



Medicare's Hospice Benefit

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Medicare Hospice Care Includes

- Generally, hospice care includes services which are reasonable and necessary for the comfort and management of a terminal illness. These services may include:
 - Physician services.
 - Nursing care.
 - Physical therapy, occupational therapy, and speech-language pathology services.
 - Medical social services.
 - Home health aide services.
 - Homemaker services.
 - Medical supplies, including drugs and biologicals and medical appliances.
 - Counseling, including dietary counseling, counseling about care of the terminally ill patient, and bereavement counseling.
 - Short term inpatient care for respite care, and pain control and symptom management which require an inpatient setting.



When Will Medicare Cover Hospice Care?

- A physician must certify that the beneficiary is terminally ill and that in the physician's judgment the individual has 6 months or less to live if the illness runs its normal course.
- The beneficiary or his/her representative must elect the Medicare hospice benefit, forgoing curative care.
- The beneficiary's attending physician and the hospice physician must certify the beneficiary for the initial 90 day benefit period. For subsequent benefit periods the hospice medical director, or the attending, or a physician member of the IDG can recertify the beneficiary's terminal illness prognosis.
 - A beneficiary may elect the hospice benefit for two 90 day periods and an unlimited number of subsequent 60 day periods.
- The care must be provided pursuant to a specific hospice plan of care, and the plan of care must be periodically reviewed.
- The care must be provided by, or under arrangements with, a Medicare certified hospice.



Certification of Terminal Illness Specific Requirements

- The hospice must obtain written or oral certification within 2 calendar days after a benefit period begins
- The hospice must have written certification prior to submitting claim.
- Initial certification must be signed by both the attending physician & Medical Director
- NPs cannot sign certifications
- Stamped signatures not acceptable
- Content of the certification:
 - Must specify prognosis
 - Must be accompanied by clinical info/ other documentation to support prognosis
 - Must be filed in medical record





Hospice Payments

- Per diem includes all services related to palliation & management of the terminal and related conditions except some physician services
- Routine home care:
 - 95 % of hospice care is provided at this level
 - FY 2009 Rate is \$139.97 per day
- Continuous home care:
 - For periods of crisis at home;
 - FY 2009 Rate: Hourly rate up to \$816.94 per day
- General inpatient care:
 - For pain or symptom management that requires an inpatient setting
 - For crisis situations of short duration
 - FY 2009 Rate : \$622.66
- Inpatient respite care:
 - Up to 5 consecutive days
 - FY 2009 Rate: \$144.79
 - 5 percent co-pay

Hospice Pre-election Counseling

- Provides payment to a hospice for pre-election evaluation and counseling services furnished by a physician who is the hospice medical director or a hospice employee
- Is a one-time payment for counseling a terminally ill patient who has not yet made a hospice election and has not previously received pre-election counseling
- If the patient's attending physician is also a physician employee of the hospice, the hospice may not bill for this service, because the attending already has the expertise to furnish these services
- Effective January 1, 2005, hospices can bill Medicare Part A for these services using revenue code 0657 & HCPCS code G0337
- Current payment is \$54.57
- Payments for pre-election counseling do not apply toward the hospice aggregate cap

