House
Legislative
Analysis
Section

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HOSPICE/HOSPICE RESIDENCE

House Bill 5490 as enrolled
Public Act 224 of 1996

House Bill 5491 as enrolled
Public Act 267 of 1996

Second Analysis (5-28-96)

Sponsor: Rep. Gerald Law
House Committee: Health Policy
Senate Committee: Health Policy and Senior Citizens

THE APPARENT PROBLEM:

In 1980, provisions were placed in the Public Health Code to license hospice programs. A hospice program is a managed system of care provided to persons with a terminal illness and their families. Hospice patients usually have a life expectancy of six months or less. Unlike hospitals and nursing homes that offer acute, curative medical services, hospices provide palliative services -- an emphasis on relieving the symptoms or effects of a disease, such as alleviating pain. Hospice care is typically rendered in a person's home with his or her family members as the primary caregivers, and focuses on encouraging patients to live fully and with dignity in the final weeks and months of life. Most hospice programs have contracts or arrangements with area hospitals and nursing homes for patients needing acute care or skilled nursing services. Hospice programs provide a wide array of support services through a multi-disciplinary team consisting of physicians, nurses, social workers, chaplains, home health aides, and trained volunteers. Together, the hospice team, patient, and family develop a care plan tailored to the ill person's needs and wishes. Typical services include home visits by licensed nurses; physician services for medical management; medications; medical supplies; physical, occupational, and speech therapy; home health aide and homemaker services; short-term inpatient care, including respite care; counseling, pastoral care services, and emotional support; and bereavement services. Because the emphasis is on symptom management and not on curing the patient, hospice costs are significantly lower than an equivalent hospital or nursing home stay. Additionally, since hospices provide services regardless of a person's ability to pay, the indigent and uninsured can also obtain hospice care.

Since 1980, when hospice programs were first established in Michigan, the hospice concept has grown to include 110 programs state-wide. However, according to the Michigan Hospice Organization, not all people have access to in-home hospice care. These would include an elderly person whose spouse is physically unable to provide the needed in-home care, people who have no family nearby or whose family members must work and so cannot provide 24-hour supervision, individuals with AIDS whose families are unable or unwilling to care for them, the homeless, and children who, due to their age, need a setting different than a nursing home. When a 24-hour caregiver is not available, an individual needing supervision who cannot afford a personal nurse or companion usually ends up in a high-cost and less personal inpatient facility such as a hospital or nursing home. In addition, the philosophy of hospitals and nursing homes to preserve life at all costs is often at odds with the hospice philosophy of comfort care.

Many believe that the establishment of hospice residences, where hospice programs could provide services to multiple patients in a single location, is a viable solution to the dilemma faced by those desiring hospice care in a home-like setting but unable to retain the necessary caregivers. Reportedly, 27 other states currently permit licensed hospice residences. A 1990 feasibility study conducted by Angela Hospice in Livonia to determine if there was a need for hospice residences in the state surveyed patients currently enrolled in hospice, families of deceased patients, social workers, discharge planners, and physicians. Eighty-six percent of the respondents indicated that a hospice residence would be beneficial. In January, 1994, Angela Hospice opened the

Angela Hospice Care Center -- Michigan's only freestanding hospice facility. In just over two years, the Care Center has provided a place of residence for 406 people (243 in 1995). According to Angela Hospice, 57 percent of those served were women, 43 percent were men; the majority of patients were widowed, divorced, or single; and 16 percent had no money or insurance to pay for their care. The average length of stay at the Care Center was 21 days, and, with the exception of two months, the Care Center has been full with an extensive waiting list. Several other hospice programs have subsequently opened facilities to provide similar services.

