Medicare added hospice services for its beneficiaries’ end-of-life care in 1982 and since then the hospice industry has rapidly expanded. In 2010, approximately 1.5 million patients received hospice care from more than 3,500 Medicare-certified hospice organizations.¹

Under the Medicare hospice benefit, patients agree to forgo curative treatments aimed at prolonging life, and receive palliative medications and treatments focused on comfort and quality of life. Specially trained physicians, nurses, social workers and others provide this care. The patient’s family also receives support. In most cases, patients are cared for in their home but care can occur anywhere, including hospice centers, hospitals, nursing homes and other long-term care facilities.²

To qualify for hospice care, two physicians must certify that a patient has less than six months to live if his or her disease runs its natural course. The patient’s treating physician and a hospice physician usually provide this certification. Medicare Part A pays an all-inclusive daily rate depending on the hospice patient’s level of care. The rate is paid for each day the beneficiary is in hospice care, regardless of the number of services furnished. Under Medicare provisions, the first six months of the hospice benefit is divided into two 90-day benefit periods. At the end of these two periods, the hospice team will evaluate whether the patient continues to have a prognosis of less than six months to live. Following these two 90-day periods, the hospice is then required to evaluate more closely and will review every 60 days. When a hospice provider re-certifies a six-month or less prognosis, the judgment is not made based upon the start of hospice, but rather on the patient’s current status.²

There are four primary levels of hospice care: routine home care, continuous care, general inpatient, and respite care. All Medicare-certified hospices are required to offer each level of care.³

- Routine home care is the most common level of hospice care provided in a patient’s home, nursing home or assisted living facility.⁴
- Continuous care is provided for patients who are experiencing severe symptoms and in need of temporary extra care. Under this care level, a minimum of eight hours a day of hospice support is provided for short periods of time.⁴
- General inpatient care is an intensive level of care provided in a contracted hospice bed in a nursing facility, hospital or in a freestanding hospice facility for patients experiencing severe symptoms requiring frequent interventions from the hospice team.⁴
- Respite is brief care provided for a hospice patient if a family member is in need of a “break” from caregiving.⁵

Many healthcare providers wait to recommend hospice care until they are absolutely certain of a terminal prognosis or until all treatment options are exhausted. As a result, the majority of patients are referred to hospice in the very end-stages of their diseases. The median length of service in 2011 was 19.1 days, a decrease from 19.7 in 2010. The average length of service increased from 67.4 days in 2010 to 69.1 in 2011.⁶

It is difficult to predict if a patient has an expected prognosis of less than six months and sometimes patients live longer. Hospices experience this difficulty as well and, while most patients are in a hospice program for a short time, approximately 19 percent receive hospice services for longer than six months, according to the Medicare Payment Advisory Commission.²
Another issue is that many hospice patients are discharged alive. Recent Medicare statistics show that between 2000 and 2012, the overall rate of live discharges increased from 13.2 percent of hospice discharges to 18.1 percent in 2012. A study, published in the Journal of Palliative Medicine, based on a 2010 analysis of more than one million records of Medicare patients found that more than 182,000 hospice patients were discharged alive.7

However, a comprehensive review of the hospice data reveals that about 33 percent of hospice patients used the benefit for less than seven days, and nearly 60 percent spent less than 30 days in hospice care. Of all hospice beneficiaries, 90 percent received less than 180 days of hospice care in 2012.8 A recent study found that 33 percent of the patients who were discharged alive from hospice died within six months of ending their hospice care, signifying ongoing appropriateness for this care. This suggests that patients discharged from hospice should be evaluated frequently, especially within the first weeks to months after discharge, for changes in status and potential need for hospice readmission.

Local coverage determinations are guidelines intended to help a physician determine appropriateness for the hospice benefit. However, they are not regulations and should not be used solely to determine hospice eligibility. Certification or recertification is based upon a physician’s clinical judgment. Prognostication is not an exact science, and it takes time to determine the trajectory of the disease. Congress made this quite clear in Section 322 of the Benefits Improvement and Protection Act of 2000 (BIPA), which says that hospice certification of terminal illness “shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.”9

If a patient does not meet criteria for hospice or chooses not to receive it, he or she can receive palliative care to manage symptoms and improve quality of life.10 Palliative care, like hospice, addresses the symptoms associated with an illness or complications of treatment, involving a broad range of concerns, starting with treatment of physical symptoms such as pain, nausea and breathlessness.11 Examples include the use of anticonvulsants to treat pain, antipsychotic medications to treat nausea, and opioids to treat dyspnea.11

Palliative care also addresses the psychological, social or spiritual issues that frequently occur in conjunction with physical symptoms. Some examples are fears about the future, loss of independence, worries about family and perceiving themselves as a burden. While some patients will want to discuss psychological or spiritual concerns and some will not, it is fundamentally important to assess each individual and his or her family’s need for support.12 Philosophy of care and treatments are similar between hospice and palliative care. The biggest differences are the patient’s wishes regarding curative treatment and his or her current illness trajectory.

It is appropriate to provide palliative care along with curative treatment at any stage of a serious illness.10

Dr. Garner is a dual-boarded physician in geriatrics and hospice and palliative medicine and works at the VISN 16 Geriatric Research, Education and Clinical Center for the Department of Veterans Affairs and the Arkansas Foundation for Medical Care.

REFERENCES