Hospice: Improving the Quality of Life for the Terminally Ill

When Should I Choose Hospice?

Hospice is an often misunderstood and underutilized benefit of the Medicare program. Many believe that a loved one must be knocking on death's door or have end-stage cancer before she will qualify for hospice. In fact, anyone diagnosed with a terminal illness may receive hospice care, when certain qualifying criteria are met. When a loved one suffers from a primary dementia such as Alzheimer's disease, it is important to recognize that this is a terminal illness and to discuss hospice care with the treating physician.

Hospice remains the gold standard for quality of care at the end of life

Researchers have shown that older adults often wait too long before accessing the hospice benefit. In a study published in the *Journal of the American Medical Association*,[1] researchers found that while more seniors are dying with hospice care than a decade ago, they are increasingly doing so for only a very few days that follow treatment in an intensive care unit. The story told by the data, said the study's lead author, is that for many seniors palliative care happens only as an afterthought.[2]

Clearly, hospice, when ordered sooner rather than later, brings greater physical comfort to the patient and important emotional comfort to both the patient and to her family. The goal of hospice is to provide high quality, compassionate care for people facing a life-limiting illness or injury. "Hospice care involves[s] a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to each individual patient's needs and wishes. At the center of hospice and palliative care models is the belief that each of us has the right to die pain-free and with dignity, and with the assurance that our families will receive the necessary support to allow us to do so."[3]

For example, one of our clients, "Ann," suffered from Alzheimer's disease for many years and lived in a nursing home. As her illness progressed into the late stage, she lost interest in eating and drinking. She refused even her most favorite activities and chose instead to stay in her bed. "Failure to thrive" was added to her long list of diagnoses. There was no family to visit her or to advocate for her. We contacted the doctor and requested an order for hospice, which he was very willing to provide. Ann began to receive hospice care to support her physical and psychological comfort. Also, with the use of the funds in her pooled trust, Ann was able to pay for her favorite caregiver to spend several hours with her a few times each week. The caregiver provided Ann with her favorite foods (McDonald's burgers and shakes), talked and sang to her, and helped her to join in group activities. Our client lived another two years very comfortably with the care provided by hospice and the extra attention from a dedicated caregiver.

Fortunately, many doctors are now writing hospice orders for people in the terminal stage of Alzheimer's and other dementing illnesses. The stages of dementia have been described in many ways; however, for purposes of hospice eligibility, dementia is classified into four functionally defined categories: mild, moderate, severe and terminal. "*Terminal dementia* is defined as loss of communication, ambulation, swallowing and continence."[4]

When a patient is in the terminal stage

of dementia, the National Hospice and Palliative Care Organization (NHPCO) recommends that the doctor order hospice when the patient also suffers from one or more specific dementia-related co-morbidities. Those co-morbidities include: aspiration, upper urinary tract infection, sepsis, multiple stage 3-4 ulcers, and persistent fever and weight loss that is greater than 10 percent of her body weight.

Other health factors also associated with shortened survival: male gender, older age, diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease, cancer, cardiac dysrhythmias, peripheral edema, aspiration, bowel incontinence, recent weight loss, dehydration, fever, pressure ulcers, seizures, shortness of breath, dysphagia, low oral intake, not being awake for most of the day, low Body Mass Index, and recent need for continuous oxygen requirement.

One of the many advantages of hospice is that it stops the "ping-pong" of frequent ER visits and hospital admissions. "Patients admitted to the hospital with acute illness and end-stage or terminal dementias have a particularly poor prognosis. A study of hospitalized patients with end-stage dementia demonstrated that the six month mortality after hospitalization for pneumonia was 53 percent compared with 13 percent for cognitively intact patients. For patients with a new hip fracture, 55 percent of end-stage dementia patients died within six months compared with 12 percent for cognitively intact patients."[5]

Who Pays for Hospice?

Hospice care is paid by Medicare, Part A. Medicare will pay for the care provided by the hospice team, which includes the patient's personal physician, the hospice physician, nurses, home health aides, social workers, clergy, and speech, physical and occupational therapists, if needed. Equipment, supplies and medications related to the terminal illness are also covered. Some medications may require a $5 co-pay. Medications that are used to manage chronic conditions such as high blood pressure are not covered by hospice, but should be covered by the Part D medication benefit.

Hospice is covered under Original Medicare Part A, even if the patient has a Medicare Advantage Plan. In order to receive hospice, a doctor must certify that the patient suffers from an illness that may cause her death within the next six months. During that six-month period, hospice care is provided in "benefit periods." When hospice begins, the first benefit period ends in 90 days. At the end of the 90-day period, the hospice medical director must recertify that the patient continues to meet the requirements for hospice. That begins another 90-day benefit period followed by an unlimited number of 60-day periods. As long as the hospice doctor recertifies the patient, she may receive an unlimited number of 60-day benefit periods.[6] Hospice care may also be discontinued should the patient's condition stabilize or improve significantly, and then re-started when clinically indicated.

The hospice benefit does not provide for 24/7 care. Medicare will cover a short stay in a facility to give the family respite or to manage acute symptoms. Otherwise, the family must be able to provide the care, hire private caregivers, or move their loved one to a nursing home or a residential hospice facility. Payment for room and board may be covered by private resources or through the Medicaid program, depending on the circumstances.

