PAYMENT FOR HOSPICE SERVICES

National data shows the following payment sources for hospice care:

Medicare	84%
Managed Care or Private Insurance	7.8%
Medicaid	5.1%
Uncompensated or "Free" care	1.3%
Self pay	0.7%
Other payment source	0.8%

Most managed care/private health insurance require authorization for hospice services.

All admissions are processed through the Intake Department. Intake obtains basic information such as demographic data and payment source. The Utilization Review Department obtains authorizations from managed care and private insurance. The MVH RN case manager may be contacted by UR in order to obtain information on the patient's status in order to obtain insurance authorization. It's important to promptly respond to these requests, so that the patient's coverage is continued.

The RN case manager and the social worker need to stay informed of the patient's insurance coverage status. Here are some examples of things that are "red flags" for change in payment source:

- Patient turns 65 years of age – probably will be Medicare eligible
- Spouse/partner loses job – may lose health insurance coverage
- Spouse/partner starts a new job – may lose Medicaid coverage and/or be eligible for other insurance

These type of events need to be communicated to the clinical manager, who will follow-up with the Fiscal Department to determine the next steps to ensure continued coverage of hospice services.

Hospice in the Nursing Home
Medicare does not pay for room and board for nursing home care. Patients and families may do so, or the patient may have Long Term Care Insurance or Medicaid, which will pay for the room and board charges.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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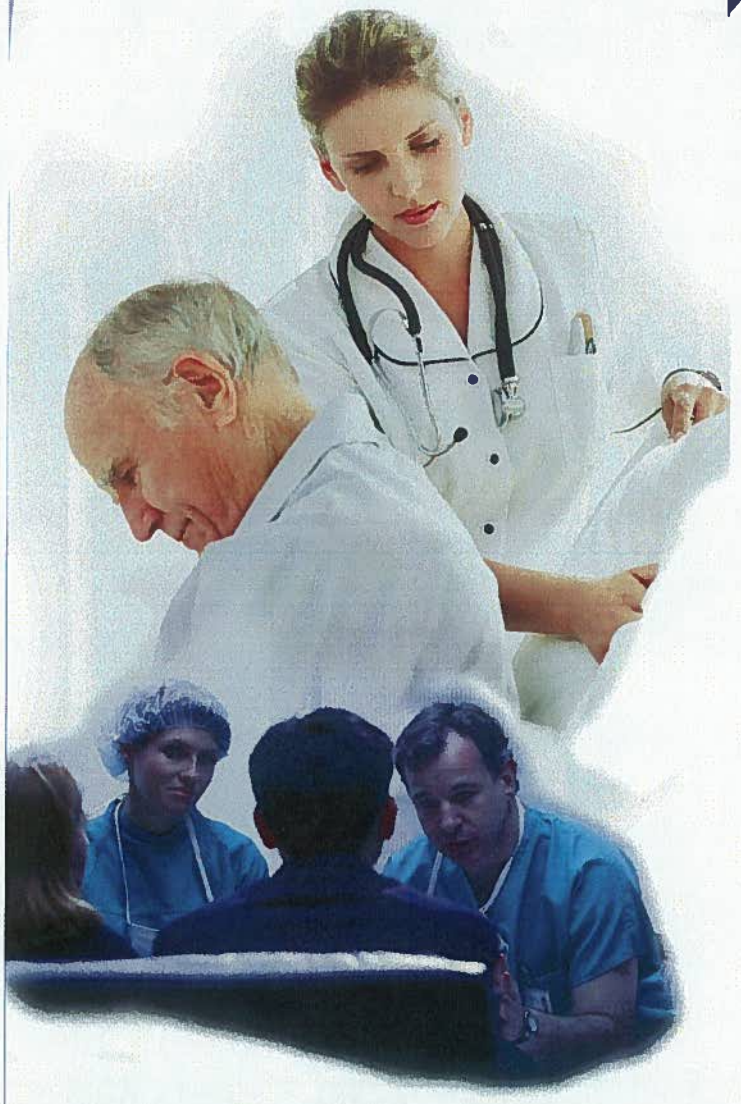
Hospice Payment System

PAYMENT SYSTEM FACT SHEET SERIES



This publication provides the following information about the Medicare hospice benefit:

- Coverage of hospice services;
- Certification requirements;
- Election periods;
- How payment rates are set;
- Patient coinsurance payments;
- Caps on hospice payments;
- Hospice option for Medicare Advantage (MA) enrollees; and
- Resources.

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

- 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.

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Coverage of Hospice Services

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

- Physician services furnished by hospice-employed physicians and nurse practitioners (NP) or by other physicians under arrangement with the hospice;
- 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 designated 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 under arrangement for those services.
- Room and board if hospice care is provided in the home, in a nursing home, or in a hospice residential facility. However, room and board are allowable services under the Medicare hospice benefit for short-term inpatient care that the hospice arranges; and
- Care in an emergency room, inpatient facility care, outpatient services, or ambulance transportation, unless these services are either arranged by the hospice medical team or are unrelated to the terminal illness.

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 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; and
- Specific clinical findings and other documentation that support a life expectancy of six months or less; and
- A brief narrative explanation of the clinical findings, composed by the physician, that supports a life expectancy of six months or less; and
- Signature(s) of the physician(s) and the date it was signed.

