

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

HOSPICE PATIENTS IN NURSING HOMES



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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To examine eligibility, services and growth in the number of hospice patients living in nursing homes.

BACKGROUND

Hospice care is an approach to treatment that recognizes the impending death of an individual warrants a change in focus from curative to palliative care. The Medicare hospice benefit began in 1983. In 1986, nursing home patients could elect Medicare's hospice benefit. Congress repealed the hospice benefit's 210 day limit effective for services furnished on or after January, 1 1990.

Earlier Office of Inspector General work on nursing home patients raised questions about hospice services provided to these patients. This earlier work led to our undertaking this study.

FINDINGS

Lower frequency of services, the overlap of services and the questionable enrollment in hospice by nursing home patients suggest that current payment levels for hospice care in nursing homes may be excessive.

Nursing home hospice patients received nearly 46 percent fewer nursing and aide services from hospice staff than hospice patients living at home. Three out of four patients received only basic nursing and aide visits. Many of these services were also provided by the nursing home staff when hospice staff were not present. Yet, hospices get paid the same amount for nursing home patients as they receive for patients living at home. In addition, two different sets of medical reviewers disagreed with the hospice's initial prognosis in nearly one out of six patients.

Continued growth in Medicare hospice expenditures for nursing home patients is expected.

In 1995, we estimate that 17 percent of Medicare hospice patients lived in a nursing home. About 1 percent of nursing home patients in 1996 elected the hospice benefit. Nursing home patients are seen by hospices as an effective way of expansion. The repeal of the 210 day limit on hospice care also provided hospices with additional incentives to serve nursing home patients.

RECOMMENDATION

Medicare's hospice benefit was intended to allow patients a choice in determining the intensity of medical care in their last 6 months of life. Since 1986, hospice patients could receive hospice care either in their home or a medical facility, including nursing homes. This inspection revealed problems and raised potential questions about hospice care provided to nursing home patients. Hospices receive the same daily reimbursement from Medicare for nursing home patients as they would receive for patients living at home, even though hospices provide fewer services in the nursing home setting.

The inspection also raised questions about the potential for growth in Medicare expenditures for nursing home patients. It also identified incentives which may financially reward hospices for premature elections by patients of the hospice benefit. The Balanced Budget Act of 1997, enacted after publication of our draft report, begins to address some of these problems by requiring periodic recertification of eligibility.

To address our findings, we recommend that the Health Care Financing Administration (HCFA) seek legislation to:

- Modify Medicare or Medicaid payments for hospice patients living in nursing homes.

These modifications can include but are not limited to lowering hospice payments for patients who reside in nursing homes or revising requirements for services provided by nursing homes for terminal patients.

We suggest that representatives from the nursing home and hospice industry along with HCFA work in a collaborative manner to develop additional options to preserve and enhance hospice care for those who need it when living in a nursing home.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Management and Budget. We also solicited and received comments on the draft report from the National Hospice Organization and the Hospice Association of America. We have made changes based on these comments and have consolidated our first three draft findings into one.

An underlying theme to the comments was a belief that it was inappropriate to recommend eliminating Medicare's hospice benefit for patients living in nursing homes. However, there was general agreement on the need to examine Medicare and Medicaid payment for hospice patients living in nursing homes and to clarify the future role of nursing home staff in providing palliative care for patients with terminal

diagnoses.

We have changed our first recommendation to remove the suggestion of eliminating entirely Medicare or Medicaid funding but to reflect that some modification of the hospice benefit for patients living in nursing homes is necessary. In addition, as noted earlier, legislation was enacted to address a second recommendation which we had included in our draft report on modifying the current benefit structure in the fourth benefit period. Because of this, we have dropped this recommendation from the final report.

The full text of the comments received on this report are included in Appendix C. While they sometimes take issue with our own analysis, we believe they provide valuable insights on the hospice program and nursing home care. We regard them as an integral part of the report and recommend them to the attention of the reader.

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INTRODUCTION

PURPOSE

To examine eligibility, services and growth in the number of hospice patients living in nursing homes.

BACKGROUND

Hospice Care

Hospice care is an approach to treatment that recognizes the impending death of an individual and warrants a change in focus from curative to palliative care. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in a home environment.

The Medicare hospice benefit began in 1983. To qualify, a patient must be eligible for Medicare and be certified as terminally ill with a life expectancy of 6 months or less if the terminal condition runs its normal course. Medicare recognizes four levels of hospice care: routine home care, continuous home care, general inpatient care and respite care. The vast majority of patients enrolled in hospice receive routine home care.

In most cases Medicare pays the hospice a fixed amount, depending on the level of care a patient needs, for each day that a patient is under their care. Medicare expenditures for hospice care have increased significantly from \$77 million in 1986, when the benefit was permanently established, to more than \$1.8 billion in 1995.

Currently, Medicare's hospice benefit provides a patient with four benefit periods. The first period and subsequent period are limited to 90 days each. The third benefit period is limited to 30 days. A fourth benefit period is unlimited in duration. If a patient revokes their hospice election, the patient loses his or her remaining days in that hospice benefit period. If a patient revokes their hospice election in the fourth benefit period, the patient would no longer be eligible for Medicare's hospice benefit.

Medicare patients enrolled in the hospice program waive coverage of all curative medical services related to the treatment of their terminal illness. The hospice assumes responsibility for all of the patient's medical needs related to their terminal illness. However, Medicare will continue to pay for services furnished by the patient's non-hospice attending physician and for the treatment of conditions unrelated to the terminal illness.

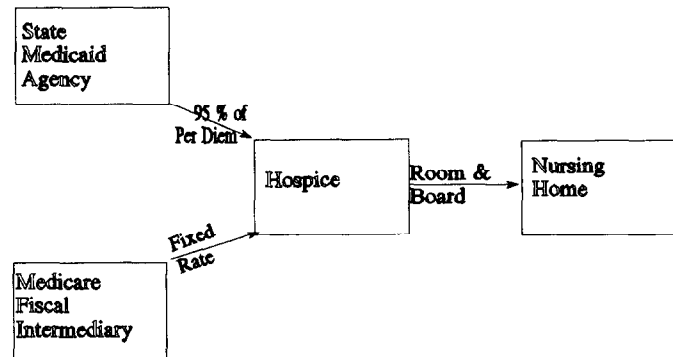
Hospice Care in Nursing Homes

Beginning in 1986, terminally ill Medicare patients living in nursing homes could elect Medicare's hospice benefit. When this occurs, the hospice assumes responsibility for the professional management of the patient's medical care for the terminal condition. The nursing home continues to provide the patient's room and board and other services. Room and board includes personal care services, assistance in the activities of daily living, socializing activities, administration of medication and other activities.

When a patient is entitled to both Medicaid and Medicare, the nursing home no longer bills the State Medicaid program for that patient's long-term care. Instead, the nursing home bills and receives payment from the hospice. The hospice then bills the State Medicaid agency for the patient's room and board. The State Medicaid agency must pay the hospice at least 95 percent of what Medicaid would have paid the nursing home. The hospice pays the nursing home, depending on the terms of the contract that exist between a nursing home and hospice, for services provided to the hospice patient. Medicaid payments for room and board are in addition to Medicare's daily fixed rate paid to the hospice. Figure 1 illustrates how payments are made for nursing home care provided to patients who are dually entitled to both Medicare and Medicaid.

Figure 1

Flow Chart for Medicare / Medicaid Payment for Hospice Patients Residing in Nursing Facilities



Office of Inspector General Work

Earlier Office of Inspector General (OIG) work on nursing home patients raised questions about hospice services provided to these patients. This earlier work led to our undertaking this study.

In 1995, a joint initiative referred to as Operation Restore Trust (ORT) was established between OIG, the Health Care Financing Administration (HCFA) and the Administration on Aging. Among its objectives, Project ORT seeks to identify vulnerabilities in the Medicare program and develop solutions that would reduce Medicare's exposure to fraud, abuse and waste. Project ORT targeted five States (California, Florida, Illinois, New York and Texas) that account for approximately 40 percent of Medicare expenditures and beneficiaries. These projects focus on home health care, nursing home care, durable medical equipment and hospice care.

In 1994, OIG conducted reviews in Puerto Rico, examining medical eligibility for hospice. These targeted audits were expanded under Project ORT and led to in-depth OIG audits of 12 hospice providers and a summary report. In conjunction with these targeted hospice reviews, additional OIG studies have and are being conducted in an effort to obtain national data concerning the hospice benefit.

Recent Legislation

The Balanced Budget Act of 1997 resulted in numerous modifications of Medicare's hospice benefit. These modifications ranged from changing how a hospice can bill for services to a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

Scope

We limited our inspection to nursing home patients receiving routine home care under the hospice benefit in December 1995. An analysis of our data showed that 94 percent of hospice patients received routine home care. Our findings do not relate to those few hospice patients receiving either continuous home care, general inpatient care or respite care. In our inspection, we also limited our discussion primarily to services provided to the patient. Our reviewers did capture visits made by hospice staff to family members which we have reported but do not make judgements about.

METHODOLOGY

Sampling Design

We used a stratified cluster sample to select hospices and hospice patients. We identified hospices that were Medicare certified before July 1, 1995. We eliminated hospices from our universe where there was previous or continuing OIG work.

We used six strata. One stratum was created for each of the five Project ORT States. The sixth stratum contained all of the remaining States. From each stratum we selected six hospices at random.

