Modeling Hospice Changes to Prepare for Medicare Reimbursement and Care Delivery Reform

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HOMECARE AND HOSPICE REIMBURSEMENT
Overview of the Hospice Final Rule

- On August 16, 2013, CMS issued the final rule that would update FY 2014 Medicare payment rates and the wage index for hospices.
- Under the final rule, hospices would see an estimated 1.0 percent increase in their payments for FY 2014. This would be the result of:
  - Hospice payment update to the hospice per diem rates of 1.7%
    - 2.5% increase in the hospital market basket
    - 0.8% decrease for reductions mandated by law
    - A 0.7% decrease in payments to hospices due to the updated wage data

Overview of the Hospice Final Rule

- **BNAF phase-out**
  - The final rule would implement the fifth year of the seven-year BNAF phase-out, reducing the BNAF by 15 percent.
- **Coding clarification**
  - Hospice providers should not use certain non-specific diagnoses that are not the principal diagnoses.
  - Hospices should code the principal diagnosis using the underlying condition that is the main focus of the patient’s care.
- **Hospice quality reporting**
  - Hospices that fail to meet quality reporting requirements will receive a two percentage point reduction to their market basket update beginning in FY 2014.
- **Medicare Hospice Cost Report**
  - There were proposed changes to the Medicare hospice cost report which are still under discussion.
Overview of the Hospice Final Rule

• **Patient Experience of Care**
  - The rule proposes to require use of the Hospice Experience of Care Survey beginning in 2015.
  - CMS includes participation in the survey as a quality-reporting requirement for hospices to receive their full annual payment update beginning in FY 2017.

• **Affordable Care Act reforms**
  - As mandated in the Affordable Care Act, CMS must reform hospice payments.
  - This must take place no earlier than October 2013.
  - CMS is authorized to collect additional data that will be used to revise the hospice payment system.

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Overview of the Hospice Final Rule

• **FY 2014 Final Payment Rates**
  - Routine Home Care $156.06
  - Continuous Home Care $910.78
  - Inpatient Respite Care $161.42
  - General Inpatient Care $694.19

• **Continuous Home Care**
  - Full Rate = 24 hours of care = $37.95 hourly rate

• **2014 Hospice Cap** $26,157.50
Overview of the Hospice Final Rule

• For agencies failing to report quality data in 2013 will have their market basket update reduced by 2 percentage points in FY 2014.

• FY 2014 Final Payment Rates for Hospices that DO NOT Submit the Required Quality Data
  • Routine Home Care $152.99
  • Continuous Home Care $892.87
  • Inpatient Respite Care $158.24
  • General Inpatient Care $680.54

• Continuous Home Care
  • Full Rate = 24 hours of care = $37.20 hourly rate

Overview of the Hospice Final Rule

• Update on Reform Options: Overview
  • Abt Associates is the hospice contractor in charge of developing a new hospice payment model.
  • Abt is continuing to conduct analyses of various payment reform models. These models include a U-shaped model of resource which MedPAC recommended be adopted.
  • A hospice’s costs typically follow a U-shaped curve, with higher costs at the beginning and end of a stay, and lower costs in the middle of the stay.
  • Payment under a U-shaped model would be higher at the beginning and end of a hospice stay, and lower in the middle portion of the stay.
Overview of the Hospice Final Rule

• **Update on Reform Options: U-Shaped Curve**
  - Abt analysis found that very short hospice stays have a flatter curve than the U-shaped curve seen for longer stays and that average hospice stays are much higher.
  - The short stays are less U-shaped because there is not a lower cost middle period between the time of admission and time of death.
  - Abt is considering a tiered approach with payment tiers based on length of stay.
  - Abt is also considering a short-stay add-on payment, similar to the home health Low Utilization Payment Amount (LUPA) add-on which would improve payment accuracy if the current per diem system were retained.
  - As Abt collects more accurate diagnosis data, including data on related conditions, Abt will also evaluate whether case-mix should play a role in determining payments.

Overview of the Hospice Final Rule

• **Update on Reform Options: Tiered System**
  - Features of a Tiered System include:
    • U-shaped payments
    • Higher payments for extremely short stays
    • Lower payments for beneficiaries who die in hospice without skilled visits at the end of life
  - The tiered model is applicable for hospice stays that end in death.
  - Abt created seven potential payment “groups” or categories based on average daily resource use.
  - This classifies each hospice day of care to the category that best fits.
  - Rates are set based on the relative costs of care for that day within the length of stay.
Overview of the Hospice Final Rule

- **Update on Reform Options: Tiered System**
  - Abt established a relative or “implied weight” for each of the seven groups.
  - The implied weight is equal to the ratio of the average resource use for the specific group divided by the total average resource use across all routine home care days in the analysis.
  - Payment for each day in the group would be equal to the routine home care base rate multiplied by the implied weight.

