

**NEW HOSPICE FACILITY REGULATIONS:  
IMPLICATIONS OF USE BY FOR-PROFIT ENTITIES**  
**PRI Staff Preliminary Report**  
**July 23, 2012**

**Observations In Brief:**

(Discussion beginning on page 12)

- I.** For-profit entities are already involved in the provision of hospice care in Connecticut.
- II.** While there is certainly general debate about the impact of for-profit provider status on health care delivery (see Item III), the reason for the concern about for-profit entities taking advantage of the proposed hospice inpatient facility regulations and providing low quality-care is somewhat unclear at this time. This is given the prevalence of hospice care currently being provided to residents of nursing homes by hospice care agencies, pursuant to contracts, and the attendant possibilities for system abuse/profit-seeking that have been the subject of federal investigations in other states.
- III.** Research studies identify differences between for-profit and nonprofit hospices, but cannot make conclusions about quality of care differences.
- IV.** Not meant as a definitive statement about nurse-to-hospice patient ratios in inpatient settings for hospice care, but as a point of information, hospice patients in Connecticut now can receive general inpatient care for pain control and symptom management in skilled nursing facilities, which are not required to have specific nurse-to-patient ratios.
- V.** The concurrent legislative and regulatory processes related to the establishment of a new type of hospice inpatient facility in Connecticut over the last year and a half complicated a situation that appears to have been in limbo for many years.
- VI.** The current proposed regulations before the regulations review committee will not affect the status of The Connecticut Hospice at Branford. It will be able to continue providing its hospice inpatient services the same way it has always provided them.

**Background**

On June 29, 2012, the PRI committee directed its staff to study what implications, if any, might arise if a for-profit entity owned and operated a “hospice inpatient facility” in the state, under a proposed new type of state license for such hospice inpatient facilities. The concern is whether a for-profit entity, especially one that is publicly traded and needing to show a return on investment for its shareholders, would provide low-quality hospice patient care at this new type of hospice inpatient facility. That question is among other quality of care concerns raised over the course of the mandatory regulation adoption process that began formally with these proposed regulations in January 2011, which was preceded by other efforts dating back to at least 1992.

At the time PRI launched this inquiry, it was likely that the proposed regulations, rejected without prejudice on June 26 and revised based on LCO comments, would be back on the regulations review agenda for July 24, 2012, which indeed has happened. This report, then, represents an effort to provide information pertinent to the proposed new type of hospice facility given the short period of time for background research, cognizant of the regulations review process underway. Assessing the impact of any regulation prior to its implementation cannot be done with certainty, but in this case it seems that clarifying issues might be of assistance. To that end, the report:

1. Describes what hospice care is and how it currently provided in Connecticut and under what conditions, and provides data showing where hospice care is actually being delivered;
2. Describes the proposed regulations to establish a different type of facility where hospices services may be provided; and
3. Presents observations related to the study question based on the above.

### **Hospice Care in Connecticut: What It Is and How It Happens**

The terminology related to hospice care can be confusing and an obstacle to understanding the proposal to establish a new kind of hospice facility. The word “hospice” generally means a philosophy of providing comfort and supportive care for persons who are terminally ill, rather than curative care. The word is used also to mean a facility or a specific program of care. In reality, both state Department of Public Health (DPH) licensing requirements and federal regulations (largely related to reimbursement by Medicare and Medicaid) combined govern how hospice services are provided, as described below.

**Who is eligible?** Since 1982, hospice care has been a specific health benefit offered by Medicare, which remains the primary payer. Hospice services include nursing care, counseling and home health aide services, as well as drugs and medical supplies. It is also a Medicaid benefit, offered in Connecticut since 2008, and may also be covered by private insurance. The discussion in this report focuses on Medicare-reimbursed care.

A person may receive Medicare hospice care (benefits) when all the following conditions are met: (from Medicare Hospice Benefits, CMS)

- The person is eligible for Medicare Part A (hospital insurance--over 65, under 65 with disability, or with certain diseases)
- The person’s doctor and the medical director of the hospice program certify that a person is terminally ill and has less than six months to live if the illness runs its normal course
- The person signs a statement choosing hospice care instead of other Medicare-covered benefits to *treat* the terminal illness (Medicare will still pay for health care not related to the terminal illness)
- The person receives hospice care from a Medicare-certified provider.

