

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-16

Subject: Concurrent Hospice and Curative Care
(Resolution 804-I-15)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee J
(Candace E. Keller, MD, Chair)

1 At the 2015 Interim Meeting, the House of Delegates referred Resolution 804, which was
2 sponsored by the Medical Student Section. Resolution 804-I-15 asked the American Medical
3 Association (AMA) to amend Policy H-85.955, “Hospice Care” to read as follows:

4
5 H-85.955, “Hospice Care”

6 Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill
7 to die in a more homelike environment than the usual hospital; and urges that this position be
8 widely publicized in order to encourage extension and third party coverage of this provision for
9 terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for
10 hospice benefits and, realizing that prognostication is inexact, to make referrals based on their
11 best clinical judgment; (3) supports modification of hospice regulations so that it will be
12 reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that
13 each patient admitted to a hospice program should have his or her designated attending
14 physician who, in order to provide continuity and quality patient care, is allowed and
15 encouraged to continue to guide the care of the patient in the hospice program; (5) supports
16 changes in Medicaid regulation and reimbursement of palliative care and hospice services to
17 broaden eligibility criteria concerning the length of expected survival for pediatric patients and
18 others, to allow provision of concurrent life-prolonging and palliative care, and to provide
19 respite care for family care givers; and (6) seeks amendment of the Medicare law to eliminate
20 the six-month prognosis under the Medicare Hospice benefit and support identification of
21 alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12
22 months as an interim measure; and (7) supports changes in Medicare regulation to allow
23 provision of concurrent curative and hospice care. (Modify AMA Policy)

24
25 The Board of Trustees assigned this report to the Council on Medical Service for a report back to
26 the House of Delegates at the 2016 Interim Meeting. This report provides background on hospice,
27 palliative and curative care; describes Medicare’s hospice benefit and the Medicare Care Choices
28 Model (MCCM); summarizes relevant AMA policy; and makes policy recommendations.

29
30 **BACKGROUND**

31
32 The American Academy of Hospice and Palliative Medicine (AAHPM) defines palliative care as
33 that which relieves suffering and improves quality of life for people with serious illnesses, no
34 matter whether they can be cured. Hospice is a specific type of palliative care for people who likely
35 have six or fewer months to live. Not all palliative care is hospice, although hospice care is always
36 palliative. Hospice is a distinct delivery system for which eligibility is usually defined by public

1 and private insurers offering the benefit. Curative care under the Medicare program refers to health
2 care practices that treat patients with the intent of curing them or modifying their underlying
3 disease as opposed to managing symptoms such as pain or stress.

4 5 *Medicare's Hospice Benefit*

6
7 Medicare is the largest insurer of end-of-life medical care, with spending on patients during their
8 last year of life making up 25 percent of total Medicare spending on patients 65 years of age and
9 older.¹ Predictably, Medicare is also the largest payer of hospice care, most frequently in patients'
10 homes but also at Medicare-certified hospices, hospitals and skilled nursing facilities. In 2014,
11 more than 1.3 million people received Medicare hospice services from 4,100 certified for-profit
12 and non-profit providers at a cost of \$15.1 billion. Average length of stay was about 88 days;
13 however, median length of stay was only 17 days. Spending on Medicare's hospice benefit has
14 doubled since 2000 but held steady between 2012 and 2014.²

15
16 The literature on hospice costs to the Medicare program has produced mixed results, with some
17 studies showing large cost savings among hospice patients and others pointing to higher costs of
18 care, particularly for long-term enrollees. A recent MedPAC analysis suggests that hospice on
19 average produces no savings and may modestly increase end-of-life costs.³ Benefits to patients and
20 their families—which are not taken into account in cost analyses—have been identified in separate
21 studies. Although there is evidence that early hospice referral reduces hospitalizations and high-
22 cost procedures, further research is needed.

23
24 The hospice benefit was introduced to the Medicare program in 1983 to provide interdisciplinary,
25 team-based services including: nursing care; physicians' services; social worker services;
26 counseling; short-term inpatient hospice care; medical appliances and supplies; drugs and biologics
27 for pain relief and symptom control; home health or hospice aid services; physical, occupational
28 and speech therapy; bereavement support and other services.⁴ To be eligible to elect hospice care
29 under Medicare, patients must be certified as having a life expectancy of six months or less if the
30 terminal illness runs its normal course. Eligible Medicare patients can file an election statement
31 with a particular hospice. The statement must include a number of elements, including the patient's
32 acknowledgement that he or she: 1) has been given a full understanding of the palliative rather than
33 curative nature of hospice care; and 2) waives all rights to Medicare payments for services related
34 to the treatment of the terminal illness and related conditions.⁵ Patients can revoke their election to
35 hospice care at any time and return to standard Medicare coverage.

