Medicares Role in End-of-Life Care

Approximately three-quarters of the 2.5 million people who die every year in the United States are aged 65 or older. Medicare is the biggest health care insurer for people during their last year of their life. One-quarter of Medicare health care spending is for services that people need in their last year of life. This stat has been the same for several decades. It’s not surprising why the health care that’s required during the last year of life is so costly – many people who die have complex health conditions to deal with. Cost isn’t the only factor when it comes to health insurance, including Medicare.

There are a variety of factors that play into complex policy and clinical conversations about patients getting the care they need during the last year or years of their life. According to research, approximately 90% of adults say that they would opt to have end-of-life care carried out in their
home if they had a terminal illness. However, data has shown that only approximately one-third of Medicare beneficiaries who are 65 years of age and older actually died in their home.

2016 Medicare Initiatives

As of 2016, Medicare will start to cover advance care planning, which refers to the conversations that health professionals, including physicians, will have with their patients about preferences when it comes to end-of-life care. This service will be separate and billable from traditional Medicare services. The following article answer many of the frequently asked questions about Medicare, how it plays a role in end-of-life care, and the 2016 introduction of advance care planning. Additionally, these explanations go into both the current and future end-of-life care coverage, as well as Administration rules and Congress’ proposals about advance care planning and caring for patients with terminal or otherwise serious conditions.

What exactly is end-of-life care and is it covered by Medicare?

End-of-life care refers to all of the kinds of healthcare that a person needs in the days or years before their death. End-of-life care relates to people who die suddenly or who die over a long period of time as a result of a terminal illness or serious medical condition. When it comes to people who are 65 years of age or older, the most common causes of death include cardiovascular disease, chronic respiratory disease and cancer. Medicare will cover a thorough set of services that beneficiaries can receive until their death. Medicare services may include hospital care or care in other medical settings; home health care; diagnostic tests; physician visits and services; and prescription drugs.
Medicare services can be used for palliative purposes, which means they relieve symptoms, or curative purposes. Some services are used for both palliative and curative purposes. Beneficiaries who have a terminal illness are also eligible for a hospice benefit that comes with extra services, such as bereavement services. These additional services aren’t normally available under regular Medicare health insurance. For more information about the hospice benefit, see question number five.

**What is advance care planning and is it covered by Medicare?**

There are multiple steps that make up advance care planning. Overall, advance care planning helps people learn about their options for end-of-life care and determines the best services to meet their wishes and needs. Additionally, advance care planning helps the beneficiary share their preferences with their doctors and loved ones. Sometimes, patients who have already gone over their end-of-life options only need to have an advance care planning discussion with their primary doctor. Experts, however, say that patients tend to need multiple conversations with their doctor and additional health professionals in order to fully understand and clarify their preferences. As of January 1, 2016, Medicare services will include advance care planning. However, this will be considered a separate service that’s provided by health professionals, including many physicians.

Health professionals that may offer advance care planning include nurse practitioners. Medicare will cover the cost of advance care planning that’s held in facility settings and medical offices, including hospitals. As is the case with many physician services, patients will share the cost for advance care planning. If a beneficiary would prefer to have the advance care planning service during their yearly wellness
visit, the health professional may be able to provide it and then bill Medicare separately for the service. Note that when a beneficiary asks for advance care planning during an annual visit, they will not have cost sharing liability.

**Are policymakers taking changes in Medicare’s advance care planning into consideration?**

Yes. The Centers for Medicare and Medicaid Services (CMS), the agency in charge of Medicare, has proposed and finalized the regulations that will let Medicare pay health professionals for offering advance care planning to patients. A regulation proposed by CMS and released on July 8, 2015, included two new billing codes that had been recommended by the American Medical Association. These billing codes were for advance care planning for Medicare beneficiaries. CMS finalized these provisions on October 30, 2015, which will allow health professionals to charge Medicare for advance care planning as a separate service as of January 1, 2016. Previously, coverage rules for Medicare allowed only for reimbursement of advance care planning and only when specific, limited requirements were met. Before the CMS regulation regarding advance care planning, there were two bipartisan bills in Congress that referred to end-of-life care and advance directives