Once determined eligible, there are conditions to continue receiving Medicare hospice benefits:

- After the first 90 days in hospice care, the person needs to be recertified as terminally ill and with less than six months to live, by the hospice program physician or nurse practitioner.
- After another 90 days in hospice care, the same re-certification as above needs to occur.
- Thereafter, there are unlimited 60 day benefit periods between re-certification. Since January 1, 2011, though, there must be a “face-to-face encounter” between the certifying hospice physician or nurse practitioner and the person 30 days before the first 180 days of hospice care ends. (This rule change was made out of concern that patients were being re-certified who in fact were not terminally ill)

**Who provides hospice care in CT?** One of the conditions of Medicare hospice coverage eligibility for a patient is that the hospice care is provided by a Medicare-certified provider. To be a Medicare-certified provider in Connecticut, a provider needs to comply with the Medicare “Conditions of Participation” set out in federal regulation and needs to hold:

- 1) a Connecticut home health care agency license, with additional DPH approval to provide hospice services (referred to as a “**hospice care agency**” for the rest of this report); **or**
- 2) a Connecticut short-term hospital, special, hospice license (referred to as a “**hospice hospital**” for the rest of this report).<sup>1</sup>

**Hospice care agencies.** These agencies are authorized to provide hospice services, either directly or via contract, but are not authorized to have a distinct facility in which to provide these services. Presently, there are 101 state licensed home health care agencies; 29 of these are hospice care agencies. Regulations governing the provision of hospice services by hospice care agencies were established in 1990. If and when a patient needs services that the hospice care agency cannot provide directly (e.g., general inpatient care for pain control and symptom management or respite care for the family caregivers), these agencies are required to have contracts<sup>2</sup> with other providers (e.g. general hospitals, skilled nursing homes).

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<sup>2</sup> These contracts are called “Coordination of Inpatient Care Agreements.” The patient is still under the primary care of the hospice care agency, but is also obviously under the care of another health care facility. PRI staff was not able in this time period to analyze the actual use of general hospitals by hospice care agencies for general inpatient care for their patients, but based on what PRI staff knows to date: 1) the contracts between a hospice care agency and a general hospital do not guarantee that a general hospital bed will be available at any given contracted general hospital when the need arises; and 2) a general hospital may, and anecdotally has, asked for more than the Medicare inpatient reimbursement as payment from the hospice care agency, effectively making a contract useless.

Under the hospice care agency license, the agency is the primary entity coordinating the provision of care and services to patients who are terminally ill from the time of admission to hospice services throughout the course of the illness until death or discharge. Each patient must have an individualized plan of care developed by an interdisciplinary team of professionals (and can include volunteers).

***Hospice hospitals.*** This license was created in 1979 for The Connecticut Hospice in Branford to provide a facility solely for hospice inpatient care, which focuses on pain control and symptom management. Connecticut Hospice pioneered hospice home care in the United States in 1974, but by 1979 had identified a need for an inpatient facility to provide care not as well provided at home. The Connecticut Hospice at Branford was the only licensed hospice hospital until recently, when the for-profit health care company VITAS became licensed as a hospice hospital co-located with St. Mary's Hospital in Waterbury.<sup>3</sup>

The two hospice hospitals also each have, or are affiliated with, a hospice care agency license that are included in the 29 total hospice home care agencies.

***Palliative care is different from hospice care.*** Hospice care is one type of palliative care, but palliative care is broader than hospice care, and generally focuses on pain and symptom-relieving care for persons who are acutely or chronically ill (but not necessarily terminally ill). Many general hospitals have palliative care programs, and palliative care beds, but this is not hospice care for two reasons: those general hospitals are not licensed by the state of Connecticut to provide hospice care and thus those general hospitals are not Medicare-certified as hospice providers. The Connecticut Hospice actually provides palliative care along with hospice care, so the 50+ bed hospice hospital is not only serving hospice patients. (When a general hospital, under contract with a hospice care agency, provides general inpatient care to a hospice patient, the hospice care agency will pay the general hospital from the Medicare hospice reimbursement.)