If your client is receiving hospice care and enters a nursing home, then she is medically qualified to receive Medicaid benefits. The dreaded Patient Admission Evaluation (PAE) is not performed. However, the hospice patient must also be financially qualified for Medicaid, in order for Medicaid benefits to pay for her room and board.[7]

On the Hospice Horizon for 2014: The 'Medicare Choices Model'

Under the current hospice guidelines, when a person elects to receive hospice care, she must agree to forgo any curative treatment. However, on March 18, 2014, the Centers for Medicare & Medicaid Services (CMS) announced a demonstration project called the "Medicare Choices Model." This project will evaluate the quality of life for those Medicare and Medicaid beneficiaries who enter hospice and continue to receive potentially life-saving treatment in addition to palliative care. This demonstration project is limited to Medicare beneficiaries who qualify for hospice and suffer from advanced cancers, chronic obstructive pulmonary disease, congestive heart failure and HIV/AIDS.

Medicare claims data show that only 44 percent of Medicare patients use the hospice benefit at the end of life, and most use the benefit for only a short period of time. The Medicare Care Choices Model will assess whether more Medicare beneficiaries would take advantage of hospice care earlier if they knew they could also receive potentially curative treatment in hospice.

How might the Medicare Care Choices Model benefit patients? Dr. James Tusky in speaking with Medscape Medical News explains: "Take for example, the patient who has advanced cancer who is still receiving therapies and [is] therefore not eligible for hospice. In this new program, the patient would be eligible for hospice. When they experience a pain crisis, instead of running them to the hospital, you'd have a nurse come to the house, assess them and get them medication. That's actually better for the patient, and obviously it would reduce costs."[8]

For the demonstration project, CMS is seeking 30 Medicare-certified and enrolled hospices from around the country to participate in the demonstration project. Participating hospice programs will provide hospice services and at the same time patients are eligible to receive aggressive therapies. CMS will pay $400 per beneficiary per month to participating hospices for palliative services and providers furnishing curative services. Hopefully, the Medicare Care Choices Model will improve the beneficiary's quality of life and prove to be cost-efficient.

In its present form, hospice remains the gold standard for quality care at the end of life. With its focus on caring rather than curing, hospice uniquely addresses

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during the litigation were not substantially justified and, therefore, awarded the fees and costs to GGS.

Conclusion

On the bright side, these recent fee awards vindicated employers who were required to defend extensive and costly enforcement claims. Unfortunately, it is the taxpayers who have been saddled with these expenses (both for the initial litigation and the fee awards); all for claims that either should have never been pursued in the first place, or which should have been dismissed after discovery revealed they were meritless. Employers would like to think that these awards would cause the agencies to be more diligent in their investigations and more selective in their enforcement strategies. That, however, remains to be seen.

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Notes

1. *EEOC v. Cintas Corp.*, No. 04-4013, 2011 U.S. Dist. LEXIS 86228 (E.D. Mich. Aug. 4, 2011); *EEOC v. CRST Van Expedited Inc.*, No. 07-CV-95-LRR, 2010 U.S. Dist. LEXIS 11125, *25 (N.D. Iowa Feb. 9, 2010).
2. 42 U.S.C. § 2000e-5(k).
3. 434 U.S. 412, 421 (1978).
4. No. 07-CV-95-LRR, 2013 U.S. Dist. LEXIS 107822 (N.D. Iowa Aug. 1, 2013).
5. *Id.* at *3.
6. *Id.* at *21.
7. *Id.* at **31-32.
8. *Id.* at *45.
9. See 42 USCS § 2000e-5(b) ("If the Commission determines after such investigation that there is reasonable cause to believe that the charge is true, the Commission shall endeavor to eliminate any such alleged unlawful employment practice by informal methods of conference, conciliation, and persuasion.").
10. 732 F.3d 584 (6th Cir. 2013).

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11. *Id.* at 589.
12. *Id.*
13. *Id.* at 591-92.
14. No. V-10-91, 2014 U.S. Dist. LEXIS 48859 (S.D. Tex. April 9, 2014).
15. 28 U.S.C. § 2412)(d)(1)(A) ("Except as otherwise specifically provided by statute, a court shall award to a prevailing party other than the United States fees and other expenses, in addition to any costs awarded pursuant to subsection (a), incurred by that party in any civil action (other than cases sounding in tort), including proceedings for judicial review of agency action, brought by or against the United States in any court having jurisdiction of that action, unless the court finds that the position of the United States was substantially justified or that special circumstances make an award unjust.").
16. *Id.*
17. Gate Guard Servs., supra, at *20.
18. *Id.* at *27.
19. *Id.* at *24.

Senior Moments

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the medical, the emotional, and the spiritual needs of the dying to provide comfort and well-being during life's last transition. With the passage of the Medicare Hospice Benefit in 1982, the federal government essentially declared that hospice care was so important for relieving suffering and bringing about a peaceful and meaningful closure to life, that all Americans were entitled to it, regardless of their ability to pay.

Notes

1. *Journal of the American Medical Association* (Feb. 6, 2013, Vol. 309, No. 5).
2. "The Clinical Course of Advanced Dementia," Mitchell, Teno, Kiely, Shaffer, Jones, Prigerson, Volicer, Givens, M.D., Hamel, *New England Journal of Medicine* 2009; 361:1529-1538 Oct. 15, 2009, DOI:10.1056/NEJMoa0902234.
3. The National Hospice and Palliative Care Organization, www.nhpco.org.
4. *Natural History of Dementia*, Olson (2003).
5. Morrison 2000, www.nhpco.com.
6. www.medicare.gov.
7. For a detailed explanation of hospice when the Medicaid beneficiary receives TennCare, TennCare Standard or Long-Term Care Services and Supports, see the TennCare Policy Manual, Policy No. : BEN 07-0001 (Rev. 7), February 8, 2013, Bureau of TennCare Policy Office.
8. James Tulsky, MD, chief of the Center for Palliative Care at Duke University in Durham, North Carolina.

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