36
37 Medicare pays for hospice care using per diem payment categories encompassing four levels of
38 care: (1) routine home care, for which Medicare pays \$187 per day for the first 60 days and \$147
39 per day thereafter; (2) general inpatient care, paid \$720 per day; (3) continuous home care, paid at a
40 rate of \$39 per hour; and (4) inpatient respite care, for which Medicare pays \$167 per day (payment
41 rates are for fiscal year 2016).⁶ Service intensity add-on payments are also made when hospice
42 provides direct patient care by a registered nurse or social worker during patients' last seven days
43 of life. In keeping with the hospice philosophy, routine home care accounts for the large majority
44 of hospice payments.

45
46 Despite growth in hospice utilization, fewer than half of Medicare patients (47.8 percent in 2014)
47 elect hospice services, and more than a quarter do not enroll until their final week of life.⁷ In
48 addition to late enrollments, there are concerns about extremely long hospice stays and
49 disenrollments prior to death.⁸ Utilization of hospice care is lower among racial and ethnic
50 minorities.⁹

1 The requirement that patients waive Medicare coverage for services related to the treatment of their
2 terminal illness compels Medicare patients to choose between continuing these treatments and
3 enrolling in hospice care. Reluctance among patients to stop expensive treatments, that may either
4 prolong their lives or improve their functional status and quality of life, is believed to contribute to
5 underutilization of the benefit, as is increased availability of palliative care options outside of
6 hospice.¹⁰ It is important to point out that Medicare-certified hospices are not prohibited from
7 providing treatments that may be life-prolonging or curative, and some hospices have done so
8 under “open access” policies. However, it is generally not financially viable for hospices to provide
9 curative treatments since they receive no additional payments for the significantly higher costs they
10 incur.

11
12 Restricted access policies among hospices are far more common than “open access” policies and
13 may also impact hospice utilization. Findings from a national survey of hospice providers suggest
14 wide variation among hospice enrollment policies, but found that 78 percent of the surveyed
15 providers had at least one restrictive enrollment policy. More than 60 percent of the surveyed
16 hospices will not enroll patients receiving chemotherapy; over half will not accept patients
17 receiving parenteral nutrition; and 40 percent will not take patients who receive transfusions.¹¹

18 19 *Palliative Care*

20
21 The philosophies underlying hospice and palliative care are similar; however, care location, timing
22 and eligibility often differ. At its core, palliative care is designed to assess, prevent and manage
23 physical and psychological symptoms, address spiritual concerns, and focus on communications
24 that establish patient goals of care and assist patients with medical decision-making about treatment
25 options. Whereas services provided by hospice are most commonly provided to patients in their
26 homes, non-hospice palliative care is frequently provided in hospitals or community settings such
27 as cancer centers, clinics and nursing homes, although palliative care can also be provided in-home.
28 Patients can receive palliative care while continuing curative treatment at any stage of their
29 illnesses, and many studies have shown that early palliative care interventions improve quality of
30 life and increase patient and family satisfaction.¹² Palliative care providers—either primary
31 physicians who have the skills and competencies to care for the seriously ill, or physicians with
32 specialty training and certification in palliative medicine—may also help patients who wish to
33 discontinue life-prolonging care to transition to hospice or end-of-life care. Since palliative care is
34 most commonly provided by hospitals, palliative specialists or other physicians, many of these
35 services are covered by public and private insurance.

36 37 *Concurrent Curative Care*

38
39 Some stakeholders question whether Medicare’s requirement that patients forego curative care in
40 order to elect the hospice benefit still makes sense in today’s health care environment.
41 Chemotherapy, radiation and blood transfusions are routinely provided to seriously and terminally
42 ill patients, and the distinction between what constitutes life-prolonging and end-of-life treatment is
43 significantly less clear than it once was. For example, chemotherapy or radiation treatment of
44 certain metastases can be provided to alleviate pain and/or prolong life, and may be considered
45 palliative and/or curative, depending on patient circumstances.