Indeed, without one of the two licenses noted above, state law does not allow any organization to use the title “hospice” or “hospice care program” or make use of any title, words, letters or abbreviations indicating or implying that the organization is licensed to provide hospice services. (C.G.S. Sec. 19a-122b).

**State law requires both types of hospice license holders to provide hospice care in all settings.** Since 2008, state law requires that any organization seeking one of these licenses for the first time must agree to provide hospice care services for terminally ill people on a 24-hour basis in all settings, including but not limited to a private home, nursing home, residential care home, or specialized residence that provides supportive services. The organization also needs to present to DPH “satisfactory evidence that such organization has the necessary qualified personnel to provide services in such settings.”

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<sup>3</sup> In the hospice hospital regulations, hospice is defined as a “short-term hospital having facilities, medical staff and necessary personnel to provide medical, palliative, psychological, spiritual, and supportive care and treatment for the terminally ill and their families including outpatient care and services, home-based care and services and bereavement services.”

## Hospice Care Required by State License and Medicare Reimbursement

Per state license requirements, a hospice care agency is required to give, and ultimately be responsible for the kind of care the patient needs based on the patient's individual plan of care, including respite care and general inpatient care for pain control and symptom management (requiring 24 hour nursing supervision and ready physician access), requiring a facility separate from a patient's home (and a contract). For Medicare-reimbursement purposes, which pays on a per-diem basis, the patient is likewise supposed to receive the care needed per the patient's care plan, but for Medicare purposes "levels of care" are distinguished because they trigger different levels of per-diem reimbursement. These are<sup>4</sup>:

- **Routine Home Care:** A routine home care day is a day on which an individual who has elected to receive hospice care is at home.
- **Continuous Home Care:** A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services, or both, may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.
- **General Inpatient Care:** A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.—needs 24 hour monitoring, ability for a doctor to change orders quickly.
  - “To receive payment for general inpatient care under the Medicare hospice benefit, beneficiaries must require an intensity of care directed toward pain control and symptom management that cannot be managed in any other setting. It is the level of care provided to meet the individual's needs and not the location of where the individual resides, or caregiver breakdown, that determine payment rates for Medicare services.”
- **Inpatient Respite Care:** An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite. (Medicare limits to five days in a row)

Most hospice care in Connecticut is provided by a hospice care agency in a private residence. A hospice care agency is required to provide hospice care wherever the patient is, though, so if a patient is in a nursing home, and becomes eligible for hospice care, the hospice care agency will provide the needed hospice care there.

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<sup>4</sup> From National Hospice and Palliative Care Organization website, accessed July 17, 2012

Table 1 shows the settings in Connecticut where hospice care can be provided and the type of care provided. The locations of care in blue show all the different locations that a patient under the care of a hospice care agency may actually receive the care, all the while the primary responsibility of the hospice care agency.

<b>Table 1. Different Levels of Hospice Care Services Are/May Be Provided in A Number of Settings in Connecticut (and Reimbursed by Medicare)</b>				
<b>Level of Care for Hospice-Reimbursement</b>	Routine [Home] Care	Continuous [Home] Care	Respite Care	General Inpatient Care (for pain and symptom control)
<b>Location of Care</b>				
Private Residence	Yes	Yes	No	No
Skilled Nursing Home*	Yes (per HCA contract)	No	Yes (per HCA contract)	Yes (per HCA contract)
Not Skilled Nursing Home*	Yes (per HCA contract)	Yes (per HCA contract)	Yes (per HCA contract)	No
Assisted Living Facility*	Yes (per HCA contract)	Yes (per HCA contract)	Yes (per HCA contract)	No
General Hospital**	No	No	Yes (per HCA contract)	Yes (per HCA contract)
Connecticut Hospice and Branford and VITAS Waterbury	n/a	n/a	Yes	Yes
<i>Proposed Hospice Inpatient Facility</i>	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>
<p>* These facilities may be considered the patient’s home, which is why routine home care would be provided there; routine home care is intermittent home care provided by hospice care agency staff (i.e., room and board paid separately to the nursing home via Medicaid or other LTC payer). A skilled nursing home can also provide general inpatient care (due to 24-hour staffing and physician availability to change orders) whether the patient is already living at the nursing home and receiving routine home care, or was receiving routine home care at a private residence and needed general inpatient care. In either case, if the hospice care agency has a patient in a nursing home, the hospice care agency needs to have a contract with the nursing home spelling out certain understandings.</p> <p>**A general hospital is not considered the hospice patient’s home, but can provide general inpatient care if needed for a patient under the care of a hospice care agency. As with nursing homes, the hospice care agency needs to have a contract with the hospital spelling out certain understandings.</p>				

