

**Continuous Care in Hospice:**

**The misunderstood service with great benefits for patients and providers**  
**Part Two**

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Welcome to the next segment of our overview of the Medicare Continuous Care Benefit! If you missed the first article, you'll find it on our website, [www.bethcarpenterandassociates.com](http://www.bethcarpenterandassociates.com). Click on **Publications**, then **Articles**. In this article, we'll take a look at the expense management challenges of both Continuous Care and other options for patients who require a higher level of care to manage symptoms. Finally, we'll give you a checklist of things to consider about your hospice and health care market as a precursor to introducing Continuous Care into your array of services.

**Expenses for Continuous Care**

To review, in the Continuous Care scenario illustrated in last month's article, Continuous Care was provided for a total of 9 hours on day 1, 23 hours on day 2 and 12 hours on day 3, when the patient came off Continuous Care and resumed Routine Home Care. Because all three days met both the 8 minimum and 50% skilled rules, Medicare could be billed for 44 hours of Continuous Care at \$34/hour or \$1496. The direct staffing costs (not including benefits) of visiting caregivers for the three days would be about \$1000 (3 RN hours @ \$35/hr; 24 LPN hours @ \$25/hr; 20 Aide hours @ \$15/hr). A payment of \$1496 would provide a reasonable cushion for overhead as well as additional medications and other devices and services that may be required to resolve the issues for which Continuous Care was initiated.

But what happens when the hours of care provided do not meet the requirements for billing at the Continuous Care level? Suppose on day 1, the 9 hours of care were a mix of 5 hours by Aides and 4 hours by nurses? Having not met the 50% nursing level, the day would have to be billed as a Routine Home Care Day (\$140 reimbursement). The loss for the day on staffing alone would be \$45 (1 RN hour plus 3 LPN hours plus 5 Aide hours equals \$185). If the patient's second day met requirements for 23 hours of care, the staffing costs would be \$515 and the revenue \$782. If on day 3, the patient died at 7 am, the day must be billed at Routine Home Care. The staffing cost for 8-9 hours of LPN care (which includes time for the LPN to remain after death) would exceed the Routine Home Care rate by well over \$50. Even in this scenario, total staffing costs are less than total revenue for the three days by over \$100. Not much to pay out all other expenses and overhead for the case perhaps, but not as dire a loss as one might at first assume.

The problem for any fiscally responsible CEO/Administrator is that “loss” days can overwhelm the system without a savvy, knowledgeable, and motivated manager running the Continuous Care effort. This person has to understand the benefit AND the billing. He/She has to be a patient advocate and have the ability to make the case for Continuous Care so that it is made available to patients whose symptoms qualify. And he/she has to hire, train, maintain and schedule a high quality per diem staff to carry out the plan of care.

### **Comparing Continuous Care to other Options**

#### **Contract Bed:**

A patient who goes to a contract bed at a hospital and is discharged on day three might have costs that exceed reimbursement to a similar degree as our continuous care example. In addition to the charges billed by the hospital, daily visits by the hospice team members and the costs of ambulance transportation have to be figured into those days. So, if a hospice pays 90% of its Medicare rate to a hospital for 2 days, sends a nurse to visit the patient on all three days, does a tuck in when the patient returns home on the day of discharge, and pays for roundtrip ambulance transportation, the revenue of \$1385 (\$622.40 for the days of admission and 2<sup>nd</sup> day plus the Routine Home Care rate of \$140 for the day of discharge) might not be a better financial alternative to continuous care. The good news about using contract beds is that you don't incur costs until you USE the contract bed arrangement for a specific patient. And, you always know what your reimbursement will be presuming that your reasons for initiating and continuing the days at the GIP level meet criteria and are well documented.

#### **Inpatient Unit:**

In addition to the overall cost of running and staffing a unit, there are additional expenses for each patient associated with transportation cost and medical supplies, treatments and medications. For providers who have their own units, having a patient opt for care in the unit rather than continuous care is almost always preferable because it spreads the fixed costs of the unit among a greater number of patient days of care. If a provider believes it can sustain a unit census that will at least enable a break even margin on that unit, then continuous care may not make sense unless there are patients in the census for whom the unit would NOT be a viable option when needs demand a higher level of care.

#### **Revocation for Admission to a Non-Contracted Hospital:**

From a purely financial perspective, there are three things to keep in mind about the “cost” of revocations—

- The loss of revenue (and presumably, margin) for the days that they patient could have been cared for but wasn't;

- The potential loss of the patient for subsequent days after the revocation if he/she does not return to the hospice but is referred upon discharge to another hospice, a home health agency, a LTC facility as a Medicare skilled patient, or a LTC facility where the hospice doesn't have a contract;
- The discharge and subsequent readmission COSTS that would not have been incurred and therefore would not have reduced the margin on that patient had he or she never have been discharged and readmitted

### **Should Your Hospice Offer Continuous Care?**

If it seems challenging, you're right, it is! The intricacies of reimbursement and expense control have likely kept many providers from entering into the continuous care arena. But the benefits to patients and the opportunity to manage cases so that overall the financial return is positive are two reasons to evaluate whether your hospice can effectively implement continuous care. If a substantial number of the following characteristics sound like your hospice, you might want to reconsider initiating continuous care:

- You don't have your own inpatient unit or the unit(s) you have aren't accessible to all patients when they need a higher level of care
- You have contracts with other facilities for General Inpatient Care, but the rates your pay are extremely high
- Your patients often end up getting too much aggressive, unnecessary, unwanted care when they present at the ER, even where you have a contract
- Many of your patients revoke to return to a hospital where you don't have a contract bed arrangement; some of them don't come back to your hospice
- You have strong competitors that are offering Continuous Care
- Your competition doesn't offer Continuous Care and this would set you apart from them
- Your competition has an inpatient unit and this attracts patients and families who you might otherwise serve
- You want to build your census, increase your referrals, add a new customer base
- You want to change your mix of patients to include more who have complex needs and short prognoses at the time of referral
- You are a hospice with a home health agency partner with common ownership and your organization also includes private duty and/or staffing services
- Recruiting LPNs and Home Health Aides from your community may be challenging but not impossible
- You have someone in your organization who has previously managed staffing (in a hospital, or for private duty or per diem services) or continuous care.

If you want to carry the conversation about Continuous Care further, please contact us. We are experienced in assessing the feasibility of adding continuous care given the current patient population, creating an implementation plan, walking with you during the start up phase, and providing clinical assistance to stay within the Medicare guidelines for the appropriate use of continuous care.

ABOUT THE AUTHOR: Barbara Gray is a Senior Consultant of Beth Carpenter and Associates, a consulting firm which provides real-world expertise to improve the performance and results of home care, hospice and private duty client . Barbara has more than 20 years of experience in health care management and operations as a leader and innovative problem solver creating organizations capable of delivering on their promises of revenue growth, margin performance and outstanding service. Ms. Gray has succeeded in moving start-ups from vision to reality, jump starting organizations to move to the next level and stabilizing organizations to achieve optimal financial results. Barbara can be reached at [bgray@bethcarpenterandassociates.com](mailto:bgray@bethcarpenterandassociates.com).