46
47 A provision in the Affordable Care Act stipulated that terminally ill children enrolled in hospice
48 under a state’s Medicaid or Children’s Health Insurance Program be permitted to receive
49 concurrent curative care; however, implementation of this change has proven exceedingly
50 challenging and is not working effectively in most states.

1 *Medicare Care Choices Model*

2

3 In January 2016, the Center for Medicare and Medicaid Innovation (CMMI) launched a concurrent
 4 care demonstration project called the Medicare Care Choices Model (MCCM). According to the
 5 CMMI, this pilot will test the impact of patient access to concurrent hospice and curative care on
 6 quality of care and patient and family satisfaction.¹³

7

8 To participate in the model, Medicare patients diagnosed with certain terminal illnesses must meet
 9 the program’s hospice eligibility requirements; must not have elected hospice within the last 30
 10 days; must receive services from one of about 140 Medicare-certified hospices selected by the
 11 CMMI to participate in the model; must have been hospitalized twice in the last year; and must live
 12 at home. Eligible patients can receive services from a hospice while continuing to receive curative
 13 or disease modifying care from other providers. The model will last five years and target 150,000
 14 eligible Medicare patients diagnosed with advanced cancers, chronic obstructive pulmonary
 15 disease, congestive heart failure or human immunodeficiency virus/acquired immune deficiency
 16 syndrome.¹⁴ Phase 1 hospices began delivering services on January 1, 2016, and Phase 2 will begin
 17 on January 1, 2018.

18

19 Under the MCCM, the non-hospice treating physician is the referring physician and is responsible
 20 for directing patient care. The role of the hospice under the MCCM is to provide supportive care
 21 and to integrate that care with that of the treating physician through case management, care
 22 coordination, shared decision-making and other specified services. Participating hospices are paid
 23 \$400 per month per MCCM enrollee, which is substantially less than daily rates paid under the
 24 traditional Medicare hospice benefit.¹⁵ Some have questioned whether hospice payments under the
 25 MCCM are sufficient to deliver true hospice services. The AAHPM maintains, and the Council
 26 agrees, that a true concurrent care model should include the full scope of hospice care, services and
 27 resources to be successful.

28

29 **AMA POLICY**

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31 The AMA has longstanding policy on hospice and palliative care. Policy H-85.966 maintains that
 32 the use of hospice care should provide the patient and family with appropriate support, but not
 33 preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying
 34 disease. Under Policy D-140.962, the AMA recognizes the benefits of hospice, and reaffirms that
 35 physicians: (a) have a responsibility to see that hospice services are authorized in appropriate
 36 circumstances and settings, and (b) should be allowed and encouraged to remain actively involved
 37 in managing their patients’ hospice care. Policy D-140.962 also asks the AMA to call on the
 38 Centers for Medicare & Medicaid Services (CMS) to thoroughly study Medicare’s hospice benefit.

39

40 Policy H-85.955 supports changes to the Medicaid program to allow provision of concurrent life-
 41 prolonging and palliative care, and also broadening eligibility beyond six-month prognoses under
 42 Medicaid and Medicare hospice benefits. Policy H-85.955 also encourages physicians to be
 43 knowledgeable of patient eligibility for hospice benefits and maintains that designated attending
 44 physicians should be allowed to guide the care of hospice patients. Policy H-70.915 supports
 45 improved payments for health care practices caring for dying patients, and encourages research into
 46 the needs of dying patients and how they could be better served by the health care system.

47

48 **DISCUSSION**

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50 A 2014 report from the Institute of Medicine (IOM), *Dying in America*, found that “improving the
 51 quality and availability of medical and social services for patients and their families could not only

1 enhance quality of life through the end of life, but may also contribute to a more sustainable care
 2 system.” The IOM panel further recommended “a major reorientation of payment systems to
 3 incentivize the integration of medical and social services, the coordination of care across multiple
 4 care settings, and the use of advance care planning and shared decision making to better align the
 5 services patients receive with their care goals and preferences.”¹⁶ The Council found these
 6 recommendations sensible and worthy of consideration during its discussions. The Council
 7 reviewed the literature on hospice and palliative care and will monitor evaluations of the MCCM as
 8 they become available, revisiting hospice payment and coverage issues as needed. Valuable
 9 feedback was also solicited and received from the AAHPM.