## State Snapshot-2010

Through use of Medicare claims data for 2010, a snapshot of hospice care delivery in Connecticut can be seen. It is important to remember that while Medicare is the largest payer of hospice care, Medicaid and private insurance provide coverage also. Also, for the two hospice hospitals that also operate hospice care agencies, their data is combined in this discussion.

Figure 1 on the next page shows some provider-specific information, but first as an overview, in calendar year 2010:

- There were 30 Medicare-certified hospice providers, which served a total of 11,210 Medicare hospice beneficiaries (the current number is 29).
- The number of Medicare beneficiaries they each served in 2010 ranged from 33 to 2,124, with an average daily census from 5 to 240.
- Four were for-profit and 26 were non-profit.
- The mean number of days for a person in hospice care was 49 (compared to 71 nationally), and the median, 15 (compared to 24 nationally).

Source of data: Hospice Analytics, Colorado Springs, CO (4/12/12)

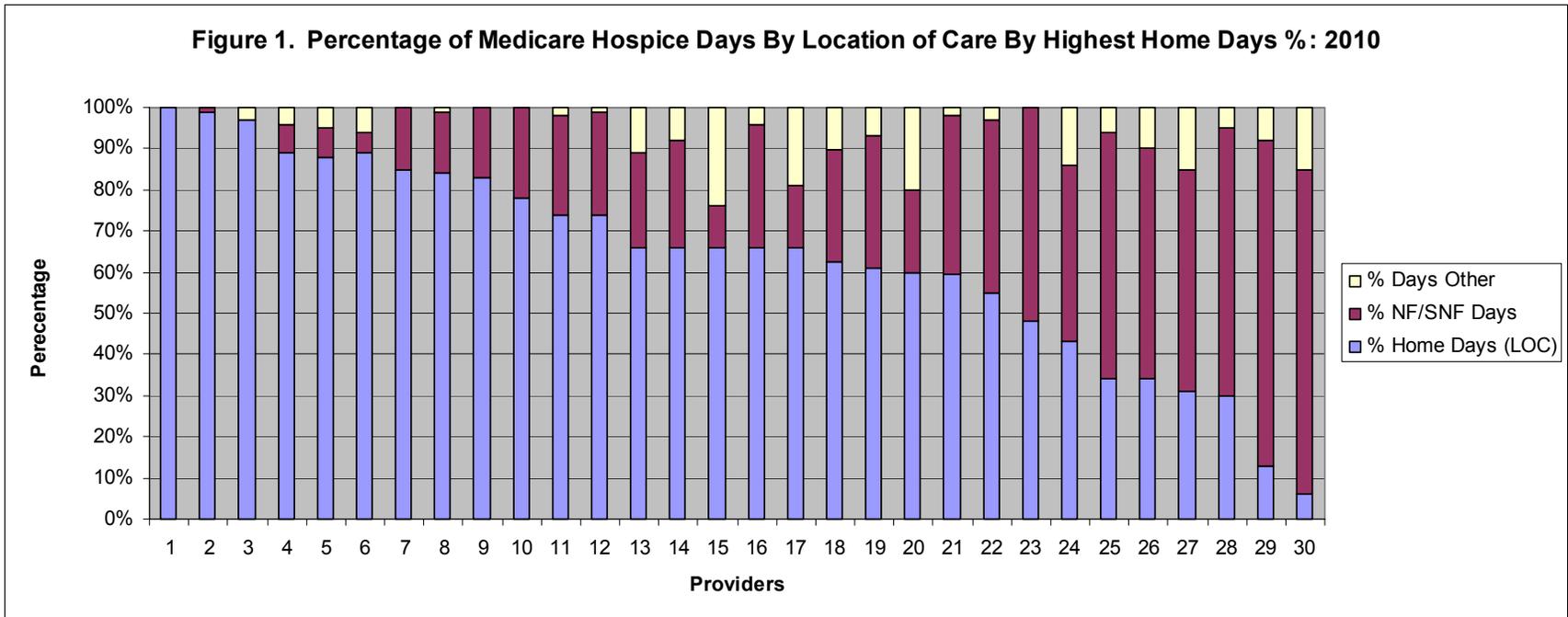


Figure 1 above shows for each provider the percentage of beneficiary days spent at home (meaning private residence), at skilled and not skilled nursing homes (equivalent to Connecticut’s chronic and convalescent nursing home and rest home with nursing supervision, respectively) or other (which would include general hospitals and the hospice hospitals) for general inpatient care services for pain control and symptom management.)

It should be noted that these are percentages and not numbers; because there is a wide range of patient size among the hospice care agencies, the percentages do not represent similar numbers of patients. The figure does show that while hospice care is mostly provided at home, almost all hospice care agencies served a portion of their patients at nursing homes, with some serving a significant portion there.

As Table 1 showed earlier, different types of care can be provided at different locations. To see what level of care was being provided at the different locations, in particular skilled nursing facilities, those two elements were analyzed. A number of caveats must be made about the results, show in Table 2.

