Title: **Hospice Policy 600**
Section: **PAYMENT FOR HOSPICE CARE**
Subject: **Payment Procedures for Hospice**
Reference: **ARM 37.40.830, 42 CFR 418.302, 42 CFR 418.306**
Supersedes: **Policy 600, July 2017**

PAYMENT PROCEDURES FOR HOSPICE CARE

Centers for Medicare and Medicaid (CMS) establishes payment amounts for specific categories of covered hospice care. Medicaid pays hospices a daily rate for each day a patient is enrolled in the hospice benefit. Daily payments are made regardless of the amount of services furnished on a given day. Payment amounts are determined within each of the following categories:

ROUTINE HOME CARE DAY:

A routine home care day is a day on which a patient who has elected to receive hospice care is at home and is not receiving continuous care.

1. RHC is a level of care day which will be paid one of two RHC rates. RHC per diem payment rates for the RHC level of care will be paid depending on the timing of the day within the patient's episode of care. Days 1 through 60 will be paid at the RHC "High" rate while days 61+ will be paid at the RHC "Low" rate.
2. Service Intensity Add-on (SIA). Routine home care days that occur during the last 7 days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.
    a. The service intensity add-on payment shall be equal to the continuous home care hourly payment rate, multiplied by the amount of direct patient care actually provided by a RN and/or social worker, up to 4 hours combined per day.

CONTINUOUS HOME CARE DAY

A continuous home care day is a day on which a patient who has elected to receive hospice care and is:

1. Not in an inpatient facility; and
2. Receives hospice care consisting predominantly of nursing care on a continuous basis at home.

Home health aide (also known as a hospice aide) or homemaker services or both, may also be provided on a continuous basis.

Continuous home care is only furnished during brief periods of crisis as described in Hospice Policy 502 and only as necessary to maintain the terminally ill patient at home.

INPATIENT RESPITE CARE DAY

An inpatient respite care day is a day on which the patient, who has elected hospice care, receives care in an approved facility on a short-term basis for respite.

GENERAL INPATIENT CARE DAY

A general inpatient care day is a day on which a patient who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

PAYMENT RATES

The payment amounts for the categories of hospice care are fixed payment rates that are established by CMS. Payment rates are determined for the following categories:

1. Routine home care;
2. Service Intensity Add-On Rate;
3. Continuous home care;
4. Inpatient respite care; and
5. General inpatient care.

Medicaid reimburses the hospice its appropriate payment amount for each day for which an eligible Medicaid beneficiary is under the hospice's care.

If a hospice makes arrangements with another hospice to provide services, Medicaid reimburses the hospice for which the beneficiary has made an election.

Medicaid makes payment according to the following procedures:

1. Payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day except for the service intensity add-on;
2. Payment is made for only one of the categories of hospice care for any particular day;
3. On any day in which the beneficiary is not an inpatient, the hospice is paid the routine home care rate, unless the patient receives continuous care for a period of at least eight hours. In that case, a portion of the continuous care day rate is paid;
4. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous care provided during a continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight hours of care must be furnished on a particular day to qualify for the continuous home care rate.
5. Except for inpatient care limitations, on any day in which the beneficiary is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care furnished.

   The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged.
6. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient.

In the case where the beneficiary is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day.

Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than five days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

a. Payment for inpatient care is limited as follows:

i. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients not exceed 20 percent of the total days for which these patients had elected hospice care.

ii. At the end of a cap period, Medicaid calculates a limitation on payment for inpatient care to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid patients.

iii. Only inpatient days that were provided and billed as general inpatient or respite days are counted as inpatient days when computing the inpatient cap.

iv. If the number of days of inpatient care furnished to Medicaid patients is equal to or less than 20 percent of the total days of hospice care to Medicaid patients, no adjustment is necessary.

v. Overall payments to a hospice are subject to the cap amount.

vi. If the number of days of inpatient care furnished to Medicaid patients exceeds 20 percent of the total days of hospice care to Medicaid patients, the total payment for inpatient care is determined in accordance with the procedures specified. That amount is compared to actual payments for inpatient care, and any excess reimbursement must be refunded by the hospice. Overall payments to the hospice are subject to the cap.

If a hospice exceeds the number of inpatient care days, the total payment for inpatient care is determined as follows:

1. Calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicaid patients;
2. Multiply this ratio by the total reimbursement for inpatient care made by the Medicaid Administrative Contractor;
3. Multiply the number of actual inpatient days in excess of the limitation by the routine home care rate; and
4. Add the amounts calculated.

Payment for routine home care, continuous home care, general inpatient care and inpatient respite care is made on the basis of the geographic location where the services are provided.