



FAST FACT AND CONCEPT # 87 MEDICARE HOSPICE BENEFIT – PART II: PLACES OF CARE AND FUNDING

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Introduction *Fast Fact #82* described eligibility for the Medicare Hospice Benefit (MHB) and the services it covers. This *Fast Fact* will review where services are provided and the reimbursement system for hospice care. *Fast Fact #90* reviews special interventions under the MHB, and #140 further discusses levels of care.

Places of Care

- **Home:** The majority (~95%) of hospice care takes place in the home. Hospice team members visit the patient and family on an intermittent basis determined by the Plan of Care (see *Fast Fact #82*), which changes based on the patient's needs. Medicare rules do not require a primary caregiver in the home, but as death nears, it becomes increasingly difficult to provide care for a patient who does not have someone (family, friends, hired caregivers) who can be present 24 hours a day in the home.
- **Long-term care facility:** 25% of patients in the US die in nursing homes. Medicare recognizes that this can be the resident's 'home' and that the patient's 'family' frequently includes the nursing home staff. Hospice care under the MHB can be provided to residents *in addition* to usual care provided by the facility. Individual hospice programs must establish a contract with the facility to provide hospice care. The MHB does not pay for nursing home room and board charges.
- **Hospice inpatient unit:** Dedicated units, either free-standing or within other facilities (such as nursing homes or hospitals) are available in some regions. Patient eligibility (e.g., whether or not a patient requires general inpatient care or not), permitted length-of-stay, and fees for room and board vary between facilities.
- **Hospital:** When pain or other symptoms related to the terminal illness cannot be managed at home, the patient may be admitted to a hospital for more intensive management, still under the MHB. The inpatient facility must have a contract with the hospice program to provide this service.

Payment Medicare pays for covered services using a per diem capitated arrangement in one of four categories (see *Fast Fact #140*). The rates below reflect 2015 Medicare and Medicaid reimbursements.

- **Routine Home Care:** care at home or nursing home (~\$159/day).
- **Respite Care:** care in an inpatient setting (nursing home, hospice facility, or hospital) for up to 5 days to give caregivers a rest (~\$164/day).
- **General Inpatient Care:** acute inpatient care (at a hospital or hospice facility) for conditions related to the terminal illness such as pain and symptom control, caregiver breakdown, or impending death that requires inpatient-level interventions (~\$709/day).
- **Continuous Home Care:** provides acute care at home with around-the-clock nursing for a crisis that might otherwise lead to inpatient care (~\$930/day).

The rates of reimbursement are fixed for each category of care on an annual basis, but they vary by geographical location. Cited rates are approximate and are intended to convey general orders of magnitude of payment. Payment is made from Medicare to the hospice agency, which then pays the hospital or nursing home (for respite or acute care), depending on the specifics of the contractual arrangement between the hospice agency and the facility.

Physician Services Direct patient care services by physicians, for care related to the terminal illness, are reimbursed by Medicare, and are not included in the per diem. If the attending physician is not associated with the hospice program via employment or similar contract, the physician bills Medicare Part B in the usual fashion. The bill must indicate that the physician is not associated with the hospice program or the claim may be denied. If the attending is associated with the hospice program (e.g. as a medical director) the physician submits the bill to the hospice

program, which in turn submits the claim to Medicare under Part A. The physician is then reimbursed based on a contract with the hospice program. Patients can see consulting physicians under the MHB if the hospice agency contracts with the consultant to do so. The hospice agency submits the claim under Medicare Part A and reimburses the consultant per their contract.

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