



# Hospice Payment Reform

## White Paper

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### SECTION ONE: REVIEW OF HOSPICE PAYMENT REFORM PROPOSALS (MEDPAC)

Congress created the Medicare Hospice benefit in the Tax Equity and Fiscal Responsibility Act of 1982; the benefit was initially created with a sunset provision and then was made permanent in 1986. In 1989, Congress included an annual increase for Hospice reimbursement, which it tied to the hospital market basket through a provision contained in the Omnibus Budget Reconciliation Act of 1989. The Hospice payment structure provides for reimbursement based on four levels of care:

- Routine Home Care (RHC)
- General Inpatient Care (GIP)
- Continuous Home Care (CHC)
- Inpatient Respite Care (IRC)

Medicare Hospice payments are made for each day the patient is enrolled, regardless of the level of services provided. Medicare also established two payment limits, or “caps”, on Hospice payment; the first is a per beneficiary cap on payment applied in the aggregate; the second a limit on the number of general inpatient days.

Hospice utilization continues to grow significantly, and in June 2008, the Medicare Payment Advisory Commission (MedPAC) issued a report to Congress entitled, “Reforming the Delivery System” that identified Hospice as one of the

benefits to be reviewed. MedPAC followed up this report with one in March 2009 that made specific recommendations on Hospice payment reform:

- Hospice should have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases.
- Payment reform should include a relatively higher payment for the costs associated with patient death at the end of the episode.
- The implementation of the payment system changes should be budget neutral in the first year, and begin in 2013, with a brief transitional period.

MedPAC also recommended the collection of additional data on hospice care and improvements to the quality of all data collected to facilitate the management of the hospice benefit. These recommendations were repeated in subsequent years.

In April, 2013 the Centers for Medicare & Medicaid Services’ (CMS’) hospice payment reform contractor ABT Associates released a Hospice Study [Technical Report](#) (available on the CMS Hospice Center Website <https://www.cms.gov/Center/Provider-Type/Hospice-Center.html> under Research and Analyses) that included a hypothetical tiered payment system comprised of seven different levels of Hospice payment, which they categorized as “groups”. The seven groups focused on length of stay on hospice and whether

a visit occurred within the last two days of life; this analysis introduced the element of visits at the end of life as a mechanism for payment. The groups are:

- **Group 1:** RHC care that occurs between days 1 and day 5 of a beneficiary's lifetime length of stay.
- **Group 2:** RHC care that occurs between days 6 and day 10 of a beneficiary's lifetime length of stay.
- **Group 3:** RHC care that occurs between days 11 and day 30 of a beneficiary's lifetime length of stay.
- **Group 4:** RHC care that occurs on day 31 or later of a beneficiary's lifetime length of stay.
- **Group 5:** RHC care that occurs during the last 7 days of a beneficiary's lifetime length of stay and the beneficiary is discharged dead. Beneficiary receives visiting service (nursing, aide, MSS, therapy) during the last 2 days of life if the last two days of life are RHC or the last two days of life are not RHC.
- **Group 6:** RHC care that occurs during the last 7 days of a beneficiary's lifetime length of stay and the beneficiary is discharged dead. Beneficiary does not receive visiting service (nursing, aide, MSS, therapy) during the last 2 days of life. Last two days of life are RHC.
- **Group 7:** RHC care when the beneficiary's lifetime length of hospice is 5 days or less, each day of hospice is RHC, and beneficiary is discharged deceased.

## SECTION TWO: REVIEW OF PROPOSED RULE

In May 2015, CMS released the proposed FY 2016 Hospice Wage Index and Payment Rate Update; the proposed rule incorporated a two-tiered payment system for RHC and also provided a Service Intensity Add-On (SIA) that would provide additional reimbursement to agencies for skilled nursing and medical social work services provided to patients in their homes during the last seven days of life. (The SIA payments would be made based on the CHC rate and would be provided for up to four hours of care each day.)

The "count of days" for determination of when the payment changes to the lower payment rate includes all days on hospice care -- as an example, if a patient was admitted on GIP for the first five days and then transitioned to RHC on day six, the maximum number of days eligible for the higher RHC payment rate would be fifty-five days. Last, CMS indicated that in order to mitigate potential high rates of discharge and readmission, in cases where patients are discharged and readmitted to hospice within 60 days of that discharge, the prior hospice days will continue to follow the patient and count toward his or her patient days in determining the RHC payment level for the receiving hospice. In the proposed rule, CMS indicated, "We believe the most important reason for proposing a different RHC rate for the first 60 days versus days 61 and beyond is that we must account for differences in average visit intensity between epi-

sodes that will end within 60 days and those that will go on for longer episodes."

