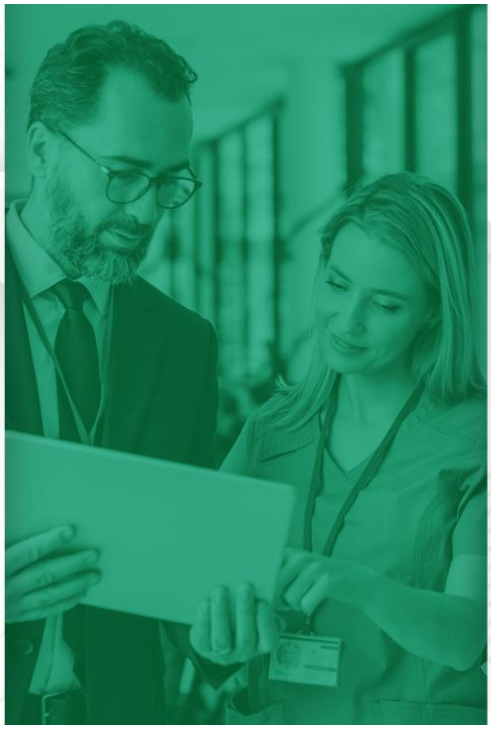
Hospice Billing Update: 2025 & Beyond!



Melinda A. Gaboury, COS-C
Chief Executive Officer

info@healthcareprovidersolutions.com

1

Melinda A. Gaboury, COS-C
Chief Executive Officer

Melinda A. Gaboury, with more than 30 years in home care, has over 20 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the NAHC/HHFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E and Home Health Billing Answers, 2024.

2

2025 Hospice Final Rule

The Centers for Medicare & Medicaid Services (CMS) released the 2025 Hospice Wage Index and Payment Rate Update Final Rule on July 30, 2024.

Finalizes a 2.9% increase in payments

- Updates the Hospice cap to $34,465.34

Effective October 1, 2024, with the following exceptions:

- Hospice Outcomes and Patient Evaluation (HOPE): On or after **October 1, 2025**
- Quality Measures: No earlier than November 2027 (FY 2028)
- CAHPS®Hospice Survey Changes: Beginning with **April 2025 decedents**

3

2025 Final Payment Rates

Code	Description	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2025 Hospice Payment Update	Final FY 2025 Payment Rates	FY 2024 Payment Rates
651	Routine Home Care (days 1-60)	1.0009	0.9983	1.029	**$224.62**	$218.33
651	Routine Home Care (days 61+)	1.0000	0.9975	1.029	**$176.92**	$172.35
652	Continuous Home Care Full Rate = 24 hours of care	N/A	1.0026	1.029	**$1,618.59** ($67.44/hour)	$1,565.46
655	Inpatient Respite Care	N/A	0.9947	1.029	**$518.78**	$507.71
656	General Inpatient Care	N/A	0.9931	1.029	**$1,170.04**	$1,145.31

4

2025 Hospice Final Rule

- For FY 2025 CBSAs were updated to calculate hospice wage index information

- **This will result in CBSA and wage index changes for some hospices**
  - Hospices would not see more than a 5% decrease in their wage index in the given year

- CMS has published a crosswalk of the changes with the FY 2025 final rule

5

Face-to-Face Requirements

Needs to be completed:

- **PRIOR** to the third benefit period and with each subsequent recertification
- Can be performed by hospice physician or nurse practitioner. If a nurse practitioner, he/she must be a hospice employee.
- Physician may be a hospice employee or contracted

Must Occur:

- **No more than 30 days prior to the recertification date**
- May occur on the first day of the benefit period
- **Prior to certifying physician's composition of written CTI narrative**
- Will be considered complete if the patient dies within 2 days of admission without a F2F encounter.

6

Face-to-Face Requirements

The following Must be Met for the Face-to-Face to be Complete:

- Physician or Nurse Practitioner attests in writing that the F2F encounter occurred.
- The Attestation is a separate and distinct section of, or an addendum to the written certification or recertification.
- The F2F documentation is clearly titled as such and includes the date of the encounter and a legible signature of the hospice physician or NP who performed the encounter.
- If the F2F encounter is performed by a non-certifying hospice physician or NP, the attestation statement must indicate that the **clinical findings were provided to the certifying physician for use in determining the terminal status.**
- The F2F encounter must be signed, along with the certification, **prior to billing the claim.** Claims will be denied if the certification and/or F2F encounter documents are not signed prior to the claim being billed.
- The F2F visit is NOT a narrative replacing the physician's narrative on CTI.

