

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713  
(A-23)

Introduced by: American Academy of Hospice and Palliative Medicine

Subject: Redesigning the Medicare Hospice Benefit

Referred to: Reference Committee G

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1 Whereas, The population of terminally ill patients enrolled under the Medicare hospice benefit  
2 today is very different than in 1983 when the benefit was established, with Alzheimer’s disease  
3 and related dementias (ADRD) representing a growing portion of hospice enrollees. And with  
4 changing primary diagnoses, the care needs for these patients are also much different today<sup>1</sup>;  
5 and  
6

7 Whereas, It has been shown that patients with ADRD can derive significant benefits from  
8 hospice care, yet a 2022 study published in *JAMA Health Forum* found that current Medicare  
9 policies aimed at reducing hospice misuse and long lengths of stay pose concerns for reduced  
10 utilization by patients with ADRD – given the unpredictable trajectory of dementia – which may be  
11 associated with poorer end-of-life experience and outcomes for these patients.<sup>2-5</sup>; and  
12

13 Whereas, Electing the hospice benefit means waiving access to all other Medicare services  
14 related to the terminal condition, consequently the desire to continue disease-directed care or  
15 certain intensive palliative treatments outside the usual scope of hospice care results in too  
16 many patients who do not access hospice services until the last hours or days of life – or not at  
17 all – depriving them and their families/caregivers of the supportive care to which they are  
18 entitled; and  
19

20 Whereas, For many patients belonging to historically minoritized or marginalized groups, a  
21 history of discrimination, structural inequities, and substandard service delivery has resulted in a  
22 lack of trust in the medical system associated with a reduced willingness to forgo life-sustaining  
23 care and lower enrollment in hospice, as confirmed by a 2020 study published in *JAMA Network*  
24 *Open* showing “despite the increase in the use of hospice care in recent decades, racial  
25 disparities in the use of hospice remain, especially for noncancer deaths”<sup>1, 6</sup>; and  
26

27 Whereas, Some aspects of the Medicare hospice benefit drive disparities in access to vital  
28 services that can improve care and quality of life for seriously ill beneficiaries. For example, the  
29 benefit was designed with the assumption that a patient has caregivers available at home; thus,  
30 patients who lack home resources, transportation, and/or caregiver availability, or are otherwise  
31 socially isolated, simply may not elect the benefit<sup>7</sup>; and  
32

33 Whereas, The payment structure of the Medicare hospice benefit contributes to reduced access  
34 to hospice care in rural settings given that rural providers receive lower payments compared to  
35 urban hospice providers, despite facing increased costs due to travel distances and greater  
36 difficulties in maintaining staff, remaining capitalized, and overcoming economic disadvantages;  
37 and  
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1 Whereas, Council on Medical Services Report 4-I-16 recommends “that our AMA support  
2 continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a  
3 variety of models for providing and paying for concurrent hospice, palliative and curative care”;

4 Whereas, In light of the above, policymakers should reconsider the hospice benefit, and pursue  
5 efforts to redesign, establish, and implement an equitable, anti-racist benefit utilizing a process  
6 that is inclusive, transparent, and iterative; therefore be it  
7

8 RESOLVED, That Our AMA advocate for a 21<sup>st</sup> century evolution of the Medicare hospice  
9 benefit that meets the quadruple aim of health care; advances health equity; and improves  
10 access, support, and outcomes for seriously ill patients across all geographies, including  
11 underserved and low-resource communities (Directive to Take Action); and be it further  
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13 RESOLVED, That our AMA advocate for a reformed Medicare hospice benefit that may  
14 incorporate the following components:  
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- 16 1) Hospice eligibility should not be based solely on a specified prognosis or life expectancy  
17 but rather on patients’ needs; ~~patients with unclear prognoses should be able to access~~  
18 ~~hospice services if their need is otherwise established.~~
- 19 2) Patients must continue to have an open choice of hospice providers.
- 20 3) Hospice services, including telehealth or telemedicine, should be provided by a full,  
21 physician-led interdisciplinary team.
- 22 4) Patients and their caregivers should receive adequate support using home- or facility-  
23 based hospice services, identified by a thorough assessment of their social determinants  
24 of health. This would incorporate 24-hour a day care for beneficiaries with very limited  
25 life expectancy who lack around-the-clock caregivers.
- 26 5) Patients should have concurrent access to disease-directed treatments along with  
27 palliative services.
- 28 6) Payments to hospices should be sufficient to support the quality, experience, scope, and  
29 frequency of care that beneficiaries deserve throughout the later stages of serious illness  
30 as dictated by their physical, psychological, social, spiritual, and practical needs.
- 31 7) The hospice benefit should be consistent, including with regard to the quality and  
32 intensity of services, regardless of which Medicare program or entity pays for services.
- 33 8) Metrics for health provider accountability should focus on those aspects of care and  
34 experience that matter most to patients, families, and caregivers.

35 (Directive to Take Action)  
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37 Fiscal Note: Modest - between \$1,000 - \$5,000

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#### References:

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- Beneficiaries With Dementia. *JAMA Netw Open*. 2022 Jun 1;5(6):e2216260. doi: 10.1001/jamanetworkopen.2022.16260. PMID: 35679046; PMCID: PMC9185179.
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  6. Ornstein KA, Roth DL, Huang J, Levitan EB, Rhodes JD, Fabius CD, Safford MM, Sheehan OC. Evaluation of Racial Disparities in Hospice Use and End-of-Life Treatment Intensity in the REGARDS Cohort. *JAMA Netw Open*. 2020 Aug 3;3(8):e2014639. doi: 10.1001/jamanetworkopen.2020.14639. PMID: 32833020; PMCID: PMC7445597.
  7. Kumar V, Ankuda CK, Aldridge MD, Husain M, Ornstein KA. Family Caregiving at the End of Life and Hospice Use: A National Study of Medicare Beneficiaries. *J Am Geriatr Soc*. 2020 Oct;68(10):2288-2296. doi: 10.1111/jgs.16648. Epub 2020 Jun 30. PMID: 32602571; PMCID: PMC7718293.

## Relevant AMA Policy

### Concurrent Hospice and Curative Care H-85.951

1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent **hospice**, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.
3. Our AMA encourages physicians to be familiar with local **hospice** and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.

Citation: (CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18)

### Hospice Care H-85.955

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care;

(2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment;

(3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare;

(4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program;

(5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers;

(6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and

(7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.

Citation: (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19; Reaffirmation: A-22)

### **Hospice Coverage and Underutilization H-85.966**

The policy of the AMA is that:

- (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy;
- (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease;
- (3) Appropriate active palliation should be a covered hospital benefit; and
- (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.

Citation: (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21)

### **End-of-Life Care H-85.949**

Our AMA supports:

- (1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's **hospice** benefit;
- (2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's **hospice** and skilled nursing facility (SNF) benefits for the same condition; and
- (3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.

Citation: (CMS Rep. 1, I-21)

### **Planning and Delivery of Health Care Services H-160.975**

(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.

Citation: (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18)