In addition, CMS proposed a SIA for patients who receive Registered Nurse (RN) and Medical Social Worker (SW) visits when the visits occur in the last seven days of life and the patient is discharged from the hospice as deceased. The payments would be made only if the patient is receiving RHC, and would be for up to four hours each day at the CHC hourly rate. The proposed rule indicated that the payment would exclude those patients residing in SNFs/NFs, and would be budget neutral (to ensure budget neutrality, CMS proposed to reduce the RHC rate for days one to sixty by 1.47 percent (payment equal to 98.53 percent) and likewise reduce the RHC rate for days greater than sixty by 0.33 percent (payment equal to 99.67 percent). Since visit reporting on hospice claims did not require separate coding of visits provided by RNs and Licensed Practical Nurses (LPNs), CMS proposed the creation of separate codes to allow for differentiation of nursing visits by type.

## SECTION THREE: REVIEW OF FINAL RULE

In August 2015, CMS issued the final rule for the Hospice Wage Index and Payment Rate Update; the rule established the two-tiered payment structure for RHC, though it delayed implementation until January 1, 2016 (it provided a single, updated RHC rate for October-December 2015). CMS also confirmed that a SIA payment would be made for ALL patients receiving RHC in the last seven days (reversing the proposed rule exclusion of SNF/NF patients), noting in the rule, "We believe that the SIA payment would help to address MedPAC and industry concerns regarding the visit intensity at end of life and the concerns associated with the profitability of hospice short stays."

During the first three months of FY2016, CMS will continue to pay hospices for RHC at an unadjusted single daily rate of \$161.89 per day. This delay was designed to provide state Medicaid programs additional time to implement changes related to the payment modifications. As of this writing, many state Medicaid programs have not met the January 1 deadline but have plans to institute the changes at a later date. Beginning on January 1, 2016, the two-tiered payment system for RHC will provide a payment of 126.03 percent of the RHC labor rate for patients receiving RHC during days one to sixty, and a payment of 87.22 percent of the RHC labor rate for any routine home care day over sixty days. CMS noted in the final rule that the new labor rates will then be reduced by applying a budget neutrality adjustment of .9978. The intermediate effect of adding the new labor payment amount (after reducing by the budget neutrality adjustment) to the non-labor portion of the RHC rate is an increase in the RHC rate of 117.69 percent for days one to sixty, and a decrease equal to 91.09 percent of the former single payment rate for RHC for days sixty one and after. CMS then applies a second adjustment



to this calculation to offset the cost of the SIA; it reduces the overall payment for days one to sixty by applying a payment adjustment of .9806 to the rate and an adjustment of .9957 to the payment for days sixty one and above; this payment is applied to the full payment (both the labor and non-labor components). In the end, the overall increase for days one to sixty is equal to 115.41 percent of the RHC rate for October-December 2015; the payment rate for days sixty one and above is 90.70 percent of the RHC rate for October-December 2015.

CMS retained its proposed plan for the “count of days” to determine which of the two RHC rates is applicable to a particular RHC day on hospice care (see Section Two, above). CMS also indicated that days of care prior to January 1, 2016 would count toward determining the appropriate RHC under the new payment model, provided a break in hospice service of no greater than 60 days had occurred.

**The new payment rates for RHC are as follow (please note the calculation excludes the wage index adjustment):**

October-December 2015 RHC rate:	\$161.89
January 1, 2016 RHC rate (Days 1-60)	\$186.84
January 1, 2016 RHC rate (Days 61+)	\$146.83

**Effective for hospice services with “Through” dates, on and after January 1, 2016, a hospice RHC level of care day will be paid one of two RHC rates based upon the following:**

1. The day is a RHC level of care day.
2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC ‘high’ rate.
3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC ‘low’ rate.
4. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may be paid at the high or low RHC rate, upon hospice election.
5. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC ‘high’ rate upon the new hospice election.

**Effective for hospice services with “Through” dates, on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) SIA payment if the following criteria are met:**

1. The day is a RHC level of care day.

2. The day occurs during the last seven days of life (and the beneficiary is discharged dead).
3. Service is provided by a RN or SW that day for at least 15 minutes and up to 4 hours total.
4. The service is not provided by a SW via telephone.