Under present law, however, hospices may not provide inpatient services unless they are also licensed as a hospital, nursing home, home for the aged, or other health facility or been awarded nursing home beds from a special pool created in 1993 under the Certificate of Need (CON) program. Unfortunately, once a hospice receives such licensure or CON beds, they are required to conform to all of the rules and regulations associated with the particular facility's licensure requirements, and, for those awarded beds under CON, the regulations governing nursing home beds. According to industry advocates, many of the resulting rules and regulations are contradictory to the hospice philosophy of palliative care. For example, hospitals and nursing homes are required to conduct various tests and use certain procedures, such as forced feedings and use of ventilators, that hospice programs would find unnecessary for the dying patient and antithetical to their purposes of neither prolonging nor shortening death. Therefore, the Michigan Hospice Organization has requested legislation to allow for an additional license for hospice programs wanting to operate hospice residences.

THE CONTENT OF THE BILLS:

House Bill 5490 would amend the Public Health Code (MCL 333.20109) to exempt hospices and hospice residences from the definition of nursing home. For the exemption, hospice residences would have to be licensed under Article 17 of the code (Facilities and Agencies) and hospices would have to be certified under federal regulations (42 C.F.R. Part 418.100) that implement a section of the Social Security Act that specifies standards for participation in the Medicare program. Further, units operated by the Department of Community Health in correctional facilities are currently exempted from the definition of nursing home. The bill would change this provision to read that a "nursing home would not include a unit in a state correctional facility."

House Bill 5491 would amend the Public Health Code (MCL 333.20106 et al.) to define a hospice residence and require a hospice residence to have a license separate from the hospice program that owned or operated it. A "hospice residence" would be a facility that:

--Is owned, operated, and governed by a hospice program that is licensed under Article 17 of the Public Health Code and provides aggregate days of patient care on a biennial basis to at least 51 percent of its hospice patients in their own homes. "Home" would not include a residence that had been established by a patient in a health facility or agency licensed under Article 17 or in an adult foster care facility licensed under the Adult Foster Care Facility Licensing Act (MCL 400.701 to 400.737).

--Provides 24-hour hospice care to two or more patients at a single location.

--Provides inpatient care directly and is in compliance with Article 17 and the standards set forth in 42 C.F.R. Part 418.100 or provides home care as described in the article. "Inpatient care" would mean a level of care that was provided to a patient consistent with the categories "inpatient respite care day" and "general inpatient care day" as described in 42 C.F.R. 418.302(b)(3) and (4). "Home care" would be defined as a level of care provided to a patient consistent with the categories "routine home care" and "continuous home care" described in 42 C.F.R. 418.302(b)(1) and (2).

(Note: "Hospice" is defined in the code as "a health care program which provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis".)

In addition, a person could not represent itself as a hospice residence unless the person were licensed as such by the department. (Note: Executive Order No. 1996 - 1, with an effective date of April 1, 1996, transferred the authority for licensing health facilities from the Department of Public Health to the Department of Consumer and Industry Services.) The bill would apply current licensure requirements for hospices to hospice residences. Further, it would prohibit hospices and hospice residences from discrimination based on race, religion, color, national origin, or sex in the operations of the hospice or hospice residence in such practices as employment, patient admission and care, or room assignment.

Additionally, an applicant for licensure as a hospice residence would be required to have been licensed as a hospice and to have been in compliance with federal hospice requirements for not less than two years immediately preceding applying for licensure. A licensed

hospice residence could provide both home care and inpatient care at the same location. Hospice residences providing inpatient care would have to comply with federal standards in 42 C.F.R. 418.100. The owner, operator, and governing body of a licensed hospice residence that provides care only at the home care level would have to do all of the following:

--Provide 24-hour nursing services for each patient in accordance with the patient's hospice care plan as required by federal regulations.

--Have an approved plan for infection control that would include provisions for isolating patients with infectious diseases.

--Obtain fire safety approval as required under the code's provisions.

--Equip patients' rooms with department approved devices to call the staff member on duty.

--Provide individualized meal service plans in accordance with federal regulations.

