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Eli's Hospice Insider

Payment: Hospice Data May Result In Surprising Payment Reform Model

The final structure may not be what you expect.

Skilled visits in the last days of death and extremely short stays may pump up your Medicare payments under upcoming hospice reform.

While the **Centers for Medicare & Medicaid Services** didn't set a timeline for hospice payment reform in the 2015 final payment rule, CMS and contractor Abt Associates are hard at work on the initiative, reps noted in the Jan. 14 Open Door Forum for hospice providers.

Timeline: The Affordable Care Act specified that any payment reform should happen no earlier than 2013, noted CMS's **Randy Throndset** in the forum. The law didn't mandate a deadline, and CMS is still working with Abt on gathering and analyzing new data, gathering input, and more. Watch for future rulemaking on the issue, Throndset said.

Abt has crunched a lot of data from 2012 and 2013 in preparation for a reform proposal, noted Abt's **Michael Plotzke** in the forum (see box, p. 19, for a sampling). And thanks to new claims reporting requirements, there will be even more data to examine going forward.

Experts have predicted that a new payment reform model would be U-shaped (higher payments at beginning and end of a stay, lower in the middle) or J-shaped (medium payments at beginning, lower payments in the middle, highest payments at the end). But that's not necessarily the case.

Why? Abt analysis shows that the highest-cost days of care are actually at the beginning of a stay, Plotzke explained. Resource use on day 1 of a hospice stay neared the $80 mark, while resource use on the last day averaged in the mid-$50s, showed 2010 data for beneficiaries with at least a 14-day stay and who received only Routine Home Care.

That cost pattern is affected by episodes in which there are no skilled services furnished in the last days of life, Plotzke noted.

"It's unrealistic to think that [skilled] visits would occur prior to death for all individuals," Plotzke acknowledged in the call. But at the same time, data suggests that skilled visits may be influenced more by the day of the week on which the patient dies rather than on that patient's needs.

"The variation ... is what the takeaway message is," he added. While the average rate of skilled services furnished in beneficiaries' last days "might be the right number ... it is concerning to see big differences in the rates that are dependent on items like the day of the week the beneficiary dies and what state the patient is located in."

Accordingly, policymakers may decide to propose a reverse-J payment curve, experts predict.

Or CMS may propose a more complex tiered system with a big payment differential when there are skilled services furnished in the last two days of life (see potential tiered model, p. 21).

Skilled visits "in the last two days of life are associated with improved bereaved family member perceptions of quality of care," Plotzke noted.

Cons: A simple U-shaped payment system has drawbacks, Plotzke explained in the forum. It could encourage extremely short stays, increase live discharges, and reduce frequency of services in response to decreased reimbursement,

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policymakers fear. Also, level of care transfers (GIP to RHC, for example) would be tricky.

Other factors that may influence the payment model and/or rate setting include:

- **Live discharges.** CMS is not pleased with the increase in live discharges (see box, p. 19). Above-cap hospices have a "substantially larger" live discharge rate than below-cap hospices, Plotzke pointed out.

And Abt has discovered a pattern of hospice discharging a patient a few days before a hospital admission, then the hospice readmitting the patient two days after her hospital discharge. This pattern is more common in small, new, for-profit hospices, Plotzke noted.

- **GIP, CHC and IRC.** Routine Home Care accounts for the vast majority of hospice days billed, Plotzke highlighted. Abt is examining utilization for General Inpatient Care, Continuous Home Care, and Inpatient Respite Care. The variation in utilization of these care levels is a concern, he added.
- **Site of service.** The feds remain concerned about hospice furnished in nursing homes, Plotzke said. "Hospice aides may be substituting for, rather than augmenting, nursing facility aides," he said.

Plotzke didn't mention assisted living facilities in his presentation, but in the wake of the **HHS Office of Inspector General's** latest report on the matter (see cover story), don't be surprised to see that factor involved in payment reform as well.

- **Short stays.** If CMS is loathe to undertake a complicated new payment system, it may just im-plement a simple add-on for short stays. The funding could come from reducing longer-stay patients' reimbursement rates, or from rebasing of the Rou-tine Home Care rate. Analysis shows that rate should be about 10 percent lower than it is, Plotzke said. But reform has to be budget-neutral according to the ACA, Throndset pointed out. So policymakers could use a RHC reduction for such funding.

Note: See the slides from the presentation at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Project-Background.pdf. They include links to more detailed reports on Abt's analysis.

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