Initial Sample

We sent each hospice a letter requesting that they identify all Medicare patients who received hospice services in December 1995. We also requested that the hospices identify whether patients were entitled to Medicaid and whether patients were residents of a nursing home.

We received responses from 31 of the 36 hospices selected. Of the five missing responses, two hospices were identified as sites included in other OIG work. One was sold and notified us that they could not provide the documentation within our time frame. One hospice did respond with information but it was received after our

deadline. After repeated attempts, we did not receive any information from the fifth hospice.

Our sampling frame was patients receiving routine home care during December 1995. A total of 1,592 patients were initially identified as having received at least 1 day of hospice care during December 1995. Of these patients, 329 were identified as living in a nursing home while receiving hospice services. Of the 31 hospices in our sample, 22 had patients who lived in a nursing home while receiving hospice services. See Appendix A for further information on our methodology.

After obtaining claims information on patients identified by the hospice, we refined our sample by eliminating patients who received services other than routine home care from hospice. This resulted in 94 patients being dropped from our universe of 1,592 patients. This also reduced the number of nursing home patients in our sample from 329 to 315.

Medical Review Sample

For hospices with 35 or fewer patients living in nursing homes, we selected all of their nursing home patients for medical review. For hospices that had 36 or more patients living in nursing homes, we selected 35 patients at random. This selection process resulted in the identification of 262 patients for medical review.

We sent a second letter to each hospice requesting the complete medical record for each of their patients in our final sample of 262 patients. We also sent letters to the nursing homes where these sampled patients resided requesting the nursing home's complete medical record for each of their patients. We also requested and received in most cases copies of contracts between hospices and nursing homes, invoices and receipts for care and supplies provided to our sampled patients.

For the hospices's medical records, we had a 100 percent response rate. Our response rate from the nursing homes was 79 percent. We submitted 208 complete medical records (both nursing home and hospice medical records) to our medical review contractor. After the contractor's review and additional review of our own, a final sample of 200 patients was used for most of our analysis.

We used a medical review contractor to examine hospice and nursing home medical records to determine eligibility. In selecting our medical review contractor, we wanted to ensure that the contractor used staff familiar with hospice and hospice philosophy. The first level reviewers were nurses who had previous experience either in hospice or nursing homes. The second level reviewers were physicians in specialties related to a patient's diagnosis and who had referred their own patients for hospice care. The medical review contractor also examined the frequency, type and nature of services provided by hospice. We asked the medical review contractor to determine whether nursing home services to patients changed after election of hospice. In addition, we asked the contractor to determine if the services provided by hospice staff could have

been provided by the nursing home staff.

For all patients that were determined to be ineligible for the hospice benefit, we had a second medical review conducted by the medical reviewers for Medicare's Regional Home Health Intermediary responsible for the hospice servicing the patient.

Provider Discussions

In addition to obtaining hospice and nursing home records, we spoke in person or by phone with 20 hospice providers in our sample. We also spoke with 79 nursing home providers where these sampled patients lived. These discussions examined how the hospice and nursing home worked together and their perspectives on how hospice operates within a nursing home environment.

Other

We used a variety of other information in designing and performing the inspection. We used HCFA's Online Survey and Certification Reporting System to identify hospice names, provider numbers, locations and participation dates. In addition, we used this same source for information on nursing home hospice patient census and overall nursing home patient census. We used HCFA's Decision Support Access Facility (now the Health Care Information System) to obtain individual claims for our sample of hospice patients and for overall expenditures on hospice by provider. We also obtained State Medicaid reimbursement information for sampled patients identified as Medicaid entitled.

All data reported is at the 95 percent confidence level. (See Appendix B for confidence intervals on our estimates.) Most data presented in the report are based on the results of a weighted sample, although non-weighted data are reported. When non-weighted data are used, we will identify the data as such.

This inspection was conducted in accordance with *Quality Standards for Inspections* as developed by the President's Council on Integrity and Efficiency.

FINDINGS

Lower frequency of services, the overlap of services and the questionable enrollment in hospice by nursing home patients suggest that current payment levels for hospice care in nursing homes may be excessive.

Lower frequency of services

The National Hospice Organization's Hospice Services Guidelines and Definitions state:

The same level, intensity and mix of hospice services should be provided to residents of a facility (i.e., nursing home, hospice residence, group home) as are provided to other hospice patients living in their homes.

Our sampled nursing home hospice patients were seen less frequently than NHO's guidelines suggest. Nursing home hospice patients were seen by a hospice nurse 1.5 times a week and by a hospice aide 1.3 times per week. Compared to hospice patients living at home, nursing home hospice patients received 44 percent fewer nurse visits and 48 percent fewer aide visits. (See Table 2) Despite providing fewer services to nursing home patients, hospices are being paid at the same level they receive for patients living at home.

Average number of visits per week per hospice specialty

Service	NHO Staffing Ratios ¹	Nursing Home Patients ²	Home Patients ³	Percent Difference ⁴
Nurse	2.0	1.5	2.7	-44%
Aide	1.5	1.3	2.5	-48%
Social Worker	.8	.42	.53	-21%
Spiritual/Pastoral	.4	.28	.16	75%

1 - Derived from NHO staffing ratios. (Example - average caseload per nurse is 10 patients, average number of visits per week per nurse for all patients is 20 - 20 visits/10 patients = 2 visits per week per patient)

2 - Based on medical review of nursing home hospice patients

3 - OIG national sample of hospice patients

4 - Percent difference between Column 3 and 4

TABLE 2

During our review period nearly all of our sampled patients were seen at least once by a hospice nurse. In the rare instances where a patient was not seen by a hospice nurse it was due to the patient dying before a nurse could see the patient. For the other disciplines, the number of patients who were seen at least once drops. For example, 38 percent of nursing home hospice patients were not seen by an aide during our review period. Only half of the nursing home hospice patients were seen by a spiritual/pastoral counselor and 67 percent were seen by a social worker. One potential reason for fewer visits by hospice staff could be that the nursing home was already providing many of the services offered by these disciplines.

In addition to providing services to patients, hospices also provide services to the patient's families. We did not extensively review or analyze the services provided to our sampled patient's families. Our reviewers did however document the encounters with the family members. Less than 25 percent of our sampled patient's families were telephoned or seen by hospice staff in December 1995. Most of the family contact that did occur was done by hospice nurses or social workers. We do not have comparable figures for patient's living at home.

Nursing homes administrators that we contacted are beginning to realize that patients in their facilities may not be getting the services hospices said they would provide. Hospices promise additional support for nursing home staff, post death bereavement, family support and pain management. Ten out of 79 nursing homes we contacted claimed that, in all too many cases, hospices are not providing these services to nursing home patients.

Overlap of services

Three out of four nursing home hospice patients received only basic nursing and aide visits. Many of these services were provided by nursing home staff as part of room and board when hospice staff were not present. The remaining one in four patients had symptoms that required additional care beyond basic nursing and aide visits. While these additional treatments were provided by hospice staff, the nature of the services provided, like nursing and aide visits, were often clearly within the professional skills possessed by nursing home staff. Because the overall responsibility for a patient's care transfers to the hospice, the hospice was responsible for the additional medical interventions provided to those patients who needed more than routine nursing and aide care.

In many cases, the nature of services provided by hospice staff, while appropriate and efficacious appeared to differ little from services a nursing home would have provided if the patient was not enrolled in hospice. The following examples can be used to illustrate this point.

A female, age 92, was being treated by the nursing home for bed sores using a special mattress. The hospice decided after seeing no change in the patient's condition to try a different mattress to resolve the problem.

A female, age 79, was admitted to hospice to treat the patient's pain. Despite the hospice's efforts to control her pain the patient claimed no relief. The hospice arranged for a neuro/psychological evaluation which indicated that the patient used her condition to manipulate the nursing home and hospice staff. The hospice established a plan of care which gave the patient the appearance that she was receiving more drugs to control her pain.

A male, age 81, was examined and found to have a growth in the spleen. The hospice made a decision to treat the growth and the pain associated with the growth through radiation therapy.

It is difficult to say whether nursing homes would have ultimately made the same decisions that the hospice did in providing additional services to these patients. In most cases, the nursing home would have taken some action to address patient care needs. Standards of care for nursing homes require that they develop a plan of care to address patient bed sores. Consultations and other interdisciplinary interventions are also not unusual in the prescriptive nursing home environment that requires nursing home staff to address weight loss and other changes in patient medical status in the plan of care.

Clearly, some of the medical interventions by hospice reflect care options that embodied the hospice philosophy. Because of current nursing home regulations, nursing home staff would find it difficult to provide some of these interventions. Some interventions, such as more one on one contact, could be accomplished with additional funding for such staff in nursing homes. Other solutions would require changes in nursing home laws, regulations and policies. Today, nursing homes must address any decline in a patients condition with a plan of care to address the cause. It would be difficult for nursing homes to dismiss the physical deterioration of a patient as normal disease progression. Nursing homes must respond with a plan to stop or reverse the deterioration which often involves hydration, tube feedings, hospitalizations and other interventions that the hospice would not by law be required to undertake.

Questionable enrollments

Based on two different sets of medical reviews, we project that 16 percent of hospice patients living in nursing homes did not qualify for Medicare's hospice benefit at the time of their enrollment. In some cases, the records showed that patients did have a terminal condition but were stable with little sign of deterioration or decline. Our medical reviewers noted that while the hospice benefit may eventually have been appropriate, at the time of election, patients were stable and the election of hospice was premature.