--Design and equip areas within the hospice residence for the comfort and privacy of the patients and their family members.

--Permit visitation around the clock, even for small children.

--Provide appropriate methods and procedures for the storage, dispensing, and administering of drugs and biologicals in accordance with federal regulations.

The bill would also add hospice residence to the definition of health facility or agency. The department would be required to make at least a biennial visit to each licensed hospice residence for the purposes of survey, evaluation, and consultation. The bill would prohibit the department from delegating survey, evaluation, or consultation functions to a local health department that owned or operated a licensed hospice or hospice residence. An annual fee of $200 would be assessed per license survey and $20 per licensed bed.

In addition, in a provision pertaining to hospice care consisting of a coordinated set of services rendered at home, in outpatient settings, or in institutional settings, the bill would replace the term "outpatient" with "in hospice residence" and would specify that these services must be provided on a continuous basis. Further, the bill would add "hospice residence" to various sections of the code pertaining to hospices.

House Bills 5490 and 5491 are tie-barred to each other.

FISCAL IMPLICATIONS:

According to the Senate Fiscal Agency, the bills would have an indeterminate fiscal impact. Currently, the supportive (as opposed to curative) services provided by hospices to the terminally ill are provided in patients' homes, and patients are placed in hospitals or nursing homes when the individuals can no longer be cared for at home. The bills would allow for the creation of hospice residences which have been assumed to be less costly than hospitals and nursing homes. The SFA reports that to the extent that this assumption is true, total health care costs for treating the terminally ill should decrease. However, the SFA notes that any additional cost or savings would "1) be marginal due to the cost/savings being the incremental difference between hospice residence and hospital/nursing home per deems, and 2) be limited due to the fact that hospice services are restricted to the terminally ill with less than six months to live." The conclusion is that the hospice residences cannot generate a demand beyond a restricted clientele group--namely, the terminally ill. Therefore, according to the SFA, due to the limitations on the demand for hospice services, the number of hospice residences that would be established is expected to be small. The costs associated with licensing hospice residences would also be small, and could be absorbed within existing state health facility licensure program resources. (5-7-96)

ARGUMENTS:

For:

Since the inpatient care provided by the hospice philosophy differs significantly from that provided by nursing homes, House Bill 5490, which would exempt hospices and Medicare-certified hospice programs from the definition of a nursing home, should be supported. Unlike nursing homes where patients are usually residents for years, hospice patients are in the final stages of a terminal illness, usually with less than six months life expectancy. Therefore, the rules and regulations that nursing homes must operate within do not always apply to the type of care provided in hospice. For example, nursing homes have stringent staff/patient ratios, requirements for medical and diagnostic equipment, and required agreements with area Community Mental Health Service Programs that are not applicable to hospice care. Certain required diagnostic tests and the use of certain types of antibiotic medications in nursing homes are not appropriate for the dying patient. This is not to say that hospice residences would be unregulated. The majority of states that allow hospice residences use federal guidelines for Medicare-certified hospices. Compliance with this stringent criteria would be required for licensure under the bills.

In addition, nursing homes must also abide by rules and regulations of the Certificate of Need Program. Exemption from the nursing home definition would spare these small hospice programs from CON provisions that are unnecessary for hospice residences. As many hospices operate under grants and donations, the exemption from CON fees is also important. Simply speaking, hospice care, with its focus on comfort care as opposed to the curative care provided by traditional health facilities, should not be forced to abide by the same rules governing nursing homes.