Overview of the Hospice Final Rule

- **Update on Reform Options: Tiered System**
  - The following are the seven groups with their associated “implied weights”:
    - Group 1: RHC care that occurs between days 1 and day 5 of a beneficiary’s lifetime length of stay. Implied weight: 2.30
    - Group 2: RHC care that occurs between days 6 and day 10 of a beneficiary’s lifetime length of stay. Implied weight: 1.11
    - Group 3: RHC care that occurs between days 11 and day 30 of a beneficiary’s lifetime length of stay. Implied weight: 0.97
    - Group 4: RHC care that occurs on day 31 or later of a beneficiary’s lifetime length of stay. Implied weight: 0.86
Overview of the Hospice Final Rule

- **Update on Reform Options: Tiered System**
- The following are the seven groups with their associated “implied weights”:
  - Group 5: RHC care that occurs during the last 7 days of a beneficiary’s lifetime length of stay and the beneficiary is discharged dead. Beneficiary receives visiting service - nursing, aide, MSS, therapy - during the last 2 days of life if the last two days of life are RHC or the last two days of life are not RHC. Implied weight: 2.44
  - Group 6: RHC care that occurs during the last 7 days of a beneficiary’s lifetime length of stay and the beneficiary is discharged dead. Beneficiary does not receive visiting service - nursing, aide, MSS, therapy - during the last 2 days of life. Last 2 days of life are RHC. Implied weight: 0.91
  - Group 7: RHC care when the beneficiary’s lifetime length of hospice is 5 days or less, each day of hospice is RHC, and the beneficiary is discharged deceased. Implied weight: 3.64

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### Overview of the Hospice Final Rule

- **Update on Reform Options: Tiered System**

<table>
<thead>
<tr>
<th>Group</th>
<th>Time Period</th>
<th>Implied Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Days 1-5</td>
<td>2.30</td>
</tr>
<tr>
<td>2</td>
<td>Days 6-10</td>
<td>1.11</td>
</tr>
<tr>
<td>3</td>
<td>Days 11-30</td>
<td>0.97</td>
</tr>
<tr>
<td>4</td>
<td>Days 31+</td>
<td>0.86</td>
</tr>
<tr>
<td>5</td>
<td>Last 7 Days with Visiting Services</td>
<td>2.44</td>
</tr>
<tr>
<td>6</td>
<td>Last 7 Days without Visiting Services</td>
<td>0.91</td>
</tr>
<tr>
<td>7</td>
<td>Length of Stay is 5 days or less</td>
<td>3.64</td>
</tr>
</tbody>
</table>
Overview of the Hospice Final Rule

Example of Tiered Reimbursement Based on a Connecticut Rate

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>With Skill in Last 2 Days</th>
<th>Without Skill in Last 2 Days</th>
<th>Current Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>$3,152</td>
<td>$3,152</td>
<td>$866</td>
</tr>
<tr>
<td>10</td>
<td>4,153</td>
<td>2,298</td>
<td>1,732</td>
</tr>
<tr>
<td>20</td>
<td>6,414</td>
<td>4,560</td>
<td>3,463</td>
</tr>
<tr>
<td>30</td>
<td>9,270</td>
<td>7,415</td>
<td>5,195</td>
</tr>
<tr>
<td>45</td>
<td>10,461</td>
<td>8,607</td>
<td>7,793</td>
</tr>
<tr>
<td>60</td>
<td>12,695</td>
<td>10,840</td>
<td>10,390</td>
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<tr>
<td>90</td>
<td>17,163</td>
<td>15,308</td>
<td>15,585</td>
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<tr>
<td>120</td>
<td>21,631</td>
<td>19,776</td>
<td>20,780</td>
</tr>
<tr>
<td>150</td>
<td>26,098</td>
<td>24,244</td>
<td>25,976</td>
</tr>
<tr>
<td>180</td>
<td>30,566</td>
<td>28,712</td>
<td>31,171</td>
</tr>
<tr>
<td>210</td>
<td>35,034</td>
<td>33,179</td>
<td>36,366</td>
</tr>
</tbody>
</table>
Overview of the Hospice Final Rule

- **Update on Reform Options: Routine Home Care Rebasing**
  - Abt will also review the hospice routine home care rate. No proposals or recommendations were made yet.
  - Rebasing the routine home care rate was discussed.
  - If rebasing were done, it would be done to the three clinical service components of (nursing, home health aide, social services/therapy).
  - Such rebasing would result in a rebased rate of $140.44 in FY 2014.
  - The FY 2014 rebased rate would be a 10.1% reduction in the FY 2014 proposed routine home care payment rate of $156.21.
  - If rebasing were to be done for FY 2014, there would be a reduction in hospice payments of $1.6 billion.
  - “Rebasing the clinical service components of the routine home care payment is one of several approaches to hospice payment reform that CMS could consider for revising the routine home care payment rate.”