The questionable enrollment of patients in hospice care seems focused on those patients already living in a nursing home before their hospice election. Additional analysis revealed that only 4 percent of the hospice admissions, where the patient

entered the nursing home after the hospice election, were questionable. In contrast, our reviewers questioned 21 percent of the hospice admissions, where the patient lived in a nursing home before their hospice election. Many of these patients were entitled to both Medicare and Medicaid.

As a result of patients being ineligible for the hospice benefit at the time of their election, the average length-of-stay for these patients is significantly longer than patients found eligible for hospice care. On average, ineligible patients received 369 days of hospice care compared to 145 days for eligible patients. Ineligible patients spent, on average, 224 more days in hospice care than did eligible patients. The average hospice cost for the ineligible patients was \$37,485 per patient.

Table 1

Residence of Patient	
	Ineligible
Nursing home patient before hospice election	21%
Nursing home admission after hospice election	4%
Source: OIG	

Continued growth in Medicare hospice expenditures for nursing home patients is expected.

Current Situation

We estimate that in 1995, 17 percent of Medicare hospice patients lived in a nursing home while receiving hospice services. We estimate that in that same year Medicare spent \$215 million on hospice care for nursing home patients. We believe this estimate is conservative because we dropped 12 very large hospices from our sampling universe. These 12 hospices recently underwent separate OIG reviews.

We found that the average nursing home hospice patient in our sample spent 181 days in hospice care. This estimate is higher than data recently released by the National Hospice Organization but nearly the same as data released by the Center for Disease Control and Prevention (CDC). The NHO data shows that the average length-of-stay for nursing home patients in hospice was 56.3 days in 1995. A 1992 publication by CDC estimates the average length-of-stay for hospice patients living in nursing homes to be 166 days.

Our data indicates that 45 percent of hospice patients living in nursing homes are entitled to both Medicare and Medicaid. Based on our sampled data, the cost for patients entitled to both Medicare and Medicaid was, on average, \$168.83 per patient per day. This cost includes an average Medicare payment for routine hospice care of \$96.30 per patient per day and an average room and board payment by State Medicaid agencies of \$72.53 per patient per day.

Nursing home market

Potential growth in the number of hospice patients living in nursing homes is significant. Since 1986 when nursing home patients were allowed to elect Medicare's hospice benefit, the number of patients on hospice and living in nursing homes has steadily increased.

A report examining the effects of the Medicare Catastrophic Coverage Act of 1988 estimated that 7.7 percent of hospice patients were living in a nursing home. Three years later the number of nursing home hospice patients increased to 9.9 percent. Moreover, a 1992 study by the National Centers for Health Care Statistics estimated that 13 percent of Medicare hospice patients lived in places other than a private or semi-private residence. As noted previously, we estimate that in 1995, 17 percent of Medicare hospice patients were living in nursing homes. Other researchers in this area believe the percentage of hospice patients living in nursing homes is even higher than our estimates.

The potential patient volume makes nursing homes ideal candidates for hospice marketing efforts. In 1995, roughly 1 percent of nursing home residents were receiving hospice care. A 1996 NHO survey revealed that 96 percent of hospices surveyed are planning to begin or increase the number of nursing home patients served. Based on current information, we expect the number of nursing home hospice patients to grow significantly.

According to a presentation by a hospice, "nursing home patients may be the key to cost effective expansion." This sentiment was also cited by hospices, in an NHO survey on nursing home issues, as one of the advantages in increasing the number of nursing home patients served. Nursing home patients allow a hospice to increase their patient census and increase the average length of stay thereby increasing hospice revenue.

Not surprisingly, hospices are informing nursing homes of the benefits the hospice can provide to nursing home patients and nursing homes themselves. Hospices have offered nursing homes the following:

- paying daily rates that are the same or more than the nursing home would have received from the State Medicaid agency for dually entitled Medicare and Medicaid patients,
- allowing the nursing home to reduce staff time for hospice patients, or
- increasing the nursing home patient census by promising to use the nursing home as the hospice's respite unit or admit patients to the nursing home whose primary care giver can no longer provide the care at home.

In addition, hospice pays for durable medical equipment, prescriptions and medical supplies related to the patient's terminal illness. In some cases, the nursing home

would have provided these items had the patient not elected hospice. This can potentially improve the financial condition of the nursing home.

Unlimited Benefit

Under current incentives, hospice directors can be more permissive when making a decision on whether to admit a patient under the hospice benefit. The repeal of the 210 day limit shifted the financial risk for patients living longer than 210 days from the hospice to Medicare. Prior to the repeal, less than 5 percent of hospice patients lived beyond 210 days. In early 1996, approximately 14 percent of active patients had length of stays longer than 210 days, a considerable growth from before the repeal of the limit.

Before the repeal of the 210 day limit for hospice care, hospices would have to provide uncompensated care for patients who lived beyond 210 days and continued to require hospice care. The 210 day limit caused hospice directors to adopt a very conservative, careful screening strategy regarding who to admit under the benefit and when to admit the patient. Based on a review of congressional testimony prior to the passage of the Medicare Catastrophic Coverage Act of 1988 and again prior to the removal of the 210 day limit, many believed that only a small number of patients would need the additional benefit period.

Number of providers

The incentives in the nursing home market along with the repeal of 210 day limit may also have contributed to an increase in the number of hospice providers. In particular there has been a substantial increase in the number of for profit providers entering the market. Before 1991, the vast majority of hospice providers were non-profit (See Chart 2). In 1995, while the majority of Medicare certified hospices continue to be non-profit, the percentage of for-profit hospice providers has risen to almost 21 percent from 7 percent.

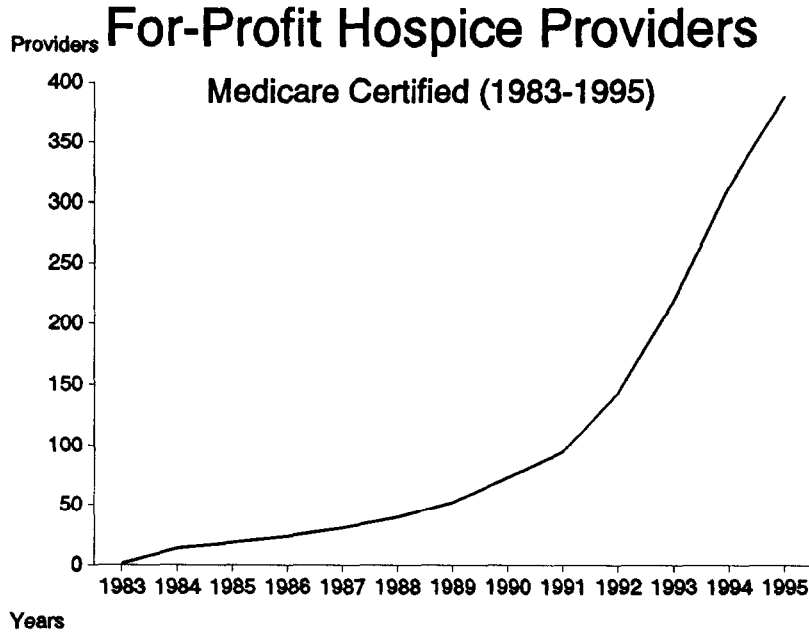


Chart 2

The Balanced Budget Act of 1997, enacted after we issued our draft report, begins to address some of the concerns about potential abuses in the fourth benefit period. The new legislation requires that a hospice medical director recertify a patient's eligibility every 60 days once a patient has been in hospice care for more than 180 days.

RECOMMENDATIONS

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APPENDIX A

METHODOLOGY

Methodology

Table 1 describes the total number of hospices in our universe by the strata. The table provides information about number of hospices sampled, number of hospices responding and number of hospices with nursing home patients.

Table 1 Number of Hospice per Stratum

Stratum	Total Number of Hospices	Total number of Sampled Hospices	Total number of responding hospices	Number of Hospices with Nursing Home Patients
California (CA)	140	6	5	3
Florida (FL)	36	6	4	3
Illinois (IL)	74	6	6	6
New York (NY)	53	6	6	4
Texas (TX)	104	6	5	3
Rest of the United States (RU)	1,394	6	5	3

Table 2, on the next page, identifies by hospice the total number of hospice patients, number of nursing home patients if any and the number of complete medical records. A medical record was considered to be complete if information was received from both the hospice and nursing home. This number represents what was sent to our medical records contractor and after our own additional review.