10
 11 The Council wishes to clarify that the Medicare program does not require patients to discontinue
 12 life-prolonging treatments in order to enroll in hospice, but Medicare will not pay separately for
 13 treatments for one’s terminal illness which are considered to be curative. The Council also clarifies
 14 that the policy modification requested by Resolution 804-I-15 would require the AMA to support a
 15 legislative rather than regulatory change, given that eligibility for election of Medicare’s hospice
 16 benefit is defined in the Social Security Act.

17
 18 The Council understands that Medicare’s existing eligibility criteria compel most patients to either
 19 pursue curative treatments or enroll in hospice care. The Council concurs with the authors of
 20 Resolution 804-I-15 that underutilization of Medicare’s hospice benefit is due in part to reluctance
 21 among patients to abandon life-prolonging treatments. The Council further agrees that hospice care
 22 should not preclude the use of appropriate palliative therapies to treat underlying disease, which is
 23 the essence of Policy H-85.966. Accordingly, the Council recommends that Policy H-85.966 be
 24 reaffirmed.

25
 26 The Council believes that in the future, thoughtfully designed, financially sustainable concurrent
 27 hospice/curative care models have tremendous potential to improve the quality of life and
 28 satisfaction of some of Medicare’s sickest patients and their families. However, the evidence base
 29 does not yet exist to determine the most effective model for providing and paying for concurrent
 30 care. The “open access” hospice model is not financially sustainable for most hospices, and there
 31 are questions as to whether the MCCM is too limited to deliver its intended value. The Council has
 32 similar misgivings about the MCCM and believes that, as designed, the pilot program may not
 33 produce meaningful data on true concurrent care. The Council is equally troubled by the low
 34 payment rates under the MCCM, which are not adequate to provide true, interdisciplinary,
 35 physician-involved hospice care.

36
 37 Additionally, the Council feels strongly that implementation issues associated with concurrent
 38 hospice/curative care models must be resolved before the AMA can credibly support a major
 39 legislative change to the Medicare statute. For example, it is unclear how life expectancy would be
 40 quantified under these models given that life-prolonging care could extend patients’ prognoses
 41 beyond six months, thereby affecting their eligibility for hospice. Because there is still so much
 42 work to be done, the Council believes it is premature to modify Policy H-85.955 as requested by
 43 Resolution 804-I-15. Instead, the Council recommends that the AMA support continued study and
 44 pilot testing by CMS of a variety of models for providing and paying for concurrent hospice,
 45 palliative and curative care.

46
 47 Numerous studies have shown that palliative care improves pain and symptom control, increases
 48 satisfaction with care among seriously ill patients and reduces costs. The Council underscores the
 49 AMA’s support for palliative care services, and recommends that the AMA encourage CMS to
 50 identify ways to optimize patient access to palliative care, which relieves suffering and improves

1 quality of life for people with serious illnesses regardless of whether they can be cured, and to
2 provide appropriate coverage and payment for these services.

3
4 Because many seriously and terminally ill patients and their families may be unaware of the
5 benefits of hospice and palliative care, or available resources in their communities, the Council
6 hopes physicians will learn more about local resources. Patients and physicians can search for
7 hospices and palliative care providers at <http://www.nhpco.org/find-hospice>. The Council
8 recommends that the AMA encourage physicians to be familiar with local hospice and palliative
9 care resources and their benefit structures, and to refer seriously ill patients accordingly.

10
11 **RECOMMENDATIONS**

12
13 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
14 804-I-15 and the remainder of the report be filed:

- 15
16 1. That our American Medical Association (AMA) reaffirm Policy H-85.966, which
17 maintains that hospice care should provide the patient and family with appropriate physical
18 and emotional support, but not preclude the use of appropriate palliative therapies to
19 continue to treat underlying disease. (Reaffirm HOD Policy)
20
21 2. That our AMA support continued study and pilot testing by the Centers for Medicare &
22 Medicaid Services (CMS) of a variety of models for providing and paying for concurrent
23 hospice, palliative and curative care. (New HOD Policy)
24
25 3. That our AMA encourage CMS to identify ways to optimize patient access to palliative
26 care, which relieves suffering and improves quality of life for people with serious illnesses,
27 regardless of whether they can be cured, and to provide appropriate coverage and payment
28 for these services. (New HOD Policy)
29
30 4. That our AMA encourage physicians to be familiar with local hospice and palliative care
31 resources and their benefit structures, as well as clinical practice guidelines developed by
32 national medical specialty societies, and to refer seriously ill patients accordingly. (New
33 HOD Policy)

Fiscal Note: Less than \$500.

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