**The SIA Payment amount shall equal:**

- The number of hours (in 15 minute increments) of service provided by an RN or SW during the last seven days of life for a minimum of 15 minutes and up to 4 hours total per day;
- Multiplied by the current hospice CHC hourly rate (\$39.37 per hour for FY2016) in 15-minute units x visit units (not greater than 16); and
- Adjusted for geographic differences in wages.

## SECTION FOUR: REVENUE RECOGNITION – GROSS REVENUE

Revenue recognition starts with a discussion of **Gross Revenue**. Gross Revenue is derived from set standard charges for Hospice services. Every Hospice must set policies regarding setting standard, community rate charges that should be reviewed periodically. Gross Revenue will be the accumulation of the standard community rate charges for all payers, regardless of what each payer may ultimately reimburse. The difference between Gross Revenue and what is reimbursed is commonly known as the **Contractual Allowance**. The term **Discount** may also be used. The amount to be reimbursed is commonly known as **Net Revenue**.

Section 2202 of the Medicare Provider Reimbursement Manual indicates that patient charges are to be established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients. All patients’ charges should be recorded at the gross value; i.e., charges before the application of allowances and discount deductions. Section 2204 requires that the Medicare charge for a specific service must be the same as the charge made to non-Medicare patients.

The accounting system should have the ability to accumulate Gross Revenue and Contractual Allowances based upon the policies of the Hospice. The following is a discussion of possible policies that a Hospice might consider.

The most common of charge structures for Hospices are charge rates for the per diem Hospice levels of care: Routine, Inpatient, Respite and Continuous. This is supplemented by other charges for Room and Board days and Physician Services outside of the Hospice levels of care. Charge rates are typically set on the basis of what will be the reimbursement and what the cost of the service will be. A common approach to setting charges is to analyze the anticipated



cost of the service and then set a target goal of percentage markup. Depending upon the Hospice margin target, this percentage markup over cost may be 10 percent, 25 percent, 50 percent or even 100 percent. Keep in mind that even though the per diem charges may not matter for Medicare reimbursement purposes, it may for other payers. There are Medicaid and other programs that will pay the lower of Medicare or other set rates or charges, so if the charges are less than reimbursement rates, the reimbursement would be less than what the Hospice could obtain. There are commercial and managed care contract arrangements that will reimburse a percentage of Medicare rates or a percentage of charges. Best recommended policy to follow would be to always charge more than what the expected reimbursement may be for any payer. If, for example, Medicare was the higher rate payer and the RHC rate was \$200.00 per day and the Hospice's policy was to charge at a rate of 25 percent above Medicare rates, the Routine Gross Revenue rate for all payers would be \$250.00 per day. These charges should be reviewed at least annually with reviews occurring possibly during the budgeting process and October 1st of every year when new Medicare Hospice rates go into effect.

Medicare and possibly other payers may require placing charge rates for visit and other services provided to Hospice Medicare beneficiaries onto Hospice claims. Medicare implemented such a requirement in 2008. HHFMA recommends determining these charge rates based upon the calculated cost of the particular service. HHFMA has provided assistance to members in determining charges for services using Excel templates. These are available for [download here](#) or on NAHC's HHFMA website under MEMBER RESOURCES.

With the change in splitting RHC rates effective January 1, 2016 where Medicare Hospice days 1 -60 will be at a higher rate than days 61+, Hospices may wish to review their rate setting policy. Rates should be adjusted for the applicable labor index in determining the particular charge rates for the Hospice. Programs that negotiate their payment as a percentage of posted charges should ensure that the revised payment amount is considered a competitive rate by the commercial/managed care payers.

**Despite the different net payment amounts for the first 60 days of care and day 61 and thereafter, the Hospice should have one standard charge for all RHC days on a claim. The higher payment for the first sixty days will result in a lower contractual adjustment on the claim. Hospices are reminded that it is Medicare policy that a Hospice charge Medicare the same as it does for all other payers.**

#### Charges and IT Vendor Systems for Hospice

At a minimum, IT Vendor systems should allow Hospice providers flexibility to load various net payment rate structures. For the new split RHC rates, the system should be

able to determine the applicable number of days for each Medicare beneficiary for the accounting cycle in computing the total Gross and Net Revenues for all patients. The system should be able to post the Net Revenue as an accounts receivable for the patient.