What is shown in Table 2 is based on Medicare claims data where the patient had all days of service in one location and at one level of care, covering 77 percent of all Connecticut Medicare hospice patients in 2010. While not covering all the Connecticut Medicare experience, it does provide meaningful information about hospice care in Connecticut: more than three-quarters of the patients received all their hospice care in one place. This means that the remaining 23 percent were patients who moved between different locations and different levels of care.<sup>5</sup>

To understand what kind of care was provided at nursing homes – i.e. was it routine care, respite care or inpatient care (using the proxy of reimbursement rate level), the location of care data was further divided by level of care data. The table shows that of the 77 percent of Medicare beneficiary days where the person stayed in one place, 51.7 percent of the days were at home, with the person receiving routine care, and over 37 percent of the days were at nursing homes, also receiving routine care.

<b>Table 2. Percentage of Medicare Hospice Beneficiary Days by Location of Care and Level of Care:</b> Based on all Medicare 2010 hospice claims where the beneficiary had all days of service in one location and at one level of care (77% of all CT Medicare data)				
	Routine [Home] Care	Continuous [Home] Care	Respite Care	General Inpatient Care
Home	51.7%	-	-	-
Skilled Nursing Facility	22.9%	-	-	0.7%
Nursing Facility	14.7%	-	-	-
Assisted Living Facility	4.5%	-	-	-
Inpatient Hospice	-	-	-	2.9%
Inpatient Hospital	0.2%	-	-	2.2%
N=448,404 Medicare hospice days.			Source of data: Hospice Analytics	

<sup>5</sup> Also missing from the data used for Table 2 are results that are too small to report per Medicare protocol.

## **Proposed New Hospice Inpatient Facility**

Presently, the only hospice-only inpatient facilities in Connecticut are the hospice hospitals, Connecticut Hospice in Branford and the Vitas Inpatient Unit affiliated with St. Mary's Hospital in Waterbury. The proposed new hospice inpatient facilities would permit hospice-only inpatient facilities under a different set of regulations than what governs the current hospice hospitals. In addition to providing general inpatient care for pain control and symptom management, the new facilities would also provide respite care to a patient's family and offer a "home" to a hospice patient who does not have a viable private residence option.

