

Concurrent Palliative and Curative Services: The Next Step in Evolution of Medicare Hospice Care

By Janet H. Forlini and Lee Goldberg

The Campaign to End Unwanted Medical Treatment hosted a briefing on April 11, 2014 that featured Chris Dawe, former health policy advisor to the National Economic Council at the White House. Dawe discussed the recent announcement of the “Medicare Care Choices Model” that would expand the availability of hospice services. What follows is a brief based on the issues raised in that discussion.

Although the Affordable Care Act (ACA) is best known for its provisions to expand coverage, it may be the many demonstration projects authorized by the legislation that have the most significant impact on the health care delivery system. One key provision in the ACA, at least from the perspective of person-centered care, is new authority to open up hospice care to Medicare beneficiaries who want to continue with curative care. The demonstration project, which targets Medicare beneficiaries with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure and HIV/AIDS, is an effort to see whether expanded care options for seriously ill people will improve quality of life, increase patient and family satisfaction, and prove to be cost-effective; it also seeks to increase utilization of hospice care.

The demonstration project has implications for individuals who are in the early stages of a serious illness and who may have no interest in traditional hospice care. Members of the Campaign to End Unwanted Medical Treatment see this demonstration is as an important development in ensuring that individuals are able to tailor care for chronic and serious illness to meet their individual preferences.

Background

Hospice care was developed by physician Dame Cicely Saunders, who created the first modern hospice in London in 1967.¹ In the 1970s, the hospice movement spread to the United States and continues to gain support: the Medicare Hospice Benefit became available as a demonstration project in 1982² and was made a permanent part of the program by Congress in 1986.³

Medicare paid for approximately 84 percent of the hospice care received in the United States in 2012.⁴ The benefit covers palliative and support services for terminally ill beneficiaries who have a life expectancy of six months or less if the illness follows its normal course.⁵ All Medicare-covered hospice services are available even if the beneficiary is in a Medicare Advantage Plan.⁶ States can offer hospice as an optional benefit for Medicaid beneficiaries, and most private health insurance companies include hospice as a covered benefit.

A broad set of services is covered under the hospice benefit including nursing care; physician services; counseling and social work services; hospice aide and homemaker services; short-term inpatient care; drugs and biologicals for symptom control; home medical equipment; physi-

Janet H. Forlini is an independent consultant focusing on aging, end of life, and long-term care public policy. **Lee Goldberg** is Vice President for Health Policy at the National Academy of Social Insurance.

cal, occupational and speech therapy; bereavement services for the patient's family; and other services for palliation of the terminal condition. However, by electing the Medicare hospice benefit, beneficiaries agree to forgo Medicare coverage for conventional treatment of the terminal illness.⁷ Although Medicare will cover treatment for health problems unrelated to the beneficiary's terminal condition, the decision to opt for hospice care is a difficult one for beneficiaries and their families. From a clinical point of view, there is in most cases no need to choose between palliative care and life-prolonging care.⁸

The three-year demonstration is expected to launch in early 2015. The Centers for Medicare and Medicaid Services (CMS) will select a diverse group of 30 rural and urban certified hospice providers and, from within those, expects to enroll approximately 30,000 beneficiaries. CMS will pay a fee of \$400 per beneficiary per month to participating hospices; providers offering curative services will be able to continue to bill Medicare for the reasonable and necessary medical services.⁹

Impact of Hospice Care

Traditional hospice care has the potential to improve the quality of care and lower costs. In a 2013 study using data from the Health and Retirement Study and individual Medicare claims, researchers found that hospice enrollment resulted in savings to the Medicare program across a number of different lengths of stay.¹⁰ More specifically, findings showed that reductions in the use of hospital services, hospital days, hospital admissions, and hospital deaths rose as the period of hospice enrollment lengthened within the study period.¹¹ These researchers noted that such outcomes are not only less costly but also are associated with improved quality and increased accord with patients' preferences.¹²

This is not the first instance of providers offering concurrent care to hospice patients. Aetna's Compassionate Care Program allows a liberalized hospice benefit for some of its members, expanding the definition of eligibility to having a terminal illness with a life expectancy of twelve months rather than the usual six months and allowing members to access hospice benefits without being required to first discontinue curative therapy.¹³ Cost analyses of the program showed a net decrease in

medical costs of 22 percent.¹⁴ Children also have increased access to concurrent care: the "Concurrent Care for Children" provision of the ACA applies to individuals under age 21 who are eligible for Medicaid or the Children's Health Insurance Program (CHIP) and requires all state Medicaid programs to pay for both curative and hospice services for this population.¹⁵

