VIEWPOINT

Hospice Carve-In—Aligning Benefits With Patient and Family Needs

William H. Shrank, MD, MSHS
Humana Inc, Louisville, Kentucky.

Kristin Russell, MD, MBA
Humana Inc, Louisville, Kentucky.

Ezekiel J. Emanuel, MD, PhD
Perelman School of Medicine, Department of Medical Ethics and Health Policy, University of Pennsylvania, Philadelphia.

Patient-centered care should be a defining feature of the health care system, and no time is more critical for having patients at the center of care than at the end of life. At this difficult and deeply personal time for patients and their families, it is paramount that the preferences of patients and their families be respected and their experiences prioritized. Compassionate end-of-life care should be available to the 2.8 million individuals who die every year in the United States and should be delivered in a way that is highly coordinated, seamless to patients and their families, and attuned to the patient's goals and wishes. One important step in realizing that goal is the new hospice benefit design proposed by the Center for Medicare & Medicaid Innovation (CMMI).

Some data suggest that the United States is moving in the right direction. The number of people dying in hospitals decreased from approximately 40% in 2003 to 30% in 2017,[1] and half of Medicare beneficiaries who died in 2017 received hospice services.[2] By focusing on symptom relief, pain control, and the physical, emotional, and spiritual needs of patients and their families, hospice care is fundamentally patient centered and has been associated with higher quality of life and higher patient and family satisfaction. However, approximately 25% of patients who received hospice services in 2017 experienced substantial clinical deterioration that prompted use of hospice and received these services only in the last week of life,[3] which did not give them and their families a quality end-of-life experience.

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Meanwhile, many patients with advanced illness still receive fragmented, hospital-based care that is not aligned with their needs and preferences. The utilization of payment from the Centers for Medicare & Medicaid Services (CMS) for discussions of end-of-life care preferences enacted in 2016 has been negligible.[4] In 2016 (the first year of policy change), 1.9% of fee-for-service Medicare beneficiaries aged 65 years or older had advance care planning visits. In the first three quarters of 2017, only 2.2% did.[4] Even when patients' preferences are known, the care they receive is often discordant. A recent study looked at the association between care received and patient preferences as documented in Physician Orders for Life-Sustaining Treatment (POLST). Of the 1162 patients who wanted only limited interventions or only comfort measures, 38% received care that was discordant.[5]

Administrative and financial factors also contribute to suboptimal end-of-life care. Specifically, the design of the Medicare hospice benefit rather than patients' needs and preferences shapes their end-of-life care. For instance, the benefit covers hospice care for patients only when their physician certifies that their life expectancy prognosis is 6 months or less, which is an arbitrary period, and life expectancy among these patients is difficult to predict. Also, the benefit requires that patients abruptly forgo all curative treatment of their terminal illness, such as chemotherapy, to be eligible for hospice care, although emergency hospital care is not limited. This design fragments care by forcing patients to choose a wholly separate path at a single moment in time rather than allowing a broader, more flexible array of palliative and hospice options that offer patients and their physicians the opportunity to choose the right care, in the right place, at the right time.

The Medicare hospice benefit is even more confusing and fragmented for the 35% to 40% of Medicare beneficiaries who are enrolled in a Medicare Advantage plan. Since being introduced in 1986, the hospice benefit has been excluded ("carved out"), in part due to low hospice use and limited cost data at the time. This means that when a Medicare Advantage beneficiary elects hospice, their coverage becomes split such that payments for hospice services revert to fee-for-service Medicare while their Medicare Advantage plan continues to cover supplemental benefits, medical services, and Part D medications unrelated to their terminal condition.

This administrative complexity is confusing for patients and creates unnecessary issues with care coordination and continuity. To address this, CMS will begin testing the effect of allowing Medicare Advantage plans to offer the hospice benefit in 2021 as a voluntary component of CMMI's Value-Based Insurance Design model. Medicare Advantage plans will have the flexibility to offer a spectrum of services to patients with advanced illness. Importantly, Medicare Advantage plans will be able to provide earlier access to palliative care for patients with a variety of conditions rather than limiting this care to patients in the last 6 months of life. Also, Medicare Advantage plans will have the flexibility to provide patients a more gradual transition into hospice with concurrent access to a range of palliative and therapeutic services.

Medicare Advantage plans have developed capabilities to provide their members access to care that is coordinated longitudinally among multiple practitioners and across settings (eg, home, community, hospital).

Corresponding Author: William H. Shrank, MD, MSHS, Humana Inc, 500 W Main St, Louisville, KY 40202 (wshrank@humana.com).

To achieve this, plans are building systems that coordinate data collection and equip clinicians with real-time access and analytics to improve handoffs and care transitions while reducing reliance on patients and families to provide information during this difficult time. Additionally, collection of data about social context, coupled with new CMS benefit flexibilities that allow Medicare Advantage plans to cover services that address social needs, will promote holistic and compassionate care.

In this model, CMS has provided additional flexibility for Medicare Advantage plans to offer services that are created specifically for this population. Designed more than 35 years ago, the hospice benefit focuses too much on reduction of pain and relief of physical symptoms. The new approach emphasizes more comprehensive care, and 2 elements of this are particularly salient. The first is the need for services that support the emotional needs of patients and their families, such as mental health care for the large number of patients experiencing depression, and grief counseling for families. The second type of care that too often does not receive attention involves services that assist caregivers and support patients with activities of daily living such as cooking, shopping, and toileting. As is being seen with the coronavirus disease 2019 crisis, adding regulatory flexibilities (for instance, those that allow broader use of telehealth and expand the roles nurses can play in the home) can improve access while increasing the ability to coordinate care for vulnerable populations with a range of medical and social needs.

For this model to be successful, plans must have the ability to work with high-quality clinicians with expertise caring for this population both within the traditional hospice benefit construct and in palliative care more broadly. Although initially CMMI will require that Medicare Advantage plans allow most hospice and palliative care providers to be in network, by the third year, Medicare Advantage plans will be able to create networks of trusted clinicians and hospice or palliative care services that have not only a proven track record but also the prioritization and capabilities to engage in integrated care.

It will be important to evaluate whether this new model has any unintended negative effects. One concern is whether the administrative burden for entities and practitioners who provide hospice services will increase because they are likely to have contracts with multiple Medicare Advantage plans, each with different processes. As Medicare Advantage plans create their networks, issues relating to patient access and choice will also need to be monitored closely, as will any new out-of-pocket costs or access concerns.

Decisions about end-of-life care should be driven by patient needs and preferences, not benefit design. Allowing continuity throughout the payment process and empowering Medicare Advantage plans with the flexibility to offer a highly coordinated hospice benefit will bring necessary change and allow care for patients with advanced illness to be more integrated, more seamless, and, above all, more patient centered.

ARTICLE INFORMATION

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