OTHER HOSPICE REIMBURSEMENT ISSUES

- **2% Sequestration Adjustment still in Effect**
  - Sequestration is a payment reduction and not a rate change. It is not cumulative in its impact.

- The Tiered approach is not final, ABT is still looking at other Hospice payment models

- There is still consideration for Site of Care Adjustment for Hospice Patients in Nursing Facilities
  - Perception that patients in nursing facilities receive more hospice aide services than their counterparts in the community and therefore substituting for the facility.
HOW TO PREPARE FOR MEDICARE CUTS

• FORECASTING
  • Hospices should be developing a template that models the potential Tiered Reimbursement systems being proposed by ABT and MedPac.
  • They should be comparing it against the current reimbursement to measure the impact on Medicare revenue.
  • Based on the results of the analysis they should looking at strategic initiatives to minimize any negative impact it might have on its gross and net margins.

TEAM WORK
HOW TO PREPARE FOR MEDICARE CUTS

• DATA
  → The clinical, financial and technology teams should be working together to identify what data is needed to do the modeling and if it is available with your current software program or whether it needs to be developed.
  → Information such as visit utilization over the Length of Stay (broken down by the recommended groupings); direct cost of services provided.
  → Percentage of patients in Skilled Nursing Facilities and the utilization service for those patients especially Home Health Aides.

THE FUTURE
MANAGE BY METRICS

• Metrics to Manage by:
  → Patient Case Load by Service (ie; Case Managers, MSW, Home Health Aide, etc.)
  → Cost per Day by Service
  → Cost per Day (Drugs, DME, Medical Supplies etc.)
  → Revenue per Day
  → Gross Profit Margin
  → ADC
  → Capture Rate (Admissions/Referrals)
  → Facility – Occupancy Rate

MANAGE BY METRICS

• Metrics to Manage by:
  → Referrals by Referral Source trended monthly
  → Payer Mix
  → Service Utilization
  → Visits by Discipline by length of Stay
  → Diagnosis
  → Length of Stay based on Discharges
  → Discharged Alive
  → ETC, ETC
IMPLEMENTATION & MONITORING LEADS TO FINANCIAL VIABILITY

QUESTIONS
Hospice Payment Reform Impact Analysis: MedPAC and Abt Associates ‘U-Shaped’ Curve and VNSNY Hospice & Palliative Care

November 1, 2013
Hospice Payment Reform Impact Analysis - Approach

- Model impact of “U-shaped curve” as defined by MedPAC and Abt Associates examples from Spring 2013:
  - Using data from all patients served by VNSNY Hospice & Palliative Care (VNSNY HPC) in 2012
  - Looking only at potential changes in reimbursement

- Key assumptions:
  - ‘U-shaped curve’ impacts Medicare and Medicaid, not Managed Care
  - ‘U-shaped curve’ impacts Routine Homecare reimbursement, not General Inpatient, Continuous Care, or Respite Care
  - In MedPAC analysis, 4% Reduction to Routine homecare rate (wage and non-wage components) for all patients in SNFs

VNSNY Hospice & Palliative Care Overview

- Non profit, serves 5 boroughs of New York City, subsidiary corporation of Visiting Nurse Service of New York; 2012 statistics below

- ADC = 826, including a 25 bed IPU and an 8 bed hospice residence

- 4,911 patients served

- ALOS of 12 when patient is admitted to GIP, ALOS of 75 when admitted at home

- 21.8% Non Death Discharge rate

- 17.9% of ADC in SNFs

- 50% of patients served have primary diagnosis of cancer
MedPAC vs Abt Associates “U-shaped” reimbursement models

<table>
<thead>
<tr>
<th>MedPAC</th>
<th>Abt Associates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tiers</strong></td>
<td><strong>U-factor</strong></td>
</tr>
<tr>
<td>1-7</td>
<td>1.97</td>
</tr>
<tr>
<td>8-14</td>
<td>1.01</td>
</tr>
<tr>
<td>15-30</td>
<td>0.95</td>
</tr>
<tr>
<td>31+</td>
<td>0.86</td>
</tr>
</tbody>
</table>

Last 7 days before Death:
- MedPAC:
  - add-on: 1.15 - w Visit: 2.44
  - w/o Visit: 0.91