As discussed earlier, most hospice care is provided by state licensed hospice care agencies in hospice patients' private residences. For a number of reasons, though, a patient who is terminally ill may not be able to receive care at home because: 1) a lack of a live-in primary caregiver, or other circumstance prevents such care-giving or 2) a need for pain control and symptom management requires services not available at home. Also, when a patient is receiving hospice services at home, family members caring for the terminally ill patient may need respite care, requiring a place for the patient to be cared for temporarily.

The current option for hospice care agency patients in Connecticut when hospice care cannot be provided at a private home for some reason and routine "home" care is needed, is a nursing home,<sup>6</sup> depending on bed availability. The current option for hospice care agency patients in Connecticut when hospice care cannot be provided at a private home because the type of care needed cannot be provided at home—pain control and symptom management—are: skilled nursing homes, general hospitals, and the two hospice hospitals, depending on bed availability.

As Table 2 shows, over 37 percent of patients receive hospice care in nursing homes of a routine nature, with less than 1 percent receiving general inpatient care in a nursing home setting. Two and two-tenths (2.2) percent of hospice care agency patients received care at general hospitals, for pain control and symptom management.

As explained, regulations require the agency to have a contract with any nursing home or hospital where it would like to provide inpatient services, which contract is to include an agreement by the facilities to make the facilities more conducive to hospice care. The supporters of the proposed new facility type want the option to provide inpatient care in a facility focused solely on hospice patients, as well as respite and routine "home" care, in the communities where the patients have established connections.

Persons opposing the proposed new facility type ask why entities seeking to provide hospice inpatient services in a free-standing, hospice-only facility do not just apply for the same license that the Connecticut Hospice in Branford and VITAS in Waterbury hold. A companion

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<sup>6</sup> The relationship between the nursing home stays and the need (and eligibility) for hospice care is unknown. Based on the literature, it seems that many patients determined eligible for Medicare hospice coverage and who receive hospice care at nursing homes are already nursing home residents when a terminal diagnosis was made. It is unknown how many, if any, nursing home residents receiving hospice care went to a nursing home specifically to receive hospice care.

concern is that the proposed regulations do not require a specific nurse-to-patient ratio and on-site pharmacist, as do the current hospice hospital regulations.

One answer cited is that the regulations on which those hospice hospital licenses are based were put in place in 1979 and appear dated (e.g., the specific treatment of physical plant, the provision that there be no more than four beds to a room, even the explicit requirements for telephone booths and water fountains). The question is does it make sense to require new entities to comply with outdated requirements. The fact that VITAS in Waterbury, a national company, chose that path recently shows it can be done. In its research, though, PRI staff has not come across any proposals to update the hospice hospital regulations to make them more current for a new entity to comply with.

PRI staff reviewed the history behind C.G.S. Sec. 19a-122b, first on the books in 1992 (see Figure 2). It seems like an implied expectation was established with that statute that a different kind of hospice inpatient facility would be developed after a pilot, and that DPH would eventually establish regulations for the new type of hospice facility. The pilot authorization date was extended several times, with the last extension occurring in 2002, to October 1, 2006. In 2003, both the references to the pilot basis and authorization date were deleted.

The presence of the statute, with its implied expectation, may explain why no Connecticut-based entity aware of the statute's history has chosen to pursue a license as a hospice hospital. A main concern about the proposed hospice inpatient facility as compared to current hospice hospital regulations is the absence of nursing staff-to-patient ratios.

**Figure 2. Public Act 92-33, Codified as First Version of C.G.S. Sec. 19a-122b**

**PUBLIC ACT NO. 92-33**  
**AN ACT CONCERNING THE OPERATION OF RESIDENCES FOR**  
**HOSPICE CARE.**

Section 1. (NEW) Notwithstanding the provisions of chapters 368c and 368v of the general statutes, an organization licensed as a hospice pursuant to the public health code or certified as a hospice pursuant to 42 U.S.C. Section 1395x, shall be authorized, until October 1, 1995, to operate on a pilot basis a residence for terminally ill persons, for the purpose of providing hospice home care arrangements including, but not limited to, hospice home care services and supplemental services. Such arrangements shall be provided to those patients who would otherwise receive such care from family members. The residence shall provide a homelike atmosphere for such patients for a time period deemed appropriate for home health care services under like circumstances. Any hospice which operates a residence pursuant to the provisions of this section shall cooperate with the commissioner of health services to develop standards for the licensure and operation of such homes.

