

Docs bill Medicare for end-of-life advice as ‘death panel’ fears reemerge

JoNel Aleccia, Kaiser Health News 6:06 p.m. ET Feb. 9, 2017

End-of-life counseling sessions, once decried by some conservative Republicans as “death panels,” gained steam among Medicare patients in 2016, the first year doctors could charge the federal program for the service.

Nearly 14,000 providers billed almost \$35 million — including nearly \$16 million paid by Medicare — for advance care planning conversations for about 223,000 patients from January through June, according to data released this week by the Centers for Medicare & Medicaid Services. Full-year figures won’t be available until July, but use appears to be higher than anticipated.

Controversy is threatening to reemerge in Congress over the funding, which pays doctors to counsel some 57 million Medicare patients on end-of-life treatment preferences. Rep. Steve King, R-Iowa, introduced a bill last month, the [Protecting Life Until Natural Death Act](#), which would revoke Medicare reimbursement for the sessions, which he called “yet another life-devaluing policy.”

“Allowing the federal government to marry its need to save dollars with the promotion of end-of-life counseling is not in the interest of millions of Americans who were promised life-sustaining care in their older years,” King said on Jan. 11.

While the fate of King’s bill is highly uncertain — the recently proposed measure hasn’t seen congressional action — it underscores deep feelings among conservatives who have long opposed such counseling and may seek to remove it from Medicare should Republicans attempt to make other changes to the entitlement program.

Proponents of advance care planning, however, cheered evidence of the program’s early use as a sign of growing interest in late stage life planning.

“It’s great to hear that almost a quarter million people had an advance care planning conversation in the first six months of 2016,” said Paul Malley, president of Aging with Dignity, a Florida nonprofit. “I do think the billing makes a difference. I think it puts it on the radar of more physicians.”

Use of the counseling sessions are on track to outpace an estimate by the American Medical Association, which projected that about 300,000 patients would receive the service in the first year, according to the group, [which backed the rule](#).

Providers in California, New York and Florida led use of [the policy](#) that pays about \$86 a session for the first 30-minute office-based visit and about \$75 per visit for any additional sessions.

The rule requires no specific diagnosis and sets no guidelines for the end-of-life discussions. Conversations center on medical directives and treatment preferences, including hospice enrollment and the desire for care if patients lose the ability to make their own decisions.

The new reimbursement led Dr. Peter Sutherland, a family medicine physician in Morristown, Tenn., to schedule more end-of-life conversations with patients last year.

“They were very few and far between before,” he said. “They were usually hospice-specific.”

Now, he said, he has time to have thorough discussions with patients, including a 60-year-old woman whose recent complaints of back and shoulder pain turned out to be cancer that had metastasized to her lungs. In early January, he talked with an 84-year-old woman with Stage IV breast cancer.

“She didn’t understand what a living will was,” Sutherland said. “We went through all that. I had her daughter with her and we went through it all.”

The conversations may occur during annual wellness exams, in separate office visits or in hospitals. Nurse practitioners and physicians’ assistants may also seek payment for end-of-life talks.

The idea of letting Medicare reimburse such conversations was first introduced in 2009 during debate on the Affordable Care Act. The issue quickly fueled allegations by some conservative politicians, such as former Republican vice presidential [candidate Sarah Palin](#) and presidential candidate John McCain, that they would lead to “death panels” that could disrupt care for elderly and disabled patients.

The idea was dropped “as a direct result of public outcry,” King said in a statement.

“The worldview behind the policy has not changed since then and government control over this intimate choice is still intolerable to those who respect the dignity of human life,” he said.

But in 2015, CMS officials quietly [issued the new rule](#) allowing Medicare reimbursement as a way to improve patients’ ability to make decisions about their care.

End-of-life conversations have occurred in the past, but not as often as they should, Malley said. Many doctors aren’t trained to have such discussions and find them difficult to initiate.

“For a lot of health providers, we hear the concern that this is not why patients come to us,” Malley said. “They come to us looking to be cured, for hope. And it’s sensitive to talk about what happens if we can’t cure you.”

A [2014 report by the Institute of Medicine](#), a panel of medical experts, concluded that Americans need more help navigating end-of-life decisions. A [2015 Kaiser Family Foundation poll](#) found that 89% of people surveyed said health care providers should discuss such issues with patients, but only 17% had had those talks themselves. (KHN is an editorially independent program of the foundation.)

Use of the new rule was limited in the first six months of 2016. In California, which recorded the highest Medicare payments, about 1,300 providers provided nearly 29,000 services to about 24,000 patients at an overall cost of about \$4.4 million — including about \$1.9 million paid by Medicare.

The data likely reflect early adopters who were already having the talks and quickly integrated the new billing codes into their practices, said Dr. Ravi Parikh, an internal medicine resident at Brigham and Women’s Hospital in Boston, who has [written about advance care planning](#). Many others still aren’t aware, he said.

A survey [conducted by Athenahealth](#), a medical billing management service, found that only about 17% of 34,000 primary care providers at 2,000 practices billed for advance care planning in all of 2016.

The numbers will likely grow, said Malley, who noted that requests from doctors for advance care planning information tripled during the past year.

To counter objections, providers need to ensure that informed choice is at the heart of the newly reimbursed discussions.

“If advance care planning is only about saying no to care, then it should be revoked,” Malley said. “If it truly is about finding out patient preferences on their own turf, it’s a good thing.”

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