Beginning in January 2011, the Patient Protection and Affordable Care Act requires that the hospice physician or NP have a face-to-face encounter with hospice patients who reach the 180-day recertification, and at each recertification thereafter, to determine continued eligibility for the hospice benefit. The physician or NP must also attest that the visit took place.

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's or representative's (if applicable) acknowledgement that, based on the education received, the patient has a full understanding of the palliative rather than curative nature of hospice services;
- The individual's 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 previously waived is resumed.

An individual may change the designation of the hospice from which he or she elects to receive hospice care one time 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 must include 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 2011 payment rates for the period October 1, 2010, through September 30, 2011, increased by 2.6 percentage points of the 2010 payment rates, as depicted in the chart below.

FISCAL YEAR 2011 HOSPICE PAYMENT RATES

Code	Description	Rate	Wage Component Subject to Index	Non-Weighted Amount
651	Routine Home Care	$146.63	$100.75	$ 45.88
652	Continuous Home Care Full Rate = 24 Hours of Care $35.66 = Hourly Rate	$855.79	$588.01	$267.78
655	Inpatient Respite Care	$151.67	$82.10	$69.57
656	General Inpatient Care	$652.27	$417.52	$234.75

Patient Coinsurance Payments

- **Prescription drugs or biologicals** – Hospices may bill Medicare hospice patients a coinsurance payment for each palliative drug or biological prescription. The coinsurance for each prescription approximates 5 percent of its cost to the hospice, determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed $5.00.
- **Respite care** – Hospices may bill Medicare hospice patients for coinsurance for each respite care day, equal to 5 percent of the payment made by Medicare for a respite care day. The amount of an individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

Caps on Hospice Payments

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 (the inpatient cap); and
2. An aggregate payment amount that a Medicare hospice provider may receive in Medicare payments for services provided in the cap year is limited to the cap amount times the number of beneficiaries who initially elected the benefit in that period (the aggregate cap).

The hospice aggregate cap is adjusted annually by the medical expenditure category of the Consumer Price Index for all Urban Consumers (CPI-U) published by the Bureau of Labor Statistics. For the cap year ending October 31, 2010, the cap amount is $23,874.98.

Hospice Option for Medicare Advantage Enrollees

Hospice is not a benefit under the MA Program and MA Plans cannot provide the Medicare hospice benefit to their MA Plan members. 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.

Resources

To find additional information about the hospice benefit, see the Hospice Center Web Page located at ***http://www.cms.gov/center/hospice.asp*** on the Centers for Medicare & Medicaid Services (CMS) website. 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). Additional information about the CPI-U can be accessed at ***http://www.bls.gov/cpi/home.htm*** on the Internet.

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MERRIMACK VALLEY HOSPICE
INFORMED CONSENT & ELECTION OF THE MEDICARE HOSPICE BENEFIT

Name:_____ID#_____

I consent to receive services from Merrimack Valley Hospice (MVH). I understand that the hospice team will work closely with me and my attending physician to develop a plan of care. MVH is financially responsible for those services that are included in my plan of care.

Hospice care includes skilled nursing care, volunteer companions, emotional and spiritual care, physical or other therapies, social workers and inpatient care, depending on the needs of the patient and family.

I understand that MVH will provide and is responsible for the services described in the MVH "Patient/Caregiver Handbook" including medications and durable medical equipment related to my hospice illness. I have received, reviewed and had explained to me the MVH "Patient/Caregiver Handbook" that includes the following detailed information:

The Medicare/Medicaid Hospice Benefit	Eligibility for Hospice Care	Patient Rights & Responsibilities
Advance Directives	Services Provided by MVH	Financial Responsibilities
Emergency Planning Guidelines	Home, Fire and Equipment Safety	Nutrition, Pain and Medication Guidelines
Notice of Privacy Practices		

I have been provided with a full understanding of hospice care, and understand that hospice care is focused on comfort and quality of life, rather than curative. It has been explained to me that the focus of hospice is to relieve pain and symptoms. I understand the following explanation of the Medicare Hospice Benefit:

Medicare will continue to make payment to my independent attending physician for services if my physician is not a hospice employee or receiving payment from MVH.

I agree to contact MVH prior to seeking hospital or outpatient services related to my hospice illness.

I waive my rights to Medicare benefits related to my hospice illness while enrolled in the Medicare hospice program.

I am responsible for the cost of my care for my hospice illness if I seek care beyond what is considered medically necessary by the hospice team and documented in my plan of care.

I may change from one hospice to another once during each benefit period. In changing to another hospice, I will not lose benefit days. To do so, I will inform MVH of my wishes so arrangements for transfer can be made.

The Medicare Benefit consists of two 90-day periods, and unlimited 60 day periods.

I may discontinue hospice care at any time by completing a revocation statement. In doing so, I lose the remaining days in the benefit period, but may re-elect at any time when I am eligible.

Acknowledging and understanding the above, I authorize Merrimack Valley Hospice to begin providing services under the Medicare Hospice Benefit effective_____(date)

Insurance Authorization: I authorize any insurance or other third-party coverage to be paid directly to MVH.

_____ _____
Signature of patient or legal representative Date

_____ _____
Signature of Witness Date

If patient not signing, state reason_____