

HOSPICE SERVICES PAYMENT SYSTEM

payment**basics**

Revised:
October 2020

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 substantial growth in use of the hospice benefit among Medicare beneficiaries and associated program spending since 2000. The share of Medicare decedents using hospice has increased from about 23 percent in 2000 to about 51 percent in 2018. About 1.55 million beneficiaries used hospice in 2018, compared with 0.53 million in 2000. The total number of providers has also increased. The number of hospice agencies participating in the Medicare program doubled between 2000 and 2018, for a total of about 4,639 providers in 2018. In addition, as of 2018, almost 70 percent of hospice agencies were for profit, compared to about 30 percent in 2000. Medicare payment for hospice grew from almost \$3 billion in 2000 to \$19.2 billion in 2018.

Defining the care Medicare buys

The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice

benefit. 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 covered services identified in patients' care plans. The range of services covered by hospice includes:

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

Setting the payment rates

Payments to hospice agencies are made according to a fee schedule that has four different levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Figure 1).

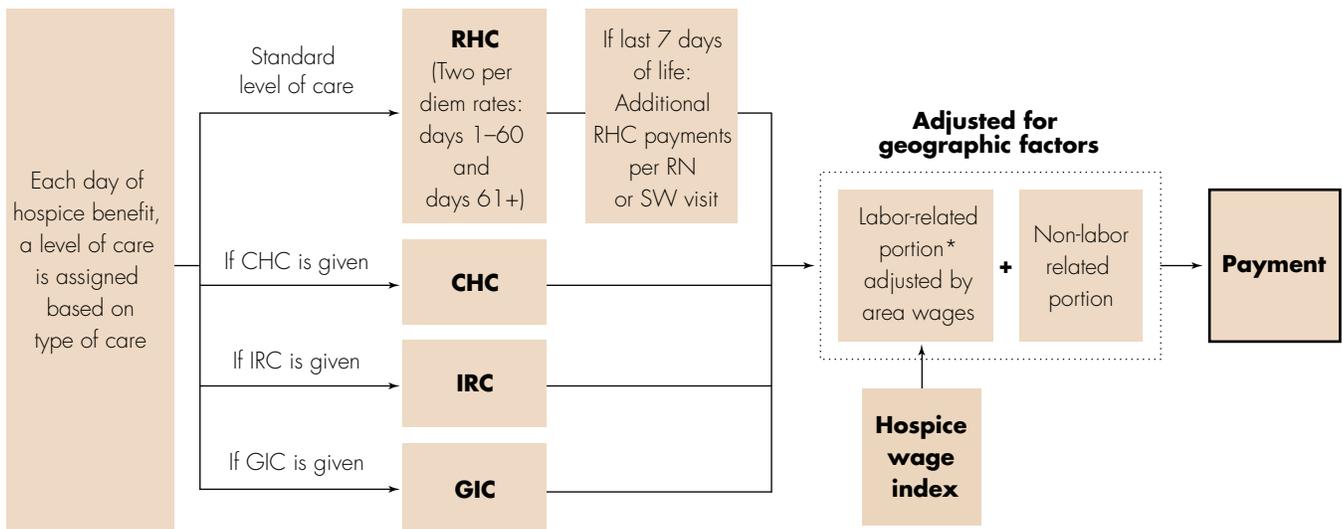
The four levels of care are distinguished by the location and intensity of the services provided. RHC is the most common level of hospice care, accounting for about 98 percent of all hospice days. Other levels of care—GIC, CHC, and IRC—are available to manage needs in certain situations. GIC is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. CHC is intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, mostly nursing.

The policies discussed in this document were current as of September 15, 2020, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
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), RN (registered nurse), SW (social worker).
 *The labor-related portion adjusted by the wage index varies, depending on level of care (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

IRC is care in a facility for up to five days to provide an informal caregiver a break. 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.

Historically, each level of care has been associated with its own base payment rate (Table 1). The different base rates reflect variation in expected input costs across the levels of care.

Prior to January 2016, Medicare had a single base rate for each RHC day in

Table 1 Hospice levels of care and rates

Level of care	Description	Base payment rate, FY 2021	Labor-related portion of payment adjusted by the wage index, FY 2021
RHC*	Home care provided on a typical day: Days 1–60	\$199	69%
	Home care provided on a typical day: Days 61+	157	69
CHC	Home care provided during periods of patient crisis	1,432	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	461	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	1,046	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 (\$59.74 per hour, with maximum payment per day equal to about \$1,432) 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. The above rates apply to hospices that submit the required quality data. The rates are 2 percentage points lower for hospices that do not submit the required quality data.
 *In addition to the daily rate, Medicare pays about \$60 per hour for registered nurse and social worker visits (up to four hours per day) that occur during the last seven days of life for beneficiaries receiving routine home care (this is referred to as the *service intensity adjustment*).

Source: CMS Manual System Pub 100–04 Medicare Claims Processing, Transmittal 10338, “Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2021.” August 27, 2020.

an episode. Beginning January 1, 2016, Medicare changed how it pays for RHC. There are now two RHC base payment rates: a higher rate for days 1 to 60 and a lower rate for days 61 and beyond. In addition, Medicare makes additional RHC payments for registered nurse and social worker visits that are provided during the last seven days of life.

These changes to the structure of RHC payments were the first changes to the hospice payment system since its inception in 1983. The new RHC payment structure is intended to better align payments with the costs of providing hospice care throughout an episode. Hospices tend to provide more services at the beginning and end of an episode and less in the middle. The new payment structure better matches that pattern of care than a single RHC base rate.

CMS also recently took steps to realign payments with costs across the four levels of care. In fiscal year 2020, CMS substantially increased the payment rates for CHC, IRC, and GIP, while decreasing slightly the payment rate for RHC (which CMS estimated was about 18 percent higher than costs in 2019).¹

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each level of care has a labor share and a non-labor share; those amounts differ across each level of care, reflecting the estimated proportion of input costs that is attributable to wage and non-wage 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 non-labor portion.

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 \$30,683.93 for fiscal year 2021, 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.

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 \$1,408 in 2020.

Payment updates

Hospice payment rates are updated annually by the hospital market basket. The market basket index is reduced by a productivity adjustment. Beginning fiscal year 2014, hospices that do not report quality data receive a 2 percentage point reduction in their annual payment update. ■

¹ The statute requires that any rebalancing of the payment rates be budget neutral. Because RHC accounts for about 98 percent of hospice days, only a small decrease in the RHC rates was needed to offset the substantial increase in payment rates for the three less frequent levels of care.