A randomized trial undertaken at the University of Michigan's Comprehensive Cancer Center revealed cost savings when concurrent care was provided. Results from this study found a 27 percent cost reduction when conventional oncology management was combined with hospice services.¹⁶ However, while the study did find significant cost savings as well as improved quality of life for the patients, the study conclusions did not indicate any significant difference in survival rates. It should be noted that some research has actually shown a link between foregoing care and extending length of life: a 2010 study of patients with metastatic lung cancer who received less aggressive care at the end of life had longer survival rates.¹⁷

Increasing Utilization

A critical part of the demonstration project is to measure its effects on utilization of the Medicare Hospice Benefit.¹⁸ Use of hospice in the U.S. has been on the rise: the number of people using hospice increased from 870,000 patients in 2005 to 1.2 million in 2011.¹⁹ Despite its growth, however, hospice remains significantly underutilized. According to the National Hospice and Palliative Care Organization (NHPCO),²⁰ the median length of service in 2011 was only 19 days, and the average length of service was 69 days that same year. This suggests that, while there were some very long hospice stays, there were a great many more short stays reflecting the underutilization of the benefit. One goal of the demonstration project is to address this underutilization.

Underutilization of hospice may be the result of hospice providers' own enrollment policies. A recent study found that a significant number of hospices have enrollment policies in place that restrict access for those patients with high-cost needs.²¹ Given that the Medicare per diem hospice reimbursement rate is not adjusted for cost or intensity of care, there is a financial disincentive to enroll patients who require chemotherapy or intravenous

nutrition, for example. The study authors propose increasing the hospice per diem rate for patients requiring complex treatment, which thereby might encourage more hospices to expand their enrollment policies.²²

While research has explored the causes of hospice underutilization, there has, at the same time, been concern over utilization that is the result of misguided incentives and even fraud among hospice providers. MedPAC's Report to Congress in 2008 stated: "our current work suggests that the hospice payment system provides an incentive for hospices to seek patients likely to have long hospice episodes, which are more profitable than short episodes."²³ More recently, in 2013, the U.S. Department of Justice filed a lawsuit against the largest for-profit chain in the country, alleging false Medicare billings for hospice services.²⁴ While this demonstration is not intended to address issues of fraud in the program, it nevertheless remains a concern in any discussion that would expand eligibility or increase utilization.

The demonstration program has raised concerns as to whether the \$400 per beneficiary per month payment is adequate to cover patient costs given the complex needs of the hospice-eligible population or whether payment levels will reinforce the incentives that dampen utilization. Limited funds may lead to creative solutions, such as hospice organizations partnering with community providers such as local aging or transportation services providers.²⁵

Offering concurrent curative and palliative care for Medicare beneficiaries may increase hospice utilization rates generally, particularly among certain ethnic and cultural groups that currently do not use the benefit much. In 2009, 41 percent of people who died in the United States used hospice services; cancer was the single most common diagnosis, comprising approximately 40 percent of this population. Although African-Americans have a higher incidence rate of cancer, shorter survival time after diagnosis, and higher cancer death rates, African Americans comprised only 8.7 percent of the hospice population that year. They were also less likely to use hospice services than other racial groups.²⁶

There are different theories about the disparity in utilization. For some demographics, the notion of comfort care only may be incompatible with cultural norms; for some minority populations, the demand for aggressive

treatment is tied to the perception that this was care that was for many years denied to their community.²⁷ Others posit that the lower utilization of hospice may be due to variation in referrals, geographic disparities in health care service provision or lack of awareness.²⁸ This is an issue that has consistently been raised as a challenge in expanding the provision of hospice and the demonstration project may provide some guidance as to how it can be addressed. The Campaign to End Unwanted Medical Treatment strongly supports efforts to ensure that everyone gets the care they want and this demonstration may help to ensure this. Articulation of a patient's needs is critical to ensuring that the care they receive reflects their wishes (for instance, quality of life may be a higher priority than extending length of life); this demonstration may allow individuals considering hospice care to make the same kinds of distinctions with respect to palliative and curative care.²⁹

Conclusion

This demonstration is yet another example of an ongoing trend toward more person-centered health care, as it looks at ways to improve quality of life while also ensuring the individual gets the type of care they want as opposed to measuring success in terms of how much care was provided. As Dawe suggested, the findings of the demonstration may also have broader implications for patients not yet ready for hospice – helping them address questions of how best to prepare for advanced illness. These issues will be more pressing as more and more Americans continue to live longer lives than previous generations.

Endnotes

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- 3 See NHPCO, *supra* note 1.
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