Table 2

**Hospice/Nursing Home Hospice patients by Hospice
December 1995 Census**

Hospice	Number of Hospice Patients	Number of Nursing Home Patients	Number of Sampled Patients	Complete Medical Records
CA - 1	35	7	7	7
CA - 2	31	7	7	4
CA - 3	38	32	32	23
CA - 4	32	0	0	NA
CA - 5	5	0	0	NA
FL - 1	7	0	0	NA
FL - 2	217	37	35	11
FL - 3	6	6	6	4
FL - 4	48	6	6	4
IL - 1	92	15	15	12
IL - 2	31	4	4	2
IL - 3	57	2	2	2
IL - 4	28	10	10	9
IL - 5	29	7	7	6
IL - 6	11	3	3	1
NY - 1	229	58	35	35
NY - 2	105	2	2	2
NY - 3	32	4	4	4
NY - 4	26	14	14	13
NY - 5	46	0	0	NA
NY - 6	7	0	0	NA
TX - 1	34	8	8	5
TX - 2	61	0	0	NA
TX - 3	51	22	22	21
TX - 4	159	77	35	29
TX - 5	1	0	0	NA
RU - 1	3	0	0	NA
RU - 2	22	4	4	3
RU - 3	3	0	0	NA
RU - 4	5	2	2	2
RU - 5	42	2	2	1

APPENDIX B

Confidence Intervals

Variance and Estimated Confidence Intervals

		Estimate	Standard Error	95% Confidence Interval	
				Lower Limit	Upper Limit
Ineligible patients		16.08%	4.31%	7.63%	24.53%
Nursing home admission before hospice election	Ineligible	20.78%	4.89%	11.20%	30.36%
Nursing home admission after hospice admission	Ineligible	3.62%	2.85%	0%	9.21%
Patients dually entitled		44.93%	4.93%	35.27%	54.59%
Average length of stay for eligible patients		144.50	22.99	99.44	189.56
Average length of stay for ineligible patients		368.70	59.61	251.86	485.54
Average reimbursement for total hospice stay for ineligible patients		\$37,485.10	\$2,903.41	\$31,794.42	\$43,175.78
Average length of stay for nursing home patient		180.55	33.00	114.55	246.55
Percent Medicare Patients living in a nursing home		17.17%	5.15%	7.08%	27.26%
Medicare daily rate		\$96.30	\$1.58	\$93.20	\$99.40
Medicaid Nursing Home Rate		\$72.53	\$3.72	\$65.24	\$79.82

APPENDIX C

AGENCY COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUL 29 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hospice Patients in
Nursing Homes: Eligibility, Services and Growth," (OEI-05-95-00250)

We reviewed the above-referenced report that examines eligibility, services, and growth in the number of hospice patients living in nursing homes.

Our detailed comments are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA) on
Office of Inspector General (OIG) Draft Report:
“Hospice Patients in Nursing Homes: Eligibility, Services, and Growth.”
(OEI-05-95-00250)

OIG Recommendation 1

Eliminate or reduce Medicare or Medicaid payments for hospice patients living in nursing homes.

HCFA Response

We concur. For reasons discussed in the next paragraph, we suggest you add the following to the recommendation: “and require nursing homes to provide end-of-life care as may be needed.” Your report makes a good case for reform of the hospice benefit when it is provided to beneficiaries who reside in nursing homes. In particular, the higher lengths of stay (LOS) by individuals who were residents of the nursing home at the time of hospice election, and the even higher LOS for individuals who were eligible for both Medicare and Medicaid, contrasted with the significantly fewer services received by hospice patients residing in nursing homes compared to hospice patients in their own homes, lend strong support to reform for the benefit. Further support for change is evident in your finding that approximately 75 percent of the additional services provided by hospices to its nursing home patients were ones that differed little from services a nursing home would ordinarily provide to its residents. The projected growth of hospice programs providing services in nursing homes needs to be addressed, and your recommendation will help at a time when Congress is seeking ways to reduce unnecessary Medicare expenditures.

We suggest amending this recommendation to require nursing homes to provide needed end-of-life care; an important safeguard for beneficiaries who actually may need hospice care in a nursing home should the benefit undergo the proposed change. Currently, the law does not explicitly describe this service as a requirement for nursing homes under Medicare or Medicaid, and palliative care would be an appropriate service to offer. Your report correctly recommends the reduction or elimination of the hospice benefit in nursing homes, but without requiring nursing homes to provide end-of-life care we would be doing a disservice to our beneficiaries.

Earlier this year, HCFA prepared a legislative proposal that would have ended payment for hospice for beneficiaries residing in nursing homes, and would require nursing homes under Medicare and Medicaid to provide all necessary end-of-life care to its residents. Subsequent discussions of this proposal with representatives of the hospice industry and

the Administration indicate it is unlikely the proposal will be considered during this session of Congress. However, the discussions found the industry recognizing and agreeing with HCFA that reform of the hospice benefit when provided to nursing home residents is needed. HCFA will use the OIG recommendation as an additional impetus for the changes that need to be made, including the possibility of lower hospice payments for patients who reside in nursing homes, revising the requirements for services provided by nursing homes, or some other option to preserve this type of care for those who need it when living in a nursing home. HCFA anticipates it will be working with representatives of the hospice industry in the development of needed legislative reforms for this part of the hospice program.

Another factor to consider is while many hospice services may be capable of being provided by nursing home staff, many other hospice services (family counseling, bereavement counseling, etc.) probably are not. Nursing home staff may lack the professional skill and training necessary to deliver the full range of hospice services to individuals electing this type of care.

OIG Recommendation 2

Modify the benefit period structure to prevent abuses in the fourth benefit period.

HCFA Response

We concur. We have had a long-standing legislative proposal to address the problem of the fourth unlimited benefit period. Our preference had once been to impose a limit (360 days) on the number of hospice days available to any beneficiary in his or her lifetime. It would have returned the hospice admission process to its earlier conservative requirement, whereby a hospice would carefully consider an admission since the financial risk was on the provider if the beneficiary lived beyond the original number of 210 covered days. Presently, we have a legislative proposal we believe has a reasonable chance to be considered by Congress that will repeal the third 30-day period and fourth unlimited period, and replace them with an unlimited number of 30-day periods. There is a bill before Congress similar to our legislative proposal, except it provides for an unlimited number of 60-day periods.

We plan to support whichever proposal Congress accepts, and to implement it as quickly as the law permits.

Other comments:

- o **Page 1, Background section, last sentence, should be revised to read: “Congress repealed the hospice benefit’s 210-day limit, effective for services furnished on or after January 1, 1990.” The Omnibus Budget Reconciliation Act of 1990 made this change.**
- o **Page 1, 5th paragraph, line 4: Change “looses their” to “loses his or her.”**
- o **Page 1, last paragraph: You should specify that Medicare patients enrolled in the hospice program waive coverage of all curative medical services related to the treatment of the terminal illness. The way it is currently written, the hospice patient receives no care at all for a terminal condition.**
- o **Page 2, first paragraph: It should be specified that the hospice assumes the professional management of the patient’s medical care for the terminal condition. Management of a patient’s other conditions, unrelated to the terminal condition, is not the responsibility of the hospice, but of the nursing home. The only exception to this is if the patient’s attending physician is unwilling or unable to prescribe care for the unrelated condition, at which point the hospice would be responsible for that care as well.**
- o **Page 2, 1st paragraph, line 5: Insert “personal care services,” following the word “includes.” This is an important room and board service that we want clearly presented as a nursing home responsibility.**
- o **Page 3, Scope section: You limited your inspection to services provided to patients in the nursing home, but not to the patients’ families. It would help your presentation if you could provide a rationale for that decision, since bereavement counseling is a mandatory hospice benefit and a volunteer, counselor, or a hospice social worker could presumably be providing such services to the patient’s family at their home. We doubt the volume of such services would alter your findings, but you may wish to remove this as a potential issue with a brief explanation for your decision. Since your reviewers examined the hospice records, if significant services had been provided to the families, presumably your reviewers would have noted it.**
- o **Page 4: We suggest you offer some information about the qualifications, training, or preparation your medical review contractors had before beginning their examination of patient records. Eligibility for the hospice benefit (physician**

certification that the beneficiary has a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course) is one of the most controversial aspects of the program at this time. With the higher numbers of ineligible patients identified in the report, greater credence will be given if the reviewers' credentials are bolstered by some reference to their competence to perform the reviews.

- o Page 6, 2nd paragraph, Eligibility Rate: You state 73 out of 200 sampled patients had 1 of the 4 diseases covered by the National Hospice Organization (NHO) guidelines, and under these guidelines, 27 percent were determined to be ineligible for the benefit at the time of election. We suggest you provide information about the other 127 patients whose diseases were not described in the NHO guidelines. This would give us a more complete picture of the population studied, as well as make the study more defensible.
- o Page 6: The footnote at the bottom of the page states "1994" as the publication date for the NHO guidelines. The correct year is "1995."
- o Page 7, second paragraph: The \$168.83 figure for the combined cost to both Medicare and Medicaid for providing hospice care to dual-eligibles should be further specified as a per patient per day figure.
- o Page 8, last paragraph: The word "were" in the second line should be replaced with "where."
- o Page 8: The differential level of services discussed on this page is one of the most important findings about hospice patients who reside in nursing homes. Why are there so many fewer services for a patient who resides in a nursing home compared to a patient who resides in what is considered a regular home? Why is Medicare paying so much more for so much less? One reason may be the purchase of non-core services by the hospice from the nursing home (see 42 CFR 418.56). This is acceptable and the hospice should be able to document its purchase in the papers completed to meet the cited requirement. The report should deal with these issues to ensure its findings are solid.
- o Page 9, first sentence ending at top of page: It should be specified that one reason for fewer visits by hospice staff could be that nursing home staff was already providing many of the hospice's services.

- o Page 9: Tied to the comment made above regarding intensity of services, the finding that approximately 75 percent of the hospice patients in a nursing home were receiving services that were “clearly within the professional skills possessed by the nursing home staff,” presents, if true, another strong indication that this area of the program is in need of change. Accordingly, you may wish to strengthen the explanation as to why this is true.
- o Page 12, final paragraph: You report that in early 1996 about 14 percent of active patients had lengths of stay exceeding 210 days. Please cite your source, as it is an important figure that indicates the growth of a program that needs to be controlled.
- o Page B-2, second and third boxes from the bottom: The language should be changed to “Average length of stay for nursing home hospice patients” and “Percent Medicare Hospice Patients living in a nursing home,” respectively.

