*The labor-related portion adjusted by the wage index varies, depending on payment category (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

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; those amounts differ across each category, reflecting the estimated proportion of each rate that is attributable to wage and nonwage costs.

The labor share of the base payment amount is adjusted by the hospice wage index for the location in which care is furnished and the result is added to the nonlabor portion.

From 1983 to 1997, Medicare adjusted hospice payments using a 1983 wage index, based on 1981 Bureau of Labor

**Table 1 Hospice payment categories and rates**

Category of care	Description	Base payment rate, FY 2012	Labor-related portion of payment adjusted by the wage index, FY 2012
RHC	Home care provided on a typical day	\$151	69%
CHC	Home care provided during periods of patient crisis	881	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	156	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	672	64

Note: FY (fiscal year), RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care). Payment for CHC is an hourly rate (\$881.46=24 hours of care at \$36.73 per hour) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver half of the hours of this care to qualify for CHC-level payment.

Source: CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 2260, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2012." July 29, 2011.

Statistics data. In fiscal year 1998, after a negotiated rulemaking process, CMS began using the most current hospital wage index to adjust hospice payments, and applied a budget neutrality adjustment each year to make aggregate payments equivalent to what they would have been under the 1983 wage index. This budget neutrality adjustment increased Medicare payments to hospices by about 4 percent. In fiscal year 2010, CMS began phasing out the budget neutrality adjustment over seven years, reducing it by 0.4 percentage points in 2010 and by an additional 0.6 percentage points in 2011. The adjustment will be reduced by an additional 0.6 percentage points each subsequent year until it is eliminated entirely in 2016.

Two caps limit the amount and cost of care that any individual hospice agency provides in a single year. One cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The other cap is an absolute dollar limit on the average annual payment per beneficiary a hospice can receive. If a hospice's total payments exceed its total

number of Medicare patients multiplied by \$24,527.69 in the year ending October 31, 2011, it must repay the difference. Unlike the daily rates, this cap is not adjusted for geographic differences in costs. The hospice cap is adjusted annually by the medical expenditure category of the consumer price index for all urban consumers.

Hospice payments were calculated based on information from a Medicare demonstration project completed in the early 1980s. The program has not examined the set of services included in the payment since then to reflect changes in patterns of hospice care and associated costs.

Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed \$5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day. Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which was \$1,132 in 2011. ■