

Hospice and Palliative Care

Background

Palliative care is defined as that which relieves suffering and improves quality of life for people with serious illnesses, no matter whether they can be cured. Hospice is a delivery system for which eligibility is defined by public and private payers. Not all palliative care is hospice, although hospice care is always palliative.

The philosophies underlying hospice and palliative care are similar; however, there are important differences. Whereas most hospice care is provided to patients in their homes, non-hospice palliative care is usually provided in hospitals, cancer centers and clinics. Additionally, hospice is a specific type of palliative care for people who likely have six or fewer months to live and no longer wish to pursue curative treatments. Palliative care can be provided at any stage of illness regardless of whether or not patients continue receiving curative care. Curative treatments are those which modify underlying disease rather than exclusively manage symptoms such as pain or stress.

Medicare's hospice benefit

Medicare is the largest insurer of end-of-life medical care and the primary payer of hospice care, although private insurers also offer hospice coverage. In 2014, more than 1.3 million people received Medicare hospice services from 4,100 certified for-profit and non-profit providers at a cost of \$15.1 billion.

The hospice benefit was introduced to the Medicare program in 1983 to provide interdisciplinary, team-based services including: nursing care; physicians' services; social

worker services; counseling; short-term inpatient hospice care; medical appliances and supplies; drugs and biologics for pain relief and symptom control; home health or hospice aid services; physical, occupational and speech therapy; and bereavement support. To be eligible to elect hospice care under Medicare, patients must be certified by physicians as having a life expectancy of six months or less if the terminal illness runs its normal course. Eligible Medicare patients must file an election statement with a hospice provider. The statement must include a number of elements, including the patient's acknowledgement that he or she: 1) has been given a full understanding of the palliative rather than curative nature of hospice care; and 2) waives all rights to Medicare payments for services related to the treatment of the terminal illness and related conditions. Patients can revoke their election to hospice care at any time and return to standard Medicare coverage.

Some stakeholders question whether Medicare's requirement that patients forego curative care in order to elect the hospice benefit still makes sense in today's health care environment. Chemotherapy, radiation and blood transfusions are routinely provided to seriously and terminally ill patients, and the distinction between what constitutes life-prolonging and end-of-life treatment is significantly less clear than it once was. A federal demonstration project called the Medicare Care Choices Model (MCCM) is currently testing the provision of concurrent hospice and curative care. However, critics question whether payments to hospices under this model are sufficient to deliver true hospice services.

Medicare payment & costs

Medicare pays for hospice care using per diem payment categories encompassing four levels of care: routine home care; general inpatient care; continuous home care; and inpatient respite care. Service intensity add-on payments are also made when hospice provides direct patient care by a registered nurse or social worker during patients' last seven days of life. In keeping with the hospice philosophy, routine home care accounts for the large majority of hospice payments.

Despite growth in hospice utilization, fewer than half of Medicare patients elect hospice services, and more than a quarter do not enroll until their final week of life. Underutilization of Medicare's hospice benefit is likely due in part to reluctance among patients to discontinue life-prolonging care. Although the Medicare program does not require patients to abandon curative treatments in order to enroll in hospice, Medicare will not pay for them. As a result, it is not financially viable for hospices to provide life-prolonging treatments since they receive no additional payments for them.

The literature on hospice costs to the Medicare program has produced mixed results, with some studies showing large cost savings among hospice patients – particularly among early hospice referrals – and others pointing to higher costs of care, especially for long-term enrollees. Many studies have shown that early palliative care interventions improve patients' quality of life and symptom burden. Palliative care providers – either primary physicians who have the skills to care for the seriously ill, or those trained in palliative medicine – can also help patients transition to hospice or end-of-life care. Palliative care is most commonly provided by hospitals, and many palliative services are covered by public and private insurance.

Where the AMA stands

The American Medical Association believes that thoughtfully designed, financially sustainable hospice and palliative care programs are essential to improving the life quality of seriously ill patients. The AMA's extensive policy recognizes the benefits of hospice and palliative care to patients and their families and supports:

- Improved payments for health care practices caring for terminally ill patients.
- Broadening patient eligibility criteria beyond six-month prognoses under Medicaid and Medicare hospice benefits.
- Allowing hospice patients to utilize appropriate palliative therapies that treat underlying disease if patients respond to such therapies.
- Allowing community physicians to remain involved in the management of their patients' hospice care.
- Encouraging all physicians to become skilled in palliative medicine.
- Encouraging physicians to be familiar with local hospice and palliative care resources, as well as clinical practice guidelines developed by national medical specialty societies.

Additionally, the AMA supports ongoing research in the fields of hospice and palliative medicine, and urges the Centers for Medicare & Medicaid Services to:

- Thoroughly study Medicare's hospice benefit, including its structure and payment methodology.
- Identify ways to optimize patient access to palliative care, and to provide appropriate coverage and payment for palliative services.
- Continue pilot testing a variety of models for providing and paying for concurrent hospice, palliative and curative care.

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