7

TELEHEALTH Face-to-Face

- Telehealth visits allowed to meet the **Face-to-Face (F2F)** requirement for all patients
- This visit would be conducted by allowed physician or NP (PA not allowed)
- These visits are NOT reported on the claim.
- F2F via telehealth is extended through **March 31, 2025**, after which CMS expects telehealth services to be summarily limited to follow-up contact with patients and would not expect to see provision of hospice services furnished via telecommunications systems
- Telehealth system utilized must be HIPAA Compliant

8

Physician Certification Clarification

Alignment of Medicare hospice payment and CoP requirements:

- Update CoPs to clarify that physician member of hospice interdisciplinary group may review patient clinical information and certify a patient's terminal illness
- Update CoPs to clarify that a physician designee may review patient clinical information and certify their terminal illness if the medical director is unavailable

9

Notice of Election and Election Statement Regulations

- CMS will reorganize regulations to clearly distinguish between the Hospice Election Statement and the Notice of Election (NOE)
- Does not reflect a change in policy, but is intended to promote clarity

Election Statement	Notice of Election
An individual who meets the eligibility requirements in §418.20 may file an election statement with a particular hospice.	Within five days after the hospice election date, a hospice must submit a NOE, which must be accepted by the Medicare Administrative Contractor

10

LEVELS OF CARE

The four levels of care into which each day of care is classified:

Routine Home Care	Revenue code 0651
Continuous Home Care	Revenue code 0652
Inpatient Respite Care	Revenue code 0655
General Inpatient Care	Revenue code 0656

11

ROUTINE HOME CARE

Hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care

- *Paid without regard to the volume or intensity*

A hospice day billed at the RHC level of care will be paid one of two RHC rates based upon the following:

1. The day is billed as an 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.

12

ROUTINE HOME CARE

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 bill 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

13

CONTINUOUS HOME CARE

- CHC is provided during periods of crisis as needed to maintain the patient in their home.
- To qualify as CHC, a minimum of 8-hours of care must be provided in a 24-hour period, beginning and ending at midnight.
    - The care does not need to be continuous.
- Care can be provided by nurses (RN or LPN) and home health aides; however, at least half (50%) of the care must be provided by a nurse.
- When billing CHC, units are billed to indicate the number of 15-minute increments provided in each 24-hour period of CHC.
- Example: 8 hours of CHC = 32 units
- If these criteria are not met (e.g. only 7 hours of care was provided), routine home care must be billed.

14

CONTINUOUS HOME CARE

CHC can be provided in the place where a patient resides such as:

- A private residence
- An Assisted Living Facility
- A long-term care facility (LTC) or non-skilled nursing facility (NF) (if the patient is not receiving a skilled level of care, i.e., Medicare Part A skilled benefit)
  - Providers need to be aware of how nursing facilities are licensed in their state as this will impact location of care codes on the hospice claim form. For example, all nursing facilities in Connecticut and New York are licensed as skilled nursing facilities.
  - This location of care would be coded on the claim form as Q5003, Hospice care provided in a nursing long term care facility (LTC) or non-skilled nursing facility (NF)
- CHC MAY NOT be provided in an: • Acute Care Hospital • Skilled Nursing Facility (SNF) (where patient is receiving skilled care) • Inpatient Hospice Facility

15

CONTINUOUS HOME CARE

Billing: The amount of payment for CHC is determined based on the number of hours, reported in increments of 15 minutes of continuous home care furnished to the patient on that day. (These increments are used in calculating the payment rate) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. (A minimum of 8 hours must be provided)

Payment is based upon the number of 15-minute increments that are billed for 32 or more units (4 units of 15 minutes equals one hour). Rounding to the next whole hour is no longer applicable. Units should only be rounded to the nearest increment. Billing for CHC should not reflect nursing shifts and nondirect patient increments (e.g., meal beaks, report, and education of staff).

16

INPATIENT RESPITE CARE

- Respite care is provided in a hospital, skilled nursing facility, or other inpatient facility, to provide temporary relief to the patient's family members or other caregivers.
- Respite care should be used on a short-term, occasional basis, when necessary to relieve the caregiver.
- Respite is payable for up to 5 consecutive days. Days beyond day 5 are billed at the routine rate.
- More than one respite stay in a billing period is allowed.
- The day of admission to respite is billed as a respite day. The day of discharge is billed as a routine home care day. If the patient dies while in respite, the day of death is billed as respite.