We also would add one final caution. HCFA does not have comparable bases for some of the data and cost estimates presented in your report. While we do not suggest that any of them are inaccurate, we do urge OIG to make certain that it can substantiate them.



JUL 22 1997

TO: June Gibbs Brown
Inspector General

FROM: David F. Garrison
Principal Deputy Assistant Secretary
For Planning and Evaluation

SUBJECT: OIG report entitled, "Hospice Patients in Nursing Homes: Eligibility, Services, and Growth" – Conditional Concurrence

We have reviewed the draft OIG report entitled, "Hospice Patients in Nursing Homes: Eligibility, Services, and Growth" and have concerns with the specific recommendations made in this report, and, at the same time, are intrigued by the payment issues only hinted at in this report. Specifically, we are concerned that the recommendation to eliminate hospice payments for nursing home patients may be premature and that the report may over-generalize the survey findings. We conditionally concur. We would like to meet with you to discuss developing recommendations with which we will all be comfortable and noting the methodological limitations of the OIG study. The following develops these concerns and comments.

Report Summary

The OIG found that almost 20 percent of hospice patients residing in nursing homes were ineligible for the Medicare hospice benefit at the time the hospice benefit was initially elected, that these ineligible individuals have hospice lengths of stays more than twice as long as eligible beneficiaries, and that ineligibility is linked to residing in a nursing home prior to electing hospice and being dually-eligible. The OIG makes two recommendations. First, that the Medicare or Medicaid hospice benefits be eliminated or reduced in nursing homes. Second, that the Medicare hospice benefit be modified to prevent abuses in the fourth benefit period – a recommendation advanced in response to the enrollment of beneficiaries into the hospice program whose life expectancy exceeds six months.

Overall Comments

Prior to eliminating the hospice benefit in nursing homes, we believe the roles and responsibilities of hospices and nursing homes caring for beneficiaries electing hospice and residing in nursing homes should be more completely understood. Implicit in a recommendation to "eliminate" the Medicare hospice benefit for nursing home residents, is an assumption that nursing homes are (or should be) able to provide hospice services. However, before such a recommendation is advanced, we believe additional information is needed regarding the:

- "hospice philosophy";
- Medicare requirements for providing hospice benefits in non-institutional and institutional settings and how, if at all, the implementation of these requirements varies across settings;
- service requirements of hospice patients and how these are the same or different from typical nursing facility residents;
- additional value, if any, of having a hospice (rather than a nursing home) provide end of life care to the terminally ill;
- additional costs that would be incurred by nursing homes (and consequently the Medicare and Medicaid programs, and private pay patients) if they were to become responsible for providing hospice care; and
- barriers nursing homes would encounter in providing end of life care to those with terminal illnesses.

ASPE is exploring the feasibility of studying the Medicare hospice benefit using Medicare claims and other data, and interviews of hospice and nursing home providers. The goal of such a study is to produce information on:

- the number of Medicare hospice patients, their level of care (including those receiving hospice services in nursing homes), length of stays, and Medicare payments made on behalf of beneficiaries electing hospice coverage;
- the extent to which, if at all, aggregate Medicare expenditures to hospices exceed the hospice cap;
- the quality of care received by hospice beneficiaries in nursing homes; and
- the hospice philosophy, service requirements of hospice patients and typical nursing facility residents, the value of hospices (rather than nursing homes) providing end of life care to the terminally ill, and barriers nursing homes would encounter in providing this level of care.

While we believe the OIG report raises some important issues, we are concerned that the very small sample size used in the study is not adequate to permit findings to be generalized. The report should acknowledge these methodological limitations. Because of the sensitive issues involved, caution seems to be warranted.

Further, we are concerned that without more complete information about the hospice benefit, how it is used, and paid for, recommendations to eliminate or reduce the benefit will be perceived as too draconian. We would like to have an opportunity to discuss these concerns with you and how our study could be used to inform the current discussion on hospice issues.

Other Specific Comments

The report finds that hospice patients in nursing homes receive half the nursing and aide services compared to hospice patients living at home. This finding is based on a review of hospice medical records compared with the number of nursing and aide visits recommended by the National Hospice Organization. While the OIG reviewed the medical records of nursing homes and contracts between nursing homes and hospices, the results of these reviews were not presented in the report. Absent a discussion of the services provided by nursing homes, the reader is left with the impression that the quantity and possibly quality of hospice care provided to nursing home patients is less than that provided to other hospice patients. We understand that the OIG was not intending to comment on the quality of care received by nursing home hospice patients. Instead, we believe the OIG was attempting to suggest (in part) that Medicare is overpaying because the level of effort by hospice staff is less for nursing home patients than for other hospice patients despite receiving the same Medicare hospice payment amount (plus a Medicaid add-on for dually-eligible persons). We recommend the report be modified to provide information about the contracts between hospices and nursing homes, nursing and aide services provided by nursing homes to hospice patients, and clarify that variations in service delivery as reported in medical records for hospice patients in nursing homes compared with hospice patients not in nursing homes does not necessarily reflect on the quality or level of care received by these patients.

The report discusses how current nursing home rules would have to be changed and nursing home payments increased to provide hospice services (p.10). We do not believe that it is accurate to state that nursing homes "must respond with a plan to stop or reverse the deterioration" by providing active interventions. We believe that current nursing home rules permit patients to refuse treatments. We recommend that the report describe current nursing home requirements of meeting each patient's needs and the right to refuse services.

The report does not provide information about how Medicare payments for hospice care are established, any limits that apply, and the effectiveness of these limits. We recommend the report discuss these issues, particularly in view of a recommendation to modify Medicare payments for hospice services to residents of nursing homes.

Page 4 - June Gibbs Brown

The report recommends that the hospice benefit be modified to prevent "abuses in the fourth benefit period." However, the report does not provide information about "abuses in the fourth benefit period." Instead, the OIG found that between (approximately) 11 percent and 27 percent of nursing home hospice patients were ineligible "at the time of [their] election" of the hospice benefit. OIG staffs report that many of these initially ineligible persons become eligible over time. Thus, it would appear the problem is not with the fourth benefit period but instead with initial eligibility determinations.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MAY 22 1997

MEMORANDUM TO: Office of the Inspector General
Attention: George Grob

FROM: John J. Callahan *John J. Callahan*
Assistant Secretary for Management and Budget

SUBJECT: **Concur with Comment:** Draft OIG Report -- "Hospice Patients in Nursing Homes: Eligibility, Services, and Growth"

ASMB has the following comments with regard to this report:

1. OIG's first recommendation -- "to reduce or eliminate Medicare or Medicaid payments for hospice patients living in nursing homes" -- implies that HCFA should discourage covering hospice services in the nursing home setting. This is clearly not a policy the Department should advocate. For many hospice patients, there's no alternative but to receive this care in a nursing facility.

We believe that OIG's intent in offering this recommendation was to address abusive payment practices. For instance, in many cases, nursing facilities receive duplicative Medicare and Medicaid payments for hospice services they provide to dually eligible beneficiaries. In addition, the OIG described situations in which a nursing home was paid for hospice services it did not provide.

ASMB suggests that OIG revise this first recommendation to address fraudulent and/or abusive payment practices for hospice services provided in nursing homes.

2. OIG's second recommendation -- "to modify the current benefit period structure to prevent abuses in the fourth benefit period" -- does not reflect recent fraud and abuse legislation HCFA sent to the Congress to address this problem.

ASMB recommends that OIG revise the language of this report to recognize recent legislation offered by HCFA to address problems with the fourth benefit period. This legislation would replace the third and fourth hospice benefit periods with an unlimited number of thirty-day periods, each of which would require recertification of a patient's terminal diagnosis.

3. OIG's report emphasizes problems with the hospice eligibility process, but only offers recommendations dealing with the back-end of the hospice benefit.

ASMB would ask the OIG to consider including recommendations to improve hospice eligibility determinations on the front end.



August 8, 1997

The Honorable June Gibbs Brown
Inspector General
Department of Health and Human Services
330 Independence Ave., S.W.
Room 5246
Washington, DC 20201-0001

Attention: George F. Grob
Deputy Inspector General
Office of Evaluation and Inspections

Dear Inspector General Brown:

Thank you for the opportunity to review and respond to a draft of the Office of the Inspector General report, *Hospice Patients in Nursing Homes: Eligibility, Services and Growth* as developed by the Office of Evaluation and Inspections (OEI). I would also like to express NHO's appreciation for the cooperative efforts of OEI staff provided our office during the development of this report.

We believe the report serves as a warning that the Medicare Hospice Benefit is more vulnerable to waste and abuse when provided to Medicare/Medicaid-eligible residents of nursing homes. It should be noted, however, that the report suggests only the potential for such behavior.

The report is most useful in underscoring the need to collect additional information regarding the nature and cost of hospice care provided in the nursing home. The development of such information has been a long-standing interest of the National Hospice Organization (NHO). As you may know, in January 1993, at NHO's urging, the Chairmen of the House Ways and Means and Senate Finance Committees asked the Office of Technology Assessment to study hospice care in the nursing home. Unfortunately, the request was ignored. If the request had been honored we might have the information today to evaluate the payment levels.