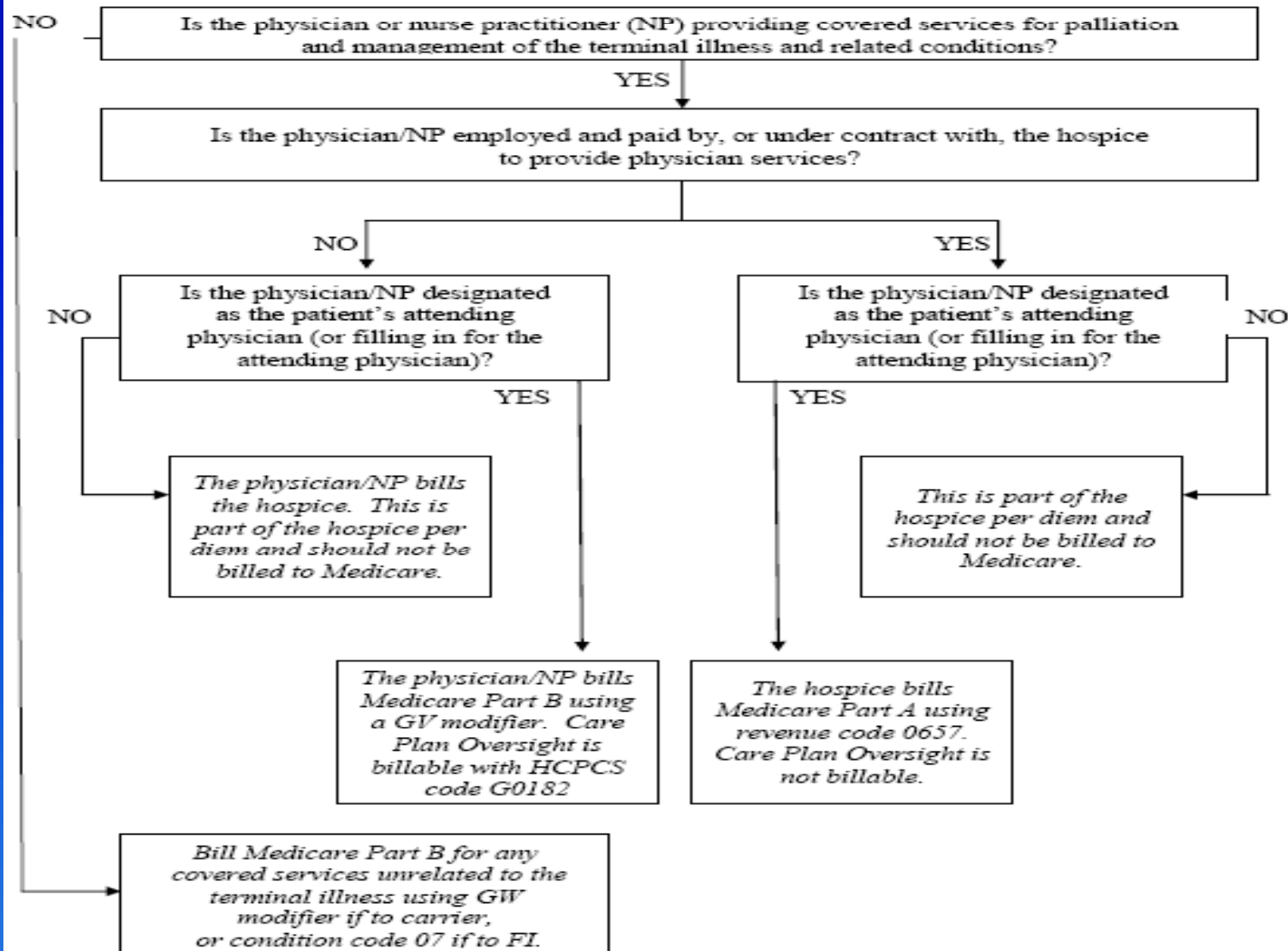


Hospice Physician Billing

- Certain physician services also billable to Part A through the Hospice, or to Part B by the physician
- Note that “attending” physician is designated by patient/representative at the time of election



Billing of Physician Services for Medicare Hospice Patients



Notes: 1) Billable NP services are those which, in the absence of the NP, would be performed by a physician and not a nurse. 2) When a physician substitutes for the designated attending, the attending physician bills using a GV modifier in conjunction with either a Q5 or Q6 modifier.



What happens if a beneficiary requires care for a condition unrelated to the terminal, illness?

- Medicare benefits available for co-morbidities UNRELATED to the terminal diagnosis
- Treating provider bills Medicare outside of the hospice benefit
- System knows the patient is a hospice patient; will reject bills for unrelated conditions unless they include special modifiers/condition codes



Trends in Hospice

- Tremendous growth
 - \$12.6B projected expenditures for FY 2009
 - Growth rate approximately 1 B per year.
 - Over 3,200 hospices
 - Most of growth in for-profit
- Changes in Hospice Patient Characteristics
- Changes in Length of Stay
 - Average LOS in 1997 was 48 days
 - Average LOS in 2008 was 73 days





Top Diagnoses

• 1998	%	LOS	• 2006	%	LOS
• Lung CA	16	43	• Non-Alz dem	10	89
• CHF	7	52	• Lung CA	10	46
• Col.rec CA	7	49	• CHF	9	83
• NI Resp	5	63	• Debility NOS	8	77
• CVA/stoke	5	36	• NI Resp	7	86
• Prostate CA	4	53	• Other heart	6	85
• Other heart	4	57	• Alzheimer's	6	110
• Blood/lymph	4	37	• CVA/stoke	6	61
• Breast CA	4	56	• Fail. to thrive	6	81
• Non-Alz dem	4	57	• Col.rec CA	3	56

FY 2010 Payment Updates

- Hospice Wage Index Final Rule targeted to display at OFR on or before July 31, 2009
- Proposed Rule published April 24, 2009 : Received 729 comments
- Key Proposed Rule provisions
 - 75 % reduction in BNAF
 - Requirement for physician narrative on the certification and recertification of terminal illness
 - Solicited comments about
 - MedPAC’s suggested requirement that physician or advance practice nurse see the hospice patient around certification and recertification time
 - Payment reform
- Payment rates are updated via an administrative notice
 - We expect 2.1 percent market basket update
 - Notice will be posted early-mid August



Hospice Payment Reform

- MedPAC, GAO, OIG have been critical of CMS for not collecting data needed to assess the adequacy of hospice payments
- Hospice Claim Data Collection
 - Site of service data collected beginning January 2007
 - Visit data collected beginning July, 2008
 - Visit intensity data to be collected beginning January, 2010
 - Cost report changes may be on the horizon
- MedPAC Suggested Payment Model
 - Higher Payments in the beginning of the stay, and period prior to death
 - Applies to Routine Home Care, only
 - Suggests current model incentivizes abuse; recommends CMS reform hospice payments no later than 2013



PAYMENT POLICY QUESTIONS?

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