There are currently time lags related to posting of beneficiary hospice status in the Common Working File (CWF) that may lead a hospice to believe a patient has not previously been on hospice service, and to anticipate a different payment level for RHC. It is also possible that a hospice that previously served a patient has not yet submitted a Notice of Election (NOE) and claims related to that stay, and the hospice providing care may not have record from the patient of previous hospice services. In such cases, when the CWF status of the patient is updated, the hospice providing care may receive notice that a rate adjustment is being made to reflect the full hospice history of the patient. In such cases, it is recommended that Hospice agencies monitor the frequency of these changes to the patient history and ensure the appropriate revenue adjustments are processed. The Hospice agency may also consider whether it wishes to establish a reserve if the volume of patients with prior Hospice admissions is significant.

### SECTION FIVE: PAYMENT REFORM AND CLAIMS PROCESSING

In the final rule, CMS indicated that Hospices will not be required to change how they bill for RHC days to comply with the proposed higher RHC rate for the first 60 days of care and a lower rate thereafter. CMS' claims processing system will be responsible for the count of days, rather than the individual Hospices, and will pay the appropriate rate accordingly. Please note that CMS will provide all payment (both for the higher rate for the first sixty days and the lower rate for days sixty one and after) on one remit. The remittance will not have any codes that distinguish the payment rate amount (high or low).

CMS noted that prior Hospice admissions would be available to programs via the Common Working File (CWF), and that in the event the first Hospice did not bill for their services, the subsequent Hospice would need to back out their claim, as required for Sequential Billing.

### SECTION SIX: OVERVIEW OF SERVICE INTENSITY ADD-ON (SIA) PAYMENT / G CODE MODIFICATIONS

CMS believes that the SIA policy necessitates the creation of two new G codes for nursing. During periods of crisis such as the precipitous decline before death, patient needs typically surge and more intensive services are warranted. The Medicare Conditions of Participation (CoPs) at §418.56(a) state that a registered nurse (RN) is responsible for ensuring that the needs of the patient and family are continually as-



sessed. CMS would expect that at end of life the needs of the patient and family would need to be frequently assessed and thus the skills of a RN are required. RNs are more highly trained clinicians with commensurately higher wage rates.

In order to quantify the amount of RN services provided to a patient, CMS believes the claims should differentiate between the levels of nursing services provided. Since the existing codes do not distinguish between services provided by a RN and a Licensed Practical Nurse (LPN), CMS sought new codes to distinguish between RN and LPN services effective with implementation of the new payment system on January 1, 2016.

The SIA daily payment calculated by the Hospice PRICER will be entered on the first applicable visit line item for each date of service payable. The following is an excerpt from CMS [Change Request 9369](#).

#### Skilled Nursing (revenue code 055x)

For dates of service before January 1, 2016: G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

For dates of service on or after January 1, 2016: Visits previously reported with G0154 are reported with one of the following codes:

- G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting
- G0300 Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting.
- G0154 is retired as of 12/31/2015.

*Effective for hospice services with dates of service on and after January 1, 2016, a service intensity add-on payment will be made for the social worker visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day, i.e. from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. In addition, the time of a social worker's phone calls is not eligible for an SIA payment.*

*The SIA payment amount is calculated by multiplying the continuous home care (CHC) rate (per 15 minutes) by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.*

#### EXAMPLE CLAIM 1: End of Life (EOL) 7 day SIA:

Billing Period: 12/01/XX – 12/09/XX, Patient Status: 40 RHC in home, discharged deceased.

Revenue Code	HCPCS	Line Item Date of Service	Units
0651	Q5001	12/01/XX	9
0551	G0299	12/01/XX	4
0571	G0156	12/02/XX	6
0561	G0155	12/05/XX	4
0571	G0156	12/05/XX	3
0551	G0299	12/06/XX	3
0571	G0156	12/06XX	4
0551	G0299	12/09/XX	4
0561	G0155	12/09/XX	6
0571	G0156	12/09/XX	2

\*Visits reported prior to 12/03/XX are not included in the EOL 7 day SIA.

- Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.
- Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.
- Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4
- Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/06/XX UNITS 3
- Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.
- Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.
- Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/09/XX UNITS 4.

**Special Note** – changes to HCPCS codes are applicable to all payer types. However, payers other than Medicare may not follow the same implementation schedule as CMS.