Sec. 2. This act shall take effect from its passage.

Approved May 1, 1992

## OBSERVATIONS

Based on the background above, and as discussed further here, PRI staff make a number of observations related to the immediate study question based on its research to date – that is, what implications, if any, might arise if a for-profit entity owned and operated a “hospice inpatient facility” in the state, under a proposed new type of state license for such hospice inpatient facilities – and also comments on some related areas.

### RE: FOR-PROFIT STATUS AND QUALITY OF CARE

#### **I. For-profit entities are already involved in the provision of hospice care in Connecticut.**

- Currently, four of the 29 licensed hospice care agencies are for-profit.
- One of the hospice hospitals, VITAS, is for-profit.
- All of the hospice care agencies contracts with skilled nursing homes, the majority of which are for-profit facilities.
- Per Medicare data for 2010, over 37 percent of Medicare patient days (for those who received care in one place) were spent at nursing homes.

**II. While there is certainly general debate about the impact of for-profit provider status on health care delivery (see Item III), the reason for the concern about for-profit entities taking advantage of the proposed hospice inpatient facility regulations and providing low quality-care is somewhat unclear at this time. This is given the prevalence of hospice care currently being provided to residents of nursing homes by hospice care agencies, pursuant to contracts, and the attendant possibilities for system abuse/profit-seeking that have been the subject of federal investigations in other states.**

The general concern *nationally* with how some hospice care providers handle nursing home patients and hospice care is in two areas. One concern, within the “rules”, is that a hospice provider will “cherry-pick” nursing home patients who are terminally ill for its caseload, who are often lower-cost hospice patients (e.g., less hospice staff travel from residence to residence, when multiple patients live at the nursing home). The other concern is when a provider operates outside the “rules”, by colluding with nursing home providers to certify persons as terminally ill who really are not, and knowingly collect per diem Medicare reimbursement well past the six-month time period.

Medicare, as the prominent payer of hospice care, is aware of the potential for fraud and abuse in the hospice area, regardless of type of provider. For example, the concerns raised by the federal Office of Inspector General related to companies making arrangements with nursing homes and “cherry-picking” nursing home residents to sign up for hospice services are being addressed by Medicare, including:

- face-to-face encounters between doctors and patients after 180 days for re-certifying the terminally ill status (to address invalid hospice eligibility determinations); and

- consideration of reimbursement rate changes that recognize hospice care costs are higher at the beginning and end of care.

According to the Department of Public Health, Connecticut recognized the potential problem of hospice providers “cherry-picking” hospice patients in nursing homes in 2008, when it required statutorily that any new licensed hospice care agency had to provide hospice care in all settings. This means that a hospice care agency needs to be able to show it is also serving hospice patients at private residences, as well as nursing homes. Further, the organization also needs to present to DPH “satisfactory evidence that such organization has the necessary qualified personnel to provide services in such settings.” *This “all settings” requirement will apply to the proposed new hospice inpatient facilities as well.*

Reliance on the new regulations to protect Connecticut hospice patients and their families and provide good quality care is also based on the role of Department of Public Health to carry out its regulatory inspection and enforcement responsibilities. Those include the inspections it performs for Medicare (called surveys), and its complaint investigations.

**Reimbursement issues.** While quality issues around hospice care are under the purview of DPH, it has little to do with reimbursement. There are no doubt possibilities for profit-seeking, bill-padding, and other abuses in the provision of hospice care, certainly based on reports from other states. Much of that system abuse may be based on Medicare reimbursement issues, and can be used or “gamed” by any provider, not just for-profits.

