



## Cost Savings when Hospice Care is Provided in the Nursing Home

Hospice in the Nursing Home Task Force – September 2012

### **Medicaid nursing home payments are lower when Medicare-Medicaid eligible beneficiaries elect Medicare hospice.**

Medicaid NH Room and Board payments (for Medicare/Medicaid beneficiaries) are paid to the hospice at 95% of the customary Medicaid rate. While hospices receive 95% of the customary rate, they typically “pass through” or reimburse the nursing facility for 100% of the customary rate. A study showed the practice of the State paying 95% of the customary NH per diem rate in 2007 alone saved Florida Medicaid \$9,958,700 in room & board payments.<sup>1</sup>

### **While the use of Medicare hospice care in nursing homes has grown, this growth hasn't outpaced that observed in the Medicare hospice program overall.**

The number of Medicare beneficiaries who elected hospice care grew by 98.6% between 1999 and 2006. The Medicare beneficiaries in nursing homes who enrolled in hospice doubled during the same time frame, but with this doubling there was only a slight increase in the proportion of total Medicare hospice beneficiaries residing in nursing homes. In 1999, 21.7% of Medicare hospice beneficiaries resided in nursing homes; this rose to 24.2% in 2002 and remained constant through 2006, at approximately 25%.<sup>2</sup> In 2009 the proportion of Medicare hospice beneficiaries in nursing homes was 27.5%.

- **During the last year of life Medicare hospice saves the Medicare program on average \$2,309 for each beneficiary served.**<sup>3</sup>
- **Nursing home residents with hospice care have lower rates of hospitalization and fewer hospital deaths.**<sup>4,5</sup>
- **Hospice philosophy and practice appears to “spill-over” to nursing home staff and greater hospice use by nursing homes has been associated with fewer hospitalizations for non-hospice residents.**<sup>4,5</sup>

For nursing home residents receiving the hospice care benefit, the probability of end of life hospitalization(s) is reduced. Therefore, transitions that adversely affect residents' quality of life are reduced. The resulting improved quality of life coupled with potential Medicare savings powerfully supports the benefit's value in the nursing home setting. Additional benefits of hospice care delivered in the nursing home include enhanced pain management and increased family satisfaction with end-of-life care.

### **Hospice Patients receiving care in the nursing home are primarily geriatric patients with advanced chronic illness, and 56% of persons who die in nursing homes have mild to advanced dementia.**<sup>5</sup>

Hospice patients in nursing homes are different from hospice patients at home; they are a very vulnerable older population. The average age of nursing home patients is 76.6 years compared to 70.3 years for home patients and nursing home patients are more often female (55.3% vs. 47.4%), unmarried (68.5%vs. 44.6%), and dually eligible. They also have higher rates of dementia

and other non-cancer diseases as primary diagnoses.<sup>6</sup> Considering the vulnerability of hospice patients in nursing homes, research is needed to better understand on how discharge from hospice affects end-of-life care transitions and thus the costs and quality of care.

**Hospice access for vulnerable nursing home residents is restricted since most residents qualifying for Medicare Skilled Nursing Facility (SNF) cannot simultaneously receive hospice,<sup>5</sup> and this may affect the meeting of resident preferences regarding desired end-of-life care.**

Medicare beneficiaries who elect hospice care must waive their right to other Medicare Part-A payments for services related to their terminal illness. Under the Medicare SNF benefit, Medicare pays a significant portion of the short-term care (100% for the first 20 days), which is financially advantageous to both the nursing home and the resident. Inherent pressures may exist for dying nursing home residents to choose between their Medicare Part-A benefits - SNF or hospice. For dually eligible residents, if the resident elects to receive hospice care, the nursing home receives a lesser amount for the room and board (Medicaid versus Medicare payment). For private pay residents, residents and families must assume the financial responsibility. Today, it is a more frequent practice for dying residents to be admitted under their SNF benefit for “end of life” care. This contributes to later hospice referrals and an increased likelihood that residents will have hospital deaths and aggressive care at the end of life.<sup>5,7</sup> Ultimately, the financial tension between the benefits appears to impact the decision-making processes and perhaps the meeting of preferences regarding the choice of care. Needed is cost-effectiveness research to examine the impact of residents’ choices between their Medicare Part-A benefits--SNF or hospice care.

**There is no evidence that hospice care is diminished when provided in the nursing home versus other settings.<sup>6</sup>**

It is imperative that hospices provide comparable individualized care for patients receiving care in the home versus the nursing home setting, and research has supported that this is the case. Two studies found the volume of hospice care in nursing homes to be equivalent to care provided in non-nursing home settings.<sup>6</sup> While there is some suggestion that hospice care provided in the nursing home is somewhat more comprehensive (in terms of hospice disciplines providing care), the volume of care appears to be equivalent. Also, research has shown that there is no reduction in nursing home aid staffing when nursing homes introduce hospice or increase their volume of hospice use.<sup>8</sup>

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<sup>1</sup> Will Elimination of the Optional Medicaid Hospice Benefit Save the State of Florida Money? A White Paper, The Moran Company, December 2008.

<sup>2</sup> Miller SC, Lima J, Gozalo P, Mor V. 2010. The Growth of Hospice Care in U.S. Nursing Homes, *Journal of American Geriatrics Society*, 58:1481-88.

<sup>3</sup> Taylor DH et al. 2007. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Social Science & Medicine*, 65: 1466-1478.

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<sup>4</sup> Miller SC, Gozalo P, Mor V. 2001. Hospice Enrollment and Hospitalization of Dying Nursing Home Patients. *The American Journal of Medicine*, 111: 38-44.

<sup>5</sup> Miller SC, Lima JC, Looze J, Mitchell SL. 2012. Dying in US Nursing Homes with Advanced Dementia: How Does Health Care Use Differ for Residents with, versus without, End-of-Life Medicare SNF Care? *Journal of Palliative Medicine*, 15(1):43-50.

<sup>6</sup> Stevenson DG, Huskamp HA, Grabowski DC, Keating NL. 2007. Differences in Hospice Care between Home and Institutional Settings. *Journal of Palliative Medicine*, 10(5):1040-1047.

<sup>7</sup> Miller, S. C., Lima, J. C., & Mitchell, S. L. (in press). Influence of Hospice on Nursing Home Residents with Advanced Dementia Who Received Medicare-Skilled Nursing Facility Care Near End of Life. *Journal of American Geriatrics Society*.

<sup>8</sup> Tyler C, Leland N, Lepore M, Miller SC. 2011. Effect of Increased Nursing Home Hospice Use on Nursing Assistant Staffing. *Journal of Palliative Medicine*, 14(11): 1236-1239.