### SECTION SEVEN: SIA REVENUE RECOGNITION WHEN PAYMENT CROSSES MONTH END

In the final rule, CMS indicated that operational staff and contracting partners would work in concert to fully automate the review of claims with a discharge of death in order to identify eligible visits and generate appropriate SIA outlays. In addition, in response to a question regarding



the payment for SIA-eligible services that overlap months, CMS suggested the SIA payments would be paid on the applicable lines on each monthly claim. The prior month claim would be adjusted using a void and replacement. The replacement would have an 8xG adjustment type of bill. This claim will be paid after the submission of the monthly claim for the time period during which the patient dies -- as an example, if the patient dies in February and has eligible visits in January, the SIA payment for the January visits will occur on a separate remittance advice after the February claim has processed. CMS also indicated that the hospice electronic remit will continue to show a payment on the level of care lines for the SIA and a sum total payment amount at the claim level. As such, there will be payment on the level of care lines, payment on the visit lines for which the SIA applies, and a sum total payment amount at the claim level.

Overall, we believe the reimbursement amount for the SIA will have an immaterial impact to the overall Hospice financial statements, probably less than 1 percent of Total Gross Revenue. This percentage will vary from one Hospice to another. Since CMS will void and replace the prior month claim, it is not yet known how long it will take for the Hospice to actually receive the SIA payment for the qualifying visits at the end of the prior month. Since there would be less than seven days of potential visits, we propose to record the SIA payment as an adjustment (reduction) to the contractual adjustment in the month when the payment is actually received. For example, if a patient dies on February 3 and had a qualifying SIA visit on January 30, then the January claim will be voided and replaced after the February claim is paid which could be March or April. The adjustment for the January SIA visit would be recorded then. If the original payment for January was \$1,000 and with the SIA payment is now \$1,100, there will be a \$100 credit balance when the void and replacement is posted in the AR system. The \$100 should then be used to zero out AR and reduce contractual adjustments. This method is contingent upon what the specific Hospice agency's billing software will do. Therefore, it is critical to understand what process the billing system will follow.

### SECTION EIGHT: CALCULATION OF SIA WITHHOLDS AND CALCULATION OF PROJECTED AMOUNT OF TIME REQUIRED FOR OFFSET

CMS noted in the final rule that payment for the SIA, as required by Section 1814(i)(6)(D)(ii) of the Affordable Care Act, must be budget neutral the first year of implementation. As such, CMS proposed that the SIA payments be budget neutral through a reduction to the RHC rates.

The proposed rates indicated payment of 98.53 percent of the RHC rate, a reduction of 1.47 percent, for patient days one to sixty, and a payment of 99.67 percent (a reduction of 0.33 percent for days greater than sixty one). The final rule reduced the payment for days one to sixty to 98.06 percent, a reduction of 1.94 percent, and the payment for days sixty one and greater to 99.57 percent, a reduction of 0.43 percent--the additional reduction in each case is likely due to the additional expense of extending the SIA to the SNF/NF population.

The SIA reduction for patients on program from days one to sixty is equal to \$3.64 per patient day. Given the CHC rate of \$39.37 per hour, it would require 1.85 hours of services eligible for the SIA payment per day for every ten patients receiving RHC for the program to receive an amount equal to the SIA adjustment.

### SECTION NINE: IMPACT ON HOSPICE CAP

CMS noted in the final rule that their calculations of the impact of the revised payment were as follows: "For those hospice providers who did not exceed their aggregate cap in 2013, we estimated that the proposed RHC rates would result in a 0.14 percent increase in payments. However, for those hospice providers that exceeded their aggregate cap, hospice payments were estimated to decrease by 5.40 percent." The aggregate cap is not directly impacted by the payment changes. However, if a hospice exceeds the hospice inpatient cap, payment for any days above 20 percent of total care days that are billed at an inpatient rate will be reduced to the RHC rate. CMS has indicated that if a hospice should hit the inpatient cap those inpatient days in excess of the 20 percent threshold will be reduced to the lower of the two RHC rates -- which is set at \$146.83 for the period of Jan. 1 through Sept. 30, 2016.

### SECTION TEN: CONCLUSION

Hospice Payment Reform has been under development by CMS for some time. However, this is probably just the first change of other changes to come in the upcoming years. These initial changes will impact each individual Hospice agency to a different degree. Hospice agencies with shorter lengths of stay will benefit with the enhanced reimbursement during the first 60 days. The opposite can be said for those Hospices' with very long lengths of stay. There may also be reimbursement issues with the Hospice CAP, also. As previously stated, the additional payments for the SIA will probably be de minimis. Therefore, it is incumbent upon each Hospice to determine how all of these changes to the payment policies will impact its own bottom line.