- Abt:
  - LOS <= 5 w Death: 3.64

- SNF: .97 - .95

- Curves have similar ‘tiers’, both disincent non-death discharges
- Abt “U-shape” is higher on both sides, incents visits within 2 days of death
- MedPAC reduces payments for all days in SNF


![Graph showing reimbursement models over days](image-url)
Hospice Payment Reform Impact Analysis – MedPAC ‘Inflection Points’

<table>
<thead>
<tr>
<th>Patient Final Status</th>
<th>Patient Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not in SNF</td>
</tr>
<tr>
<td>Non-death Discharge</td>
<td>72</td>
</tr>
<tr>
<td>Death</td>
<td>129</td>
</tr>
</tbody>
</table>

- Above shows LOS at which MedPAC “U-shaped” and current reimbursement are equal
- Longer stays in each case above will result in reduced reimbursement in “U-Shaped” reimbursement, and vice versa

Hospice Payment Reform Impact Analysis – Abt ‘Inflection Points’

- Non-death Discharge 76 days
- Death wo Visit in last 2 days 78 days
- Death with Visit in last 2 days 155 days

- Above shows LOS at which Abt “U-shaped” and current reimbursement are equal
- Longer stays in each case above, will result in reduced reimbursement in “U-Shaped” reimbursement, and vice versa
### Hospice Payment Reform Impact Analysis – MedPAC Summary

<table>
<thead>
<tr>
<th></th>
<th>2012 Actual</th>
<th>% total</th>
<th>MedPAC Difference</th>
<th>$difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not impacted by &quot;U-Shape&quot; (1)</td>
<td>$8.8</td>
<td>14.4%</td>
<td>$0.0</td>
<td>$0.0</td>
</tr>
<tr>
<td>Routine Homecare, not in SNF</td>
<td>$42.4</td>
<td>69.1%</td>
<td>($1.3)</td>
<td>$1.9</td>
</tr>
<tr>
<td>- Additional pmt for last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Homecare, in SNF</td>
<td>$10.1</td>
<td>16.5%</td>
<td>($0.4)</td>
<td>$0.4</td>
</tr>
<tr>
<td>- Additional pmt for last 7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- SNF penalty</td>
<td></td>
<td></td>
<td>($0.4)</td>
<td></td>
</tr>
<tr>
<td>Total Reimbursement</td>
<td>$61.3</td>
<td>100.0%</td>
<td>$0.3</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

(1) GIP, Continuous Care, Respite, and/or Managed Care

- Additional payment for 7 days prior to death, more than offsets the decreases to Routine rate, and SNF penalty
- If VNSNY HPC had been able to reduce its NDD rate from 21.8% to 18.5%, the MedPAC incremental revenue would double

### Hospice Payment Reform Impact Analysis – Abt Summary

<table>
<thead>
<tr>
<th></th>
<th>2012 Actual</th>
<th>Abt</th>
<th>$difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not impacted by &quot;U-Shape&quot; (1)</td>
<td>$8.8</td>
<td>$0.0</td>
<td>$0.0</td>
</tr>
<tr>
<td>Routine Homecare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 5 Day or less LOS, not NDD</td>
<td>$0.2</td>
<td>$0.6</td>
<td></td>
</tr>
<tr>
<td>- Non-death Discharges</td>
<td>$32.1</td>
<td>$2.3</td>
<td></td>
</tr>
<tr>
<td>- Death w Visit in last 2 days</td>
<td>$19.4</td>
<td>$2.6</td>
<td></td>
</tr>
<tr>
<td>last 7 days component</td>
<td></td>
<td>$6.0</td>
<td></td>
</tr>
<tr>
<td>- Death w Visit in last 2 days</td>
<td>$0.7</td>
<td>$(0.1)</td>
<td></td>
</tr>
<tr>
<td>last 7 days component</td>
<td></td>
<td>$0.1</td>
<td></td>
</tr>
<tr>
<td>Total Reimbursement</td>
<td>$61.3</td>
<td>$1.6</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

(1) GIP, Continuous Care, Respite, and/or Managed Care

- Higher payment for 7 days prior to death, with visit in last 2 days, more than offsets decreases to Routine rate, and NDD penalty
- If VNSNY HPC had been able to reduce its NDD rate from 21.8% to 18.5%, the Abt incremental revenue would be approx $0.9m
Hospice Payment Reform Impact Analysis – by Referral Source

• Biggest increases, and smallest decreases, are in Hospital referrals – with lowest ALOS and lower NDD
• Biggest decreases, and smallest increases are in SNF referrals – with longest ALOS, plus penalty in MedPAC “U shape”
• Reimbursement increases for patients with Cancer, decreases for non-cancer