For:

The establishment of licensed hospice residences is a necessary alternative for those faced with a terminal illness. A hospice residence could provide either inpatient care directly or could choose to offer a residence program that would duplicate the level of services provided in a person's home. Currently, hospice services are available for patients in their own homes whose friends or families are able to assist with 24-hour care. (Most hospice programs have arrangements with area hospitals and nursing homes for their patients needing acute care or skilled nursing services.) However, people who live alone, whose families live too far away to help out, or whose family members either must work outside the home or are too frail themselves to render care usually end up in nursing homes or other facilities. These patients, though still eligible to enroll in a hospice program, are not able to experience all the benefits that the hospice philosophy can give. For example, the hospice philosophies regarding eating, medication, and visitation differ greatly from the constraints of the typical hospital and nursing home schedules and regulations. Other benefits of a hospice residence would include a home-like atmosphere and visitation policies closer to what would be experienced in a person's own home, where children and even pets could visit any time of the day or night. The opportunity to see a favorite pet or hug a grandchild are important components of encouraging patients to live life fully and with dignity.

In addition, many industry advocates report that placing hospice patients in nursing homes often results in a clash of cultures that causes confusion in patients and medical staff alike. Since nursing homes focus on a curative approach, it can be difficult for a nurse or aide to "switch" to a comfort-care approach with a hospice patient. Often hospice patients must undergo various tests and procedures that are contrary to typical hospice care. Also, hospitals and nursing homes tend not to be experts in pain management. For example, most of these facilities do not wake a sleeping person in order to dispense the next dose of pain medication. However, by the time the patient awakes, the pain may be so severe that it can take several days and much higher dosages before the pain is brought back to a manageable level. And, for those patients who are placed in nursing homes simply because they lack someone to provide 24-hour supervision, a hospice residence would be a welcome alternative.

Further, hospice residences would provide care to populations such as children, for whom nursing homes and other facilities are inappropriate; the homeless; and those dying of AIDS or other diseases who have been rejected by their families. Providing a separate license for hospice residences would ensure the continuation of the same high quality of care already being provided patients in their homes by hospice programs. Since hospices operate under a capitated, managed care system, a hospice residence would save money for individuals, insurance companies, and public assistance programs alike. In fact, according to the Henry Ford Health System, which provides hospice care to approximately 1,050 patients in the tri-county area, treating a hospice patient at home creates savings of approximately $3,000 in health care costs during the last 30 days of the patient's life, and projects that hospice residences should save more than $400 dollars per month per patient. When hospice patients receive acute care in hospitals or skilled nursing care in nursing homes, the hospice must pay the health facility for the use of the bed and staff from any reimbursement that the hospice receives from third-party insurers. Often this amount comes close to or exceeds the reimbursement, yet the hospice must still provide hospice services via hospice staff during the patient's stay in the facility. Licensure would allow hospice residences to collect Medicaid reimbursement for room and board, and to cut other costs associated with inpatient care by providing similar services to multiple patients under one roof. This is extremely important since hospices provide services regardless of a patient's ability to pay and whether the patient is insured.

Against:

Some people have expressed a concern that by exempting a hospice residence from Certificate of Need standards, there would be a proliferation of residences statewide. Considering that many hospitals and nursing homes are currently underutilized, this can only result in further loss of utilization of existing resources. The bills should be modified to require that a hospice residence, as a condition for licensure, be required to use any existing, appropriate space in area hospitals or nursing homes before being allowed to build a freestanding facility. They should, of course, be allowed to remodel the area to conform to the home-like atmosphere necessary for hospice care.

Response:

According to industry advocates, hospice programs, with their dependance on fund raising, donations, and grants,

would not be quick to build residences unless they had the necessary need and funding to support a facility. Secondly, when referring to hospitals and nursing homes, "existing space" is actually referring to licensed beds and not to vacant rooms. For a hospice program to lease such "space" in either facility for a hospice residence, the hospice would have to then abide by all the rules and regulations governing the use of licensed hospital and nursing home beds. This would once again put the hospice in the same circumstances and with the same conflicts it is currently experiencing with hospital and nursing home requirements being contrary to hospice philosophy. Further, the costs associated with leasing space from facilities compared to current insurance and Medicaid and Medicare reimbursement rates would most likely make this proposition cost prohibitive to the hospices.

Analyst: S. Stutzky

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