17

INPATIENT RESPITE CARE

- When there is more than one respite period in the billing period, the provider must include the M2 OSC for all periods of respite. The span dates will represent the date of admission through the fifth consecutive day of respite or the last day the patient was in the inpatient respite level of care through midnight, whichever is sooner.
- For example,
  - patient was in the inpatient respite level of care from 7/1/24–7/5/24
  - went back to the RHC level of care in their private residence on 7/5/24,
  - OSC M2 would be reported with 7/1/24 through 7/4/24.
  - If the patient was in the inpatient respite level of care from 7/1/24–7/8/24 and went back to the RHC level of care in their private residence on 7/8/24, the OSC M2 would be reported with 7/1/24 through 7/5/24.

18

GENERAL INPATIENT CARE (GIP)

- GIP is provided in an inpatient setting to control the patient's pain or manage the symptoms of their terminal illness that cannot feasibly be provided in another setting.
- The day of admission to GIP is billed as a GIP day. The day of discharge is billed as a routine home care day. If the patient dies while in GIP, the day of death is billed as GIP.

Where can GIP care be provided?

GIP care can only be provided in one of the following three settings:

a. A Medicare-certified hospice inpatient unit or facility;
b. A Medicare-certified hospital; or
c. A Medicare-certified skilled nursing facility ("SNF"). The hospital and SNF, in addition to being Medicare-certified, must have 24-hour RN coverage, appropriate patient areas, and allow patients to receive visitors, of any age and at any time of day, with privacy.

19

Service Intensity Add-on

- 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.

20

CAHPS Hospice Survey Changes

- Beginning with **April 2025 decedents**
- Addition of web-mail mode option as an alternate to current survey modes
  - Would include email invitation to a web-based survey, with mail follow-up to non-responders
- Addition of pre-notification letter
  - Sent by survey vendor one week prior to survey instruments
- Extension of response time from 42-49 days
- Removal of Care Received in a Nursing Home items
- Replacement of multi-item Getting Hospice Care Training
- Addition of new Care Preferences measure
- Additional items removed and simplified wording in multiple measures

21

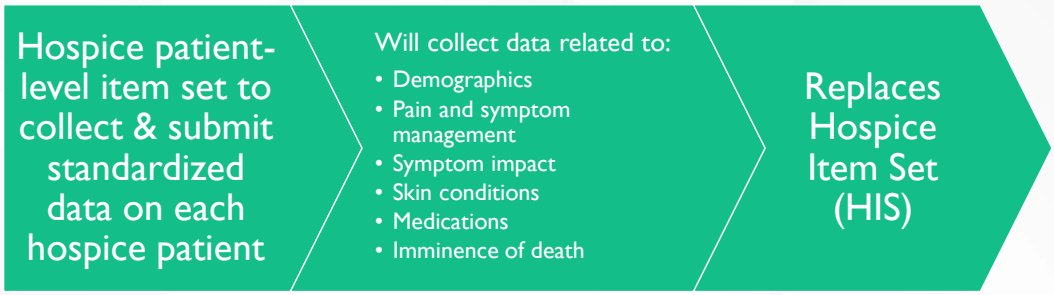
CAHPS Hospice Survey Public Reporting

Public reporting:

- Getting Hospice Care Training and new Care Preferences measure treated as new measures
  - 8 quarters of data before public reporting
- February 2028 Care Compare refresh – first anticipated public reporting
  - Scores calculated from Q2 2025 – Q1 2027
  - No public reporting of *Care Preferences* or *Getting Hospice Care Training*
  - During the transition time, Star Ratings will be based on 7 measures
- After transition time
  - Star Rating will be based on 9 measures (Training back + Care Preferences)

22

HOPE (Hospice Outcomes and Patient Evaluation)



23

HOPE Compliance and Impact

Same compliance thresholds as HIS

- Submit 90% of all required HOPE records within 30 days of the event or completion date (patient's admission, discharge, and up to two HOPE Update Visit time points based on the patient's length of stay)

Hospices that fail to submit required HOPE assessments will receive 4% payment reduction in the APU

24

HQRP Reporting Requirements

Reporting Year for HIS/HOPE and Data Collection Year for CAHPS data (calendar year)	Annual Payment Update Impacts Payment for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2023	FY 2025 APU	CY 2022
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024
CY 2026	FY 2028 APU	CY 2025

25

SPECIAL FOCUS PROGRAM - HOSPICE

Special Focus Program (SFP) – Hospice Providers

- A program conducted by CMS
- Used to identify hospices providing poor quality of care, based on defined quality indicators
- CMS will select hospices for increased oversight
- Hospices will either successfully complete the SFP (graduate) or be terminated from the Medicare program
- The selection process will start in CY 2024

26

SPECIAL FOCUS PROGRAM - HOSPICE

- 18-month cycles with Surveys every 6 months…Termination or Graduation
- State agencies will be conducting the surveys – accreditation bodies cannot conduct these audits.
- Enforcement remedies can still be actively applied during SFP cycle and can be progressive.

