



Hospice in the Nursing Home Questions and Answers

What is included in hospice care? Hospice care, under both Medicare and Medicaid (an optional benefit offered in 49 states) is a comprehensive, risk-based model of care under which the hospice is paid a flat per diem rate (roughly \$150 a day) and is responsible for acquiring and providing all aspects of the patient's care, including drugs, supplies and medical equipment. The hospice provides care via an inter-disciplinary team that includes a doctor, nurse, social worker and spiritual counselor, as well as other professionals and volunteers.

Why is hospice provided in a nursing home? Hospice is both a philosophy of care and a specialized health care delivery system. Hospices might have buildings for inpatient or residential care, but almost all hospice care is provided in whatever place (house, apartment, assisted living center, or nursing home) the patient resides. Hospice goes to the patient.

Isn't it a duplication of services if hospice gets paid to deliver its care to nursing home residents? No. Hospice delivers a set of well recognized, high quality services at the end of life to the patient and their family. End of life care is very different from general medical services and quite specialized. While hospice tends to the end of life needs of the patient, regulations require the nursing home to provide custodial services just as a family would in a home setting. So, while the roles of the hospice and the nursing home are complementary, they are very distinct.

What about the "efficiencies" that some have talked about for hospice care in the nursing home? There may be some savings (drive time and care coordination) associated with having several patients grouped at a particular nursing home, but the same can be said of hospice care delivered in a large apartment complex or a neighborhood with a high concentration of elderly seniors. Normally, a nursing home may only have one or a few hospice patients at any one time.

Are there inefficiencies? The same discussions about efficiencies seldom, if ever, mention the *inefficiencies* that are inherent in hospice care in the nursing home. These include the need for ongoing coordination of care between the hospice and nursing home staff (by regulation, the hospice is responsible for all of the care related to the terminal illness). Often, when hospice care is delivered to patients in a nursing home, hospices also have to "translate" between the nursing home staff and the family members. When the family caregivers are distant (often the reason that the patient is in the nursing home), then the hospice is also the information source for much of the care of the patient. The complexities of coordinating and

making sure patient needs are provided actually makes hospice care delivery to nursing home residents quite challenging and, indeed, *inefficient*.

Is hospice paid twice for the care they provide in nursing homes? No. Most hospice patients in the nursing home have third-party insurance (Medicaid or private insurance) or they pay out of pocket for their custodial care in the nursing home. The hospice is paid to provide end of life care.

But, what if the patient is dually eligible? As noted above, hospice is paid to provide hospice care. When a patient is dually eligible for both Medicare and Medicaid, Medicare pays for the hospice care and Medicaid continues to pay for the patient's room & board in the nursing home. This is the same payment that the nursing home would have gotten had the patient not elected to receive hospice services. This Medicaid room & board payment, if the patient is dually eligible, is re-directed by the state from the nursing home to the hospice, but the hospice is only given 95 percent of the normal room and board rate. The hospice then contracts with the nursing home and passes the room and board payment on to them. So, the state continues paying for the nursing home room and board, but with a 5% savings, and that room & board money still ends up at the nursing home but it first flows through the hospice since the hospice is responsible for managing all aspects of the patient's care.

Isn't the nursing home hospice patient receiving two Part A services?

Generally, no. The patient, when they elect to receive hospice services, must agree to allow the hospice to manage their care and give up other Part A services related to their terminal illness.

If all this is true, then why have the DHHS, OIG and MedPAC focused on hospice in the nursing home? MedPAC Commissioners has considered the ownership and referral patterns of nursing home patients when they were making transition to hospice care. But, there has been little, if any, formal discussion by MedPAC about the efficiencies or inefficiencies of hospice care delivery in the nursing home setting. Just as the hospice community has responded in the past to MedPAC's suggestions for increased transparency and account, hospices look forward to a thorough conversation about nursing home delivery. We believe that an informed discussion will clarify misconceptions about efficiencies of care.

If MedPAC hasn't discussed the issues, then where is this coming from?

MedPAC, in their attempt to offer offsets to the roughly \$300 billion repeal of the Medicare physician payment Sustainable Growth Rate (SGR) formula used to calculate Medicare physician payments, included a nursing home hospice reduction that would generate almost \$1 billion in savings. The Commissioners have not discussed or even voted on the underlying rationale for this potential revenue proposal. What citations are offered indicate that HHS and the OIG are possible sources of the proposal, but neither of those entities have put forward a single

rationale or discussion of the magnitude of the so-called “efficiencies” leading to the proposed reimbursement cuts.

Why can't the nursing home instead of the hospice just provide the end of life services? Nursing homes are already heavily burdened by staffing shortages and intense regulation. Their staff, while highly trained, isn't well equipped to offer the formalized and specific end of life services that hospice caregivers deliver. It is sort of like asking an ophthalmologist to deliver babies. They might have some of the training, but in such a critical and fragile situation, not a good idea. That is best left to an obstetrician. The same is true with end of life care. It is best delivered by the specialists, which is hospice.

But, in a time of trying to reduce health care expenditures, shouldn't we cut back on services? First, the services aren't duplicative. Hospice delivers specialized end of life care in the nursing home and the nursing home continues, under the guidance of the hospice, to provide the same custodial care that they were providing prior to the hospice choice by the patient and their family. Studies clearly show that when hospice is provided to nursing home patients, there are fewer emergency room visits, fewer ambulance transfers and higher quality of care, which all save the system money. Hospice also demonstrates greater patient and family satisfaction with the care they are receiving. In fact, the government's own studies clearly show that when hospice care is provided in a nursing home, even the non-hospice patients in that nursing home have better care experiences.

Also, an independent study from Duke University clearly showed that hospice saves, on average, more than \$2,300 per patient.