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Medicare Hospice Programs

To the Editor: In their analysis of hospice enrollment patterns, Drs. Christakis and Escarce (July 18 issue)[1] analyzed Medicare-certified hospice providers as independent agencies, without recognizing their relation to other providers of home care. In our community (northeastern Pennsylvania), seven out of eight agencies are certified by Medicare both as hospice providers and as conventional home care providers. This situation must be considered in any discussion of hospice referrals.

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Dual certification has several implications in the care of a patient with a terminal illness. It gives an agency the freedom to first develop an appropriate plan for patient care before deciding whether the plan would best be provided under hospice or conventional home care guidelines. Dual certification thus allows the same staff providing Medicare-certified home care to a patient receiving palliative cytotoxic therapy to subsequently provide Medicare-certified hospice care when cytotoxic therapy is no longer beneficial. Hospice-type protocols for the management of pain and other symptoms can be used where appropriate and not be restricted to the patients actually enrolled in a hospice care program. Finally, the timing of hospice enrollment is usually driven by the nursing staff's analysis of the patient's condition.

Fiscal realities mandate that an agency understand Medicare requirements and pick the most appropriate billing mode (home care agency or hospice) as the patient's needs dictate. Although the analysis performed by Drs. Christakis and Escarce may be statistically proper, the authors fail to realize that the same health care team commonly provides care to a terminally ill patient both before and after formal enrollment in a hospice. Their neglect of this important factor invalidates many of the points made in their discussion.

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References

1. Christakis NA, Escarce JJ. Survival of Medicare patients after enrollment in hospice programs. N Engl J Med 1996;335:172-178. [Free Full Text]

To the Editor: The exclusive use by Christakis and Escarce of Medicare claims data provides little clinical information on patients' status before admission to hospice care or even on where such care is provided. The average length of stay of hospice patients has remained virtually unchanged since Medicare began covering hospice care in 1983; indeed, it was quite close to the 36 days reported by Christakis and Escarce well before the introduction of the hospice benefit.[1,2] Furthermore, the average lengths of stay of hospice patients in the United Kingdom, Australia, New Zealand, Israel, and Canada are quite similar, in spite of different systems of reimbursement and the absence of any requirement that doctors attest to a life expectancy of six months or less. Patients' entry into hospice care when their disease is at a relatively advanced stage may be a sociobiologic phenomenon that the authors do not help us understand.

Since 1986, Medicare hospices have been reimbursed for hospice services provided to residents of nursing homes. We estimate that in 1995, about one quarter of all 280,000 Medicare hospice beneficiaries were residents of nursing homes.

Since the Medicare hospice benefit was originally structured specifically to facilitate the care of dying patients in their own homes, the transformation of the benefit to provide long-term care services to terminally ill patients in nursing homes is, perhaps, the most important development in hospice care.

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1. Kidder D. The effects of hospice coverage on Medicare expenditures. Health Serv Res 1992;27:195-217. [Medline]
2. Mor V, Greer DS, Kastenbaum R. The hospice experiment. Baltimore: Johns Hopkins University Press, 1988.

The authors reply:

To the Editor: Drs. Roda and Gandhi are concerned that the same agency might provide both home health care and hospice care and that the enrollment decision might therefore be made by agency staff rather than by the patient or doctor and hospice-type care might be delivered before a patient's official enrollment in hospice care. Regardless of who is making the enrollment decision, it is generally occurring rather late. It is possible that some patients might receive hospice-type care as a result of being cared for by the same provider both before and after enrollment, but the number of such patients is small. Only 1813 patients in the cohort (28.1 percent), a subgroup of the patients termed "outpatient," were cared for by home health agencies; moreover, as we discussed with respect to the whole cohort, 795 patients (43.8 percent) spent all or part of the 30 days preceding hospice enrollment in a hospital, thus further reducing the possibility that they were receiving hospice-type care before hospice enrollment. Finally, there may in fact be important differences in the quality of palliative care delivered before and after official hospice enrollment, even if the same provider is responsible for both periods.

Drs. Mor and Castle identify some antecedents and limitations of our paper that we recognized, cited, and discussed. Claims data permit the study of very large cohorts but have inherent limitations. We agree that the entry into hospice care of patients with cancer at advanced stages may be a "sociobiologic phenomenon"; in fact, we think that such entry depends on a complex interplay of factors, such as the wishes of and communication between patients and physicians, physicians' practices such as prognostication, and the inherent trajectory of illnesses.[1,2] As for the concern about nursing homes, only 2.4 percent of the patients in our sample, a subgroup of those termed "inpatient," were cared for in nursing home–based hospice programs and probably resided in nursing homes. Although this is an important development in hospice care, such patients are still a minority. The use of nursing homes may be having some interesting effects; for example, patients receiving hospice care from nursing homes are slightly more likely to have certain diagnoses, though the effect on the measured duration of survival after enrollment is complex. Nevertheless, as Table 2 of our paper shows, adjusting for the type of provider does not eliminate the relation between diagnosis and survival.

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1. Lynn J. Caring at the end of our lives. N Engl J Med 1996;335:201-202. [Free Full Text]
2. Lynn J, Teno JM, Harrell FE Jr. Accurate prognostications of death: opportunities and challenges for clinicians. West J Med 1995;163:250-257. [Medline]

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