27

QUALITY INDICATORS - SFP Algorithm

- Survey reports with Quality of life (QOL) **condition level** deficiencies (CLD)
  - From the last 3 consecutive years
  - Survey report states noncompliant with CONDITION
  - Typically requires a follow-up survey
- Complaints with **substantiated allegations** (State Agency or BFCC-QIO)
  - From the last 3 consecutive years
- Hospice Quality Reporting Program Data (HQRP)
  - Medicare claims data (Hospice Care Index)
  - CAHPS Hospice Survey data

28

HQRP QM – Medicare Claims Data

HQRP – Claims data

- **Hospice Care Index (HCI) – overall score**
- **Standardized – focus is on how likely the hospice is to receive the score it did, if it were an average hospice.**

Hospice Care Index (HCI)

1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided
2. Gaps in Skilled Nursing Visits
3. Early Live Discharges
4. Late Live Discharges
5. Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission
6. Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital
7. Per-beneficiary Medicare Spending
8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day
9. Skilled Nursing Minutes on Weekends
10. Visits Near Death

29

Hospice Care Index (HCI) Detail

1. **Continuous Home Care (CHC) or General Inpatient (GIP)** - % of CHC and GIP level of care days reflected on the Medicare claims during the reporting period. (Need to be greater than 0%)
2. **Gaps in Nursing Visits** - Number of Medicare Elections that had Gaps in Nursing Visits greater than 7 days within a 30-day period. (Need to be < 90%)
3. **Early Live Discharges** - % of Early Live Discharges within 7 days of admission compared to other hospice providers (Need to be < 90%)
4. **Late Live Discharges** - % of Late Live Discharges on or after 180 days from the hospice admission compared to other hospice providers (Need to be < 90%)
5. **Burdensome Transitions (Type 1)** - % of Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission (Need to be < 90%)

30

Hospice Care Index (HCI) Detail

6. **Burdensome Transitions (Type 2)** - % of Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital (Need to be < 90%)
7. **Per-beneficiary Medicare Spending** compared to other hospice providers - Calculate by the total # of payments, Medicare paid to hospice providers divided by the total # of hospice beneficiaries served. (Need to be < 90%)
8. **Nurse Care Minutes per Routine Home Care (RHC) Day** - Average SN Care Minutes per RHC Day compared to other hospice providers (Need to be Greater than 10%)
9. **Skilled Nursing Minutes on Weekends** –SN Minutes on the Weekends (Saturday & Sunday) out of all SNV during RHC services days (Need to be Greater than 10%)
10. **Visits Near Death** - The number of Visits Near Death reflected on the Medicare claims compared to other hospice providers. The % of beneficiaries receiving at least one visit by a SN or social worker during the last three days of the patient's life (Need to be Greater than 10%) - A visit on the date of death, the date prior to the date of death, or two days prior to the date of death).

31

Graduate or Be Terminated

Graduation

- have no CLDs cited or immediate jeopardy citations for any two 6-month SFP surveys, and
- have no pending complaint survey triaged at an immediate jeopardy or condition level,
- OR have returned to substantial compliance with all requirements

Termination

- Fails any two SFP surveys by having any CLDs on the surveys, or
- Pending complaint investigations triaged at Immediate Jeopardy or Condition Level

32

Provisional Period of Enhanced Oversight

- Added § 424.527(a) New provider defined for Provisional Period of Enhanced Oversight (PPEO)
  - A newly enrolling Medicare provider or supplier
  - A certified provider or certified supplier undergoing a change of ownership
  - A provider or supplier (including an HHA or hospice) undergoing a 100 percent change of ownership via a change of information.
- Added § 424.527(b) The effective date of the PPEO's commencement is the date on which the new provider or supplier submits its first claim rather than the date the first service was performed or the effective date of the ownership change

33

34


Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
Melinda A. Gaboury, COS-C
Chief Executive Officer
Healthcare Provider Solutions, Inc.
402 BNA Drive, Suite 212
Nashville, TN 37217
615.399.7499
info@healthcareprovidersolutions.com

35