RESOLUTION 68-19

Title: Hospice Care and the "Adult Failure to Thrive" Diagnosis

Introduced by: Lee Begrow, DO, for the Kent County Delegation

Original Author: Jayne E. Courts, MD

Referred to: Reference Committee A

House Action: **REFERRED**

Whereas, the cost of health care continues to rise in the United States on an annual basis, with an increasing percentage of the gross national product (GNP) expenditure attributed to the cost of health care, and

Whereas, a significant percentage of health care dollars have been shown to be spent in the last six months of a patient's life, and

Whereas, physicians are being encouraged and potentially reimbursed to address advance directives and palliative care/goals of care, including hospice care, with their patients as an important, cost-effective measure to help reduce health care costs while better meeting the wishes of the patient, and

Whereas, hospice care provides health care which is consistent with the patient's and the family's wishes with preserved dignity in dying and improved patient and family satisfaction, and

Whereas, hospice care has been shown to lessen the incidence or severity of anxiety and/or depression for the patient and/or family members during the last few months of the patient's life, and

Whereas, accessing hospice care in a timely manner provides lower cost health care, and

Whereas, the "adult failure to thrive" diagnosis as an acceptable primary diagnosis for hospice services was eliminated by the Centers for Medicare and Medicaid Services (CMS) in February 2016, along with the "debility" diagnosis, and

Whereas, access to hospice services has been reduced with elimination of the "adult failure to thrive" diagnosis as an acceptable primary diagnostic qualifier for hospice services, and

Whereas, many patients who are ready to consider hospice care cannot qualify for hospice care based on the severity of a single diagnostic condition, and

Whereas, many of these patients have one or more co-morbid conditions which, when viewed in aggregate, indicate a prognostic estimation for longevity of fewer than six months, and

Whereas, many patients now enter hospice care later and receive short-term hospice services as their major medical condition had to progress to a more severe stage before the patient could qualify for hospice services, and

Whereas, delay in timely access to hospice care potentially results in an increase in the overall cost of care and potentially reduces the value, both fiscally and emotionally, of addressing advance directives and palliative care/goals of care, including hospice care, with patients; therefore be it

RESOLVED: That MSMS work with the Michigan Hospice and Palliative Care Organization and/or the Michigan Home Care and Hospice Association to reinstate "adult failure to thrive" as a qualifying primary diagnosis for hospice care; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the Centers for Medicare and Medicaid Services and the National Hospice and Palliative Care Organization to reinstate "adult failure to thrive" as a qualifying primary diagnosis for hospice care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $5,000 or more as this Resolution directs MSMS to spearhead a collaborative effort to engage in regulatory and/or payer advocacy.

Relevant MSMS Policy: None

Relevant AMA Policy:

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; and (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.

Hospice Services Under Medicare D-140.962
1. Our AMA recognizes the benefits to patients and their families that hospice represents in end-of-life care, and reaffirms that physicians (a) have a responsibility to see that hospice services are authorized in appropriate circumstances and settings, and (b) should be allowed and encouraged to remain actively involved in managing their patients? hospice care, in collaboration with hospice staff.
2. Our AMA will collaborate with interested organizations, including hospice organizations, and other medical societies, to develop educational materials and programs for physicians to ensure that hospice services are provided in the most cost-effective, appropriate settings.
3. Our AMA will call on the Centers for Medicare & Medicaid Services, in conjunction with stakeholder groups, to thoroughly study the Medicare hospice benefit, including its structure, payment methodology, quality assurance and regulatory scheme.