Penn Wissahickon Hospice

Patrick Brown, MBA, MS
NAHC Annual Meeting
November 2013
Penn Wissahickon Hospice Overview

• Founded as a community based Hospice; integrated into Penn Home Care and Hospice Services in late 1990s
• Entity Includes:
  ❖ Wissahickon Hospice (Fiscal Year 2013 Average Daily Census of 160)
  ❖ Penn Hospice at Rittenhouse (20 bed Inpatient unit, ADC 15.75)
  ❖ Caring Way (Medicare certified home health agency specializing in pain and symptom management, ADC 194)

Penn Wissahickon Hospice Overview

Home Hospice Program Key Facts:
• ALOS equal to 52 days
• MLOS equal to 14 days
• Diagnostic Mix
  ❖ 54% of patients with CA diagnosis
  ❖ 14% of patients with CHF/Cardiac Dx
  ❖ 12% with Dementia/Alzheimers
### Penn Wissahickon Hospice: Reaction to Medicare Rate Reductions

- Focus on increasing Hospice Census via additional marketing efforts, CLAIM program (CMS Innovations Grant)
- Town Halls with Clinical staff to discuss program financials; focus on maintaining caseloads and reducing expenses.
- Right size Inpatient Census
- Wait for payment reform

### Penn Wissahickon Hospice: CLAIM Program

- Dr. David Casarett, Penn Wissahickon Hospice CMO, received a three year CMS Innovations grant for the CLAIM program.
- CLAIM (Comprehensive Longitudinal Advanced Illness Management) is designed to provide additional services to patients on Home Care with cancer diagnosis with the intent to reduce hospitalizations.
- Services include Social Work, Chaplain and Nurse Practitioner, with increased Clinical Education (Home Health Aide and Skilled Nursing are provided as supplemental services).
Penn Wissahickon Hospice: CLAIM Data

- 112 of 218 CLAIM Discharges were patients admitted to Wissahickon Hospice.
- 93 of the 118 CLAIM patients who were admitted to Wissahickon Hospice were discharged (87 deaths, 6 live discharges)
- CLAIM patients discharged to Hospice have a MLOS of Nine Days, ALOS of seventeen days.
- CLAIM patients still active on Hospice average 23 days on program census.

Penn Wissahickon Hospice: CLAIM Analysis

- CLAIM outreach was designed for patients who would not typically receive Hospice services - those not eligible and those not interested (seeking curative treatment).
- The CLAIM population is skewed towards those seen as not interested in Hospice services.
- The hoped for added benefit from CLAIM of a longer length of stay has not materialized.
- CLAIM Home Health margin is lower than margin for Penn Care at Home, reflecting longer visit time and reduced productivity for RNs.
**Penn Wissahickon Hospice:**

**Town Halls/Leadership Outreach**

- Entity Town Halls by University of Pennsylvania Health System leadership; staff Town Halls by Hospice Senior Leadership. Health System Presentations focused on payment reductions from Governmental payers and decrease in NIH Grant Revenue.
- Health System also provided interactive discussion via “Securing our Future” website.
- Health System emphasis on maintaining revenue by maximizing clinical contact time
- Town Halls followed by “Your Big Idea” cost reduction campaign
- Hospice presentations reinforced common themes across health system

**Penn Hospice at Rittenhouse**

- Inpatient unit losses greater than anticipated due to volatility in census
- Census to be capped at 15 patients (to mirror Hospital nurse to patient ratio)
- Program transitioning from an all RN model to hybrid RN/LPN model
- Reduction in Chaplain, Social Work hours with staff picking up caseload in local area
- Sharing of MD/NP resources with Hospital Palliative Care program
- Focus on reducing Medication expense
• Penn Wissahickon anticipates a 3.1% increase in the Medicare Rate (weighted increase of 4.61% times direct cost weight of 68%); increase less than initially anticipated

• Patient Population: MedPAC buckets

<table>
<thead>
<tr>
<th>Reimbursement Weight</th>
<th>Number of Patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>.86 to .95</td>
<td>120</td>
<td>46.88%</td>
</tr>
<tr>
<td>.96 to 1.0</td>
<td>6</td>
<td>2.34%</td>
</tr>
<tr>
<td>1.01-1.10</td>
<td>13</td>
<td>5.08%</td>
</tr>
<tr>
<td>1.11-1.50</td>
<td>51</td>
<td>19.92%</td>
</tr>
<tr>
<td>Above 1.5</td>
<td>66</td>
<td>25.78%</td>
</tr>
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</table>