Additionally, over NHO's strong objection, HCFA eliminated cost reports for hospice programs years ago, even after NHO, at its own expense, designed proposed new cost reports that were more accurate and easier to use. We were pleased to see that legislation reinstating cost reports for hospices has recently been signed into law.

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We clearly agree with the recommendation to modify the current benefit period structure of the Medicare Hospice Benefit. NHO has strongly supported restructuring the unlimited fourth benefit period by having two periods of 90 days and then an unlimited number of 60 day periods. Such a structure would protect the beneficiary's access to the hospice benefit while also protecting Medicare by requiring more frequent evaluations of the eligibility of the patient for the hospice benefit. Through NHO's urging, this legislation has also recently been signed into law.

As suggested above, we also agree that the payment structure for hospice services delivered in the nursing home needs to be reviewed to make certain that the payment reflects a fair and appropriate level of payment for quality-driven hospice care. In discussions with the Health Care Financing Administration (HCFA) we have pledged the resources and efforts of this organization to working with HCFA to craft a fair payment system that reinforces the appropriate incentives.

However, while we find the report to be useful in the manner we have described, we object to the conclusion that the Medicare Hospice Benefit should not be available to residents of nursing homes. The recommendation to eliminate the availability of the hospice benefit in the nursing home appears to be a draconian response to the facts as presented. We are also distressed by certain content in the draft report we reviewed as noted below.

BACKGROUND

Hospice Care

- The statement is made that the daily amount paid to the hospice is provided even if no services are provided. This statement may be misleading in that this rate also includes payments for the every day costs of durable medical equipment, medications, on-call availability and the administration of the hospice program, including the significant costs of interdisciplinary team coordination of the care plan.
- The statement is made that Medicare expenditures for hospice care have increased significantly during the period 1986-1995. While this statement is true, the context is missing. The Medicare Hospice Benefit was not made a permanent benefit until 1986, and it should not be considered unusual for significant growth to occur in an emerging benefit, particularly when the services associated with that benefit are only now becoming familiar to the public. Additionally, HCFA's statistics suggest that the increases in Medicare expenditures primarily represent increased numbers of patients served rather than increases in per patient costs. Hospice care continues to be the smallest of the Medicare benefits representing only a tiny fraction of total Medicare expenditures. Also, a 1995 Lewin-VHI study suggests that Medicare costs would have been more than a billion dollars higher in 1995 without the Medicare Hospice Benefit.

Hospice Care in Nursing Home

- The chart and accompanying text fail to describe accurately the payment flow. As you know, hospice care services must be provided strictly by the hospice. It may be misleading to suggest that all payments go to the nursing home.

Office of Inspector General Work

Scope

- The statement is made that the inspection was limited to services provided to the patient and the report does not discuss services provided to the patient's family. One of the basic principles of hospice care is that the patient and family unit is the focus of care. One of the great misconceptions of death and dying is that of a defined medical event. In hospice care we have learned that to care for the physical, spiritual and emotional needs of the patient you must also care for the patient's family, however it might be defined. To disregard the family should limit the confidence in the conclusions related to the provision of hospice services.

METHODOLOGY

- The study involves disproportional sampling at two stages, requiring a "double weighting" procedure to get from sample results to a national estimate and greatly complicating the calculation of confidence limits. For example, the report notes that "Most data presented in the report are based on the results of a weighted sample..." But disproportional sampling is used twice: First, in the selection of hospices (i.e. 6 hospices were selected to represent all hospices and 60 percent of all hospice patients in 45 states; while 6 hospices were selected from each of the 5 other states). Second, when all nursing facility hospice patients were selected from those with less than 35 patients, but a random sample of 35 patients was selected from each of the remaining hospices. While presenting a significant amount of data the report is silent on an important methodological procedure, i.e. how were the sample findings weighted to determine the estimate of those who are ineligible?
- The study is also silent on whether all stays reported in the study are actually completed stays. For example, at one point the report states that "Thirty-five percent of nursing home hospice patients in their fourth benefit period did not qualify for hospice care at the time of their hospice election." This suggests that at least some patients were studied while they were still being served, rather than only after service was completed. This is important because if some patients were studied while they were still being served the data may not be comparable between different groups.
- One of the conclusions drawn by the study is that the number of patients living more than 210 days is dramatically increasing. While the conclusion may or may not be correct it is unclear if it is actually supported by the data provided.
- The study, while noting with some alarm the number of patients living longer than 210 days, is silent on the fact that more than 15 percent of hospice patients are referred to

hospice care within a week of death (Christakis NA, Escarce JJ. Survival of Medicare Patients After Enrollment in Hospice Programs. N Engl J Med 1996; 335:172-7.).

FINDINGS

Eligibility Rate

- The report notes that 19 percent of hospice patients living in nursing homes did not qualify for Medicare's hospice benefit. This statement regarding eligibility is based on the review of medical records to determine if the reviewer agreed with the prognosis and therefore eligibility of the patient established by the attending physician and/or the hospice medical director. According to the widely reported SUPPORT study, physicians have limited ability to predict the impending death of their patients even in the controlled environment of the nation's finest teaching hospitals. This is an area in which reasonable doctors ought to be able to differ without penalty to the provider or the patient. However, your determination of ineligibility for these patients is based on your medical reviewers' judgments that certain patients were not terminally ill with a prognosis of six months or less being deemed 100 percent reliable and correct, and the differing opinions of the patients' attending physician and the hospice medical director being deemed 100 percent incorrect.
- As noted, the eligibility requirement for the Medicare Hospice Benefit is the certification of a terminal prognosis of six months or less, if the disease runs its normal course. A patient does not have to show signs of decline at the point of election nor do they have to be unstable or on the brink of death to be eligible for the Medicare Hospice Benefit.
- We applaud OEI's use of NHO's *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases* as an improvement over simply relying on the inconsistent skills of its medical reviewers in determining prognosis. Unfortunately, it is unlikely that the tool was available to the hospices and attending physicians at the time the patients elected the hospice benefit. Indeed, as you know, hospices reviewed in this report until mid-1995 were required only to obtain physicians' certifications to meet regulatory requirements.

Impact on Length of Stay

- We question the accuracy of the length of stay conclusions as they are so inconsistent with all the known data. In addition to the methodological questions that we have already posed, we would question the use and accuracy of 1992 CDC comparison data.

Hospice Services

- We certainly agree that the level and mix of hospice services should be equally available regardless of the patient's residence; however, we are uncertain that your report supports the conclusion that they are not.

- In addition to the methodological questions that appear to undermine the comparability of the data, we would also restate that disregarding the hospice's services to the family erodes the comparability of the data.
- There is absolutely no data provided to support the speculation found on page nine that nursing homes were already providing the services offered by the hospice.
- The statement is made that one out of eight nursing homes contacted "claimed that, in all too many cases, hospices are not providing these services to nursing home patients." Without knowing who was responding for the nursing home or seeing the interview tool, it is impossible to ascribe any validity to this statement. One out of eight nursing homes could have thought they were under an OIG investigation. We would also point out that "minimal" disruption to the daily routine at the nursing home is not a Medicare covered hospice service, and including it on the list biases the response.
- The examples used by the report suggest responsible actions by the hospice. To suggest that the nursing home would have responded in a similar manner is again not supported by any data. An equally plausible conclusion is that absent the hospice program, the patients would not have been cared for in the nursing home at all and would have all been transferred to a hospital at significantly higher cost to Medicare.
- NHO agrees with the report's conclusion that much of what hospice care provides in the nursing home could be done by the nursing home itself if the goals, mission and culture of the nursing home were changed; if the nursing home were paid more money, and if the laws and regulations that currently inhibit such care by the nursing home were changed. We note, however, that changes in the law to require that patients' rights to refuse treatment be honored in the nursing home setting appear not to have had the intended consequences.

SUBSTANTIAL GROWTH EXPECTED

Current Situation

- The report suggests that the inclusion of the hospices that underwent separate OIG reviews would alter the estimates. This statement appears inconsistent with statements of data reliability made as part of the methodology section.
- The report concludes that "Overall costs for the care of hospice patients residing in nursing homes appears to be substantially higher than for other hospice patients." However, no data are presented to support the conclusion. Without information on total actual Medicare and Medicaid payments for hospice patients served in the community and those served in nursing homes, conclusions regarding relative costs cannot be drawn.

RECOMMENDATIONS

- NHO agrees that the current benefit period structure should be modified and strongly supports the changes now required by law.

- NHO finds nothing in this report that supports the conclusion that the Medicare or Medicaid Hospice Benefits should not be available to nursing home residents. Additionally, no actual data is presented to support a specific reduction in payments for hospice services provided in nursing homes.
- NHO reiterates its commitment to working with the Health Care Financing Administration to craft a payment mechanism for hospice care in the nursing home that addresses concerns related to overpayments. To craft an appropriate response will take reliable information and thoughtful analysis, neither of which is currently available to the government or the hospice community.

NHO is concerned that our objections to this study and its recommendation to eliminate the hospice benefit in the nursing home will be construed as a lack of interest in and support for continually improving the Medicare and Medicaid hospice benefits and reducing any “vulnerabilities.” Neither is the case.