**III. Research studies identify differences between for-profit and nonprofit hospices, but cannot make conclusions about quality of care differences.**

**2011 study.** A study looking at the implications of profit status on hospice care was published in the February 2, 2011 Journal of the American Medical Association (Vol. 305, No. 5 pp/ 472-477). Specifically, the objective of the study was to “compare patient diagnosis and location of care between for-profit and nonprofit hospices and examined whether number of visits per day and length of stay vary by diagnosis and profit status.”

Study findings included:

- *Diagnosis and location of care both varied by profit status. Compared with nonprofit hospices, for-profit hospices had a lower proportion of patients with cancer...and higher proportions of patients with dementia...and other diagnoses.*
- *Compared with nonprofit hospices, for-profit hospices also had a higher proportion of patients residing in nursing homes and a lower percentage residing at home.*
- *After full adjustment, LOS (length of stay)remained significantly longer in for-profit hospices compared with nonprofit hospices*

- *For-profit hospices have significantly more patients with stays exceeding 365 days and fewer patients with stays less than 7 days.*<sup>7</sup>

Despite these findings, in describing the study limitations, the report stated:

*Finally, and perhaps most importantly, we are unable to assess the relationship between profit status and quality of care. While our study improves on previous research by assessing the number of visits per day by various hospice personnel, we lacked important information on the length of each visit and care provided. For example, we could not distinguish between a home health aide visit that consisted of a 5-minute “check-in” and a half-day visit providing assistance with activities of daily living.....*

The study noted the current debate about reforming the Medicare Hospice Benefit, and that the Medicare Payment Advisory Committee (MedPAC) was recommending certain changes for 2013 (i.e., paying higher rates at the beginning and end of a hospice stay).

**2002 study.** An earlier study based on California’s hospice experience published in the Journal of Palliative Medicine found that “...the for-profit hospices appear to be selecting different types of patients than the not-for profit hospices and that this differential patient selection in turn explains much of the difference in the way the for-profits and not-for-profits deliver care.”<sup>8</sup>

**RE: THE NURSE TO PATIENT RATIO**

**IV. Not meant as a definitive statement about nurse-to-hospice patient ratios in inpatient settings for hospice care, but as a point of information, hospice patients in Connecticut now can receive general inpatient care for pain control and symptom management in skilled nursing facilities, which are not required to have specific nurse to patient ratios.**

**RE: PROCESS**

**V. The concurrent legislative and regulatory processes related to the establishment of a new type of hospice inpatient facility in Connecticut over the last year and a half complicated a situation that appears to have been in limbo for many years.**

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<sup>7</sup> In regard to hospice stays over six months, the study noted that “research demonstrates that it is difficult for clinicians to prognosticate, especially for patients with non-cancer diagnoses.” It also reported that hospice patients with stays longer than a year can be “particularly lucrative for hospices in a per diem reimbursement system because, as we have found, they receive fewer visits per day from skilled hospice personnel.”

<sup>8</sup> Lorenz et al, *Cash and Compassion: Profit Status and the Delivery of Hospice Services*, Journal of Palliative Medicine, Vol. 5, Number 4, 2002, pp 507-514

**VI. The current proposed regulations before the regulations review committee will not affect the status of The Connecticut Hospice at Branford. It will be able to continue providing its hospice inpatient services the same way it has always provided them.**

The original proposed regulations filed in January 2011, and the subject of the April 2011 public hearing, did appear to affect the Connecticut Hospice at Branford by repealing the regulations on which its license was based, with the plan that the new hospice inpatient facility regulations would now govern the Branford hospital. However, after the public hearing, the proposed regulations were amended to keep the short-term hospital, special, hospice regulations the same. Only the section numbers changed.

Unfortunately, it appears the amended final regulations were not released by DPH until March 19, 2012, three days after the Public Health Committee's March 16, 2012 public hearing on a bill (HB 5499) requiring DPH to promulgate regulations for a hospice inpatient facility (presumably because of the problems the proposed regulations were having. Testimony from that public hearing suggests that some may have thought that the services at Connecticut Hospice at Branford were in jeopardy, which was not the case.