Over the years, NHO has taken the following actions to improve the delivery of hospice care in the nursing home:

- In the absence of a government or medical community initiative, NHO has spent significant resources developing guidelines for establishing terminal prognoses to encourage the referral of patients to hospice care, but also to provide attending physicians and hospice physicians the tools to increase their certainty that only appropriate patients are admitted to hospice care.
- NHO has also spent considerable resources and almost a decade in an effort to improve the quality of hospice care provided in the nursing home, and to improve the relationship between the hospice and the nursing home while minimizing the potential for abusive behavior. These efforts have been made with minimal government assistance to clarify the rules governing these relationships.
- NHO has established a Nursing Home Task Force that continues to identify problems and solutions to this complex issue.
- Despite our differences, NHO has worked closely with the OIG to identify problems and to communicate these issues to hospices.
- NHO is also working closely with HCFA to develop new Medicare Conditions of Participation, including new provisions concerning hospice care provided in the nursing home. We have worked with HCFA and the fiscal intermediaries (FI's) on focused medical review, and we are also working with the FI's Medical Directors to design “Local Medicare Review Policies” that will provide FI's and hospices better guidance in admitting appropriate patients.

- We continue to support more frequent surveys of hospice programs and better surveyor training. One of our general concerns about the entire Operation Restore Trust experience is the expenditure of extraordinary sums of money to capture a few “bad apple” actors when the day-to-day operations of the government’s oversight efforts are left to flounder. Increasing the routine surveys of hospice providers beyond the current average of 10 percent per year by appropriately trained surveyors could substantially eliminate the problems that concern us today before they happen.

NHO thanks you for your consideration of our comments. While we cannot support your recommendations to limit hospice care in the nursing home, we are confident that the steps we have already taken and the efforts that have been undertaken by various government authorities will have the desired effect of limiting fraudulent and abusive behavior by hospices and nursing homes.

Sincerely,



John J. Mahoney
President



June 26, 1997

228 Seventh Street, SE
Washington, DC
20003-4306
(202)546-4759
Fax (202)547-9559

Rosemary J. Hurzeler
Chair

Diane H. Jones
Executive Director

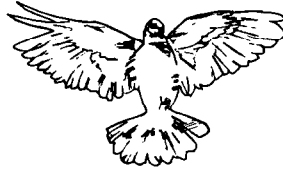
Mr. George Grob
Deputy Inspector General for Evaluation and Inspections
Office of the Inspector General
330 Independence Avenue, S.W.
Washington, DC 20201

George
Dear Mr. Grob:

The Hospice Association of America (HAA) would like to thank you and the Office of the Inspector General (OIG) for this opportunity to comment on the draft report, "Hospice Patients in Nursing Homes: Eligibility, Services, and Growth." HAA believes that while the report begins to identify some of the problems inherent with the hospice nursing home benefit, including the scope and intensity of services and reimbursement issues, the study is generally misdirected and fails to recognize the distinction between hospice and other health care services.

Our comments focus on the stated purpose of the study, which was "to examine eligibility, services, and growth in the number of hospice patients living in nursing homes." In our assessment: eligibility is examined by applying criteria from a source (*Medical Guidelines for Determining Prognoses in Selected Non-Cancer Diseases*) not available at the time patients being reviewed were enrolled in hospice care; the review of hospice services provided to nursing facility (NF) residents does not reflect an understanding of the difference between hospice care and long term care; and the growth in the number of patients served is criticized even though hospice is gaining national acceptance as an end-of-life option for care.

HAA believes that hospice services should not be denied to eligible NF residents, regardless of income status. While we would not support the elimination of the nursing home benefit, the recommendation to reduce Medicare payments for hospice patients living in NF is perhaps valid and HAA wholeheartedly supports further study and analysis in order to develop a reimbursement formula that accurately reflects the costs of hospice services. More importantly, it is clear from the study that the hospice industry must acknowledge, accept, and act upon its responsibilities in the delivery of comprehensive hospice services.



HAA looks forward to working with OIG to clarify the utility of this report. We are committed to activities that ensure Medicare and Medicaid monies for hospice care are well spent and Medicare beneficiaries who are terminally ill receive appropriate, quality hospice care.

Please do not hesitate to call if you have any questions regarding these comments. I can be reached at 202/546-4759.

Sincerely,

A handwritten signature in cursive script that reads "Diane".

Diane H. Jones
Executive Director

Enclosure

Hospice Association of America

EXECUTIVE SUMMARY

**Office of the Inspector General Report on
Hospice Patients in Nursing Homes: Eligibility, Services, and Growth**

OVERVIEW

HAA believes that while the report begins to identify some of the problems inherent with the hospice nursing home benefit, including issues of scope, intensity of services, and reimbursement, the study is generally misdirected and fails to recognize the distinction between hospice and other health care services. We would also be able to understand better the conclusions if the report had included the questions posed during interviews as well as the position of those being interviewed.

BACKGROUND

When the hospice "nursing home benefit" was added to the Medicare hospice benefit in 1986, hospice providers developed an appropriate model of hospice care for terminally ill patients who reside in a nursing facility (NF). The model, which has been used by the Health Care Financing Administration for state surveyor training, articulates three principles: 1) the NF is considered to be the patient's home; 2) the NF's staff are the patient's extended family; and 3) the same staff are members of the expanded hospice team. (Used in this context, "family" refers to person(s) who play a significant role in the patient's life. While NF staff do not replace the patient's own family members, they provide daily care and caring over extended periods of time, and in effect, become significant in the patient's life.) The Medicare hospice conditions of participation define the unit of care as the patient and family.

FINDINGS

Response to eligibility and length-of-stay

For patients with a diagnosis *other than cancer*, medical reviewers were asked to use a tool developed by the National Hospice Organization (NHO) in conjunction with HAA entitled *Medical Guidelines for Determining Prognoses in Selected Non-Cancer Diseases*. The guidelines were developed as a result of problems with inaccurate prognostications. HAA believes that it is inappropriate to use the tool to assess the appropriateness of patients enrolled in hospice prior to the publication of the guidelines.

Response to hospice services received by hospice NF patients

Statutory language defines the patient and family as the unit of care, not just the patient. It would have been instructive, and more comprehensive, had the inspections and discussions included services provided to the family, including the "nursing home family."

The study also raised the question of whether NF staff should be providing hospice care in addition to long term care. HAA believes another study would be more appropriate to determine what and how other health care providers should be caring for terminally ill patients. The interface between hospice and NF must be examined in order to ensure a "good death" for all who are terminally ill.

Response to the issue of growth of hospice services in NF

Currently only about 15%-17% of people in the US who die of disease-related causes are receiving hospice care. Access to a cost effective, humane, and compassionate approach to care for terminally ill patients should not be limited because the industry is growing too fast.

RECOMMENDATIONS

HAA believes that hospice services should not be denied to eligible NF residents, regardless of income status. HAA agrees that the hospice NF program should be evaluated with a focus on obtaining valid data related to costs. We also recommend that any legislation: 1) disconnect hospice payments from Medicaid room and board payments; 2) require studies of hospice nursing home programs to determine costs, scope, and intensity of services provided to hospice nursing home patients as compared to hospice home care patients; and 3) adjust Medicare payments for hospice services to nursing home patients according to verifiable, accurate data.

Hospice Association of America Comments

Hospice Patients in Nursing Homes: Eligibility, Services, and Growth

INTRODUCTION

When the hospice "nursing home benefit" was added to the Medicare hospice benefit in 1986, hospice providers developed an appropriate model of hospice care for terminally ill patients who reside in a nursing facility (NF). The model, which has been used by the Health Care Financing Administration for state surveyor training, articulates three principles: 1) the NF is considered to be the patient's home; 2) the NF's staff are the patient's extended family; and 3) the same staff are members of the expanded hospice team. (Used in this context, "family" refers to person(s) who play a significant role in the patient's life. While NF staff do not replace the patient's own family members, they provide daily care and caring over extended periods of time, and in effect, become significant in the patient's life.) The Medicare hospice conditions of participation define the unit of care as the patient and family. It is within this framework that the Hospice Association of America (HAA) will base its comments on the draft report, "Hospice Patients in Nursing Homes: Eligibility, Services, and Growth," prepared by the Office of the Inspector General (OIG).

There is little doubt that some hospice providers, despite having developed a conceptual framework for working with NF's, have been less than successful in implementing their NF programs. There is also general agreement that the hospice NF benefit should be protected from abuse, waste, and fraud. Both of these facts support active and ongoing inspections and the development of remedies to ferret out fraud and abuse as well as end any waste of Medicare dollars. However, HAA believes that all terminally ill Medicare beneficiaries have the right to freely access hospice care at the end of their lives. Equal access means providing the full scope and intensity of hospice services that are timely, appropriate, and professionally and compassionately delivered, regardless of the setting.

COMMENTS

Issue: Inspection and discussion was limited to services provided to the patient.

Comment: Since statutory language defines the patient and family as the unit of care, it is unclear why the OIG's inspections and discussions were limited to services provided only to the patient. It would have been instructive, and more comprehensive, had the inspections and discussions included services provided to the family, including the "nursing home family." Coordination of care and psychosocial support are hospice services delivered both to family members as well as interdisciplinary team members. Family members are often dealing with a myriad of psychosocial issues when a loved one is placed in a NF or, as in the majority of cases under inspection, when the NF resident becomes terminally ill. In addition, NF staff must be included in developing the plan of care as well as receiving hospice support in caring for a terminally ill patient. When measuring hospice services, it would seem that those provided to family members should be taken into consideration.

Issue: Definition of "services."

Comment: From the report and the tables in the report it appears as though "services" are being defined only as hospice visits using the methodology of inspecting hospice records and

conducting interviews. Since the constellation of hospice "services" involves comprehensive interdisciplinary coordinating activities, it would seem to be important to inspect all aspects of the delivery of hospice services. Inspection of hospice services should include telephone consultations, visits, and communications with all family members as well as members of the interdisciplinary team who deal with these issues.

Issue: Medical review contractor was instructed to determine whether NF services to patients changed after election of hospice.

Comment: NF services are not being inspected, hospice services are. Section 2082A, "Election of Hospice Benefit by Resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Non-certified Facility," states:

The SNF/NF Conditions of Participation are applicable to all of the residents in a SNF/NF facility. Neither the statute nor the regulations setting out SNF/NF requirements exempts hospice patients in a SNF/NF from those regulations.

It is unclear why the medical review contractor would be asking if NF services to patients changed after election of hospice. Perhaps a better question to ask is if the NF hospice patient received additional services from the hospice after election of the hospice benefit.

Issue: Medical review contractor instructed to determine if the services provided by the hospice staff could have been provided by the NF staff

Comment: When Congress enacted the hospice benefit, it defined the concept as a specific constellation of care, including services that can only be provided by hospice employees with professional management responsibilities and an interdisciplinary team of skilled professionals. It is unclear why the medical review contractor would be instructed to determine if hospice services "could have been provided by the NF staff."

If the point is to determine whether NF should be providing hospice care in addition to long term care, another study would be more appropriate. The Robert Wood Johnson Foundation's SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks for Treatments) project confirmed substantial shortcomings in care for seriously ill and dying hospitalized adults. Indeed, considerable national attention and resources are currently being directed at end-of-life issues and care. The interface between hospice and NF must be examined in order to ensure a "good death" for all who are terminally ill, and HAA would be pleased to participate in any research with OIG and others to reach this goal.

Issue: OIG inspectors spoke with 20 out of 22 hospice providers and 79 NF providers.

Comment: The report does not indicate the total number of NF providers, nor does it include the interview protocol. This raises a number of questions. Did the discussions involve only one or more than one NF and hospice provider per facility? It would be instructive to know how many actual NF were involved in the inspection rather than just the number of NF hospice patients. This is based on our assumption that the larger the number of hospice patients in any one facility, the more likely it is that the hospice philosophy and concept of care would be integrated into the NF culture. It would therefore be helpful to know the concentration of hospice patients in each NF, including the average and median number of hospice patients per facility in

order to better evaluate the findings. It would also be helpful to know if the findings were weighted because discussions were held with more than one provider from each facility.

Issue: In some cases the records showed that patients did have a terminal condition but were stable with little sign of deterioration or decline.

Comment: How is "terminal" defined by the medical reviewers? If a patient has a terminal condition with a life expectancy of six months or less, the patient is eligible to elect the Medicare hospice benefit, regardless of how long the patient lives or how stable the condition is. Hospice patients can stabilize for a period of time with hospice care and still be considered terminally ill.

Issue: For patients with a diagnosis *other than cancer*, medical reviewers were asked to use the National Hospice Organization's *Medical Guidelines for Determining Prognoses in Selected Non-Cancer Diseases*.

Comments: (1) We were pleased that the report notes the medical guidelines were not available to hospices when some of the patients being reviewed elected the hospice benefit. Was this taken into consideration when the medical reviewers made their determinations? The guidelines were developed as a result of problems with inaccurate prognostications; it is inappropriate to use the tool developed to correct the problems to assess patients enrolled in hospice prior to its publication.

(2) Seventy-three out of the 200 sampled patients had one of the four diseases covered by the guidelines. What were the diagnoses of the remaining 127 patients and what criteria were used to evaluate their records?

Issue: As a result of patients being ineligible for the hospice benefit at the time of their election, the average length-of-stay for these patients is significantly longer than patients found eligible for hospice care.

Comment: Did the study take into consideration the difference in lengths-of-stay between cancer and non-cancer patients? The "art" and "science" of prognostication are both underdeveloped and unrefined for non-cancer diseases, the course of the diseases are more unpredictable, and the majority of hospice NF patients have non-cancer diagnoses. The end result is longer lengths-of-stay for these patients than patients with cancer diagnosis.

Issue: The inspection found that the average length-of-stay for NF hospice patients was significantly higher than data recently released by NHO (181 days vs. 56.3 days).

Comments: (1) Why is there more than a three-fold difference in the lengths-of-stay between OIG and NHO? Does it call into question the measurement differences between the OIG sample or NHO's survey?

(2) What is the average length-of-stay for home-based patients in the hospices included in the study?

Issue: NF hospice patients receive nearly 46% fewer nursing and aide services than hospice patients living at home

Comments: (1) The report appears to use "visits" interchangeably with "services" (see earlier comment on this subject).

(2) There is no information regarding hospice interactions to coordinate the plans of care with NF staff, which is an important component of hospice care in a NF.

(3) Was an evaluation of the types of nursing visits conducted? The fewer number of nursing visits could be related to NF not using the hospice R.N. on-call availability as frequently as home-based hospice patients and families. This information would be important when determining any rate adjustments for the NF hospice program.

(4) Hospice is the only Medicare provider required to provide volunteer services, even though they are not reimbursable. Because of this, volunteer support, such as visits, phone calls, running family errands, and providing services to family members, are a vital component of hospice care and should be included in any inspection of hospice.

Issue: Table 2 compares medical reviews of NF hospice patients and preliminary results of OIG national sample of hospice patients.

Comment: Why not compare medical reviews of NF hospice patients to the sampled hospices non-NF patients? There is no information about practice patterns to determine if the sampled hospices practiced the same or differently in NF and home settings.

Issue: The report states, "One out of eight nursing homes we contacted claimed that, in all too many cases, hospices are not providing these services [additional support for nursing home staff, post death bereavement, family support, pain management, and minimal disruption to the daily routine] to nursing home patients."

Comments: (1) This is speculative, not empirical evidence.

(2) How were nursing and aide visits defined and counted?

(3) "Services" were not measured, nursing and nurse aide "visits" were the only elements included in the study which concluded that 46% fewer "services" were provided (see earlier comment on this subject).

(4) Were the discussions conducted with equivalent staff in each NF? What controls were in place to ensure against bias during the interviews?

Issue: Three out of four nursing home patients received only routine nursing and aide visits.

Comment: The inspection was designed to look only at routine hospice care, so the meaning of this conclusion is unclear.

Issue: The remaining one in four patients received additional services, which the report characterizes as services NF staff could have provided.

Comment: We are pleased that the report acknowledges some of the medical interventions by hospice reflect care options that are embodied in the hospice philosophy. However, it is unclear what purpose is served in stating that NF staff could have provided the same services as the hospice. Hospice services are not interchangeable with NF services. The examples given of care provided to NF hospice patients by hospice staff reflect the unique constellation of disciplines, skills, perspective, and problem-solving abilities hospice brings to the terminally ill patient and family. If the NF (or any other provider) could (or would) provide hospice services as defined by the Medicare hospice conditions of participation, then the hospice concept and philosophy of care would be fully integrated into the continuum of health care in the US. Until that time, hospice services must be delivered and reimbursed separately.

Issue: Overall costs for the care of hospice patients residing in NF appears to be substantially higher than for other hospice patients.

Comment: What factors were used to determine the costs of other community-based services for non-NF hospice patients that are funded by Medicare and Medicaid? Additionally, data should be collected about expenditures for hospitalizations and NF bed-hold costs while NF patients are hospitalized.

Issue: Potential growth in the number of hospice patients living in NF is enormous.

Comment: Currently only about 15%-17% of people in the US who die of disease-related causes are receiving hospice care. With the national spotlight on end-of-life issues, heightened emphasis on including end-of-life care in medical education, a prohibition of using federal dollars to fund physician-assisted suicide, the aging of "baby boomers", and increased integration of the delivery of health care, it can be expected that hospice care, including hospice care provided to NF patients, will continue growing at a fairly rapid rate. Access to a cost effective, humane, and compassionate approach to care for terminally ill patients should not be limited.

Issue: The report states that hospices have offered to reduce NF staff time for hospice patients.

Comment: This comment is located under the section "Nursing Home Market" and is addressing marketing to NF providers. The report earlier stated under "Three out of four nursing home patients received only routine nursing and aide visits. Nursing home administrators that we contacted are beginning to realize that patients in their facilities may not be getting the services hospices said they would provide. Hospices promise additional support for nursing home staff. . ." The hospice regulations state: "substantially all core services must be routinely provided directly by hospice employees and cannot be delegated to the SNF/NF." Hospices should be promising and providing additional support for nursing home staff.

Issue: OIG recommendation to eliminate or reduce Medicare or Medicaid payments for hospice patients living in NF

Comment: HAA agrees that the hospice NF program should be evaluated with a focus on obtaining valid data related to costs. HAA also recommends that any legislation: 1) disconnect hospice payments from Medicaid room and board payments; 2) require studies of hospice nursing home programs to determine costs, scope, and intensity of services provided to hospice nursing home patients as compared to hospice home care patients; and 3) adjust Medicare payments for hospice services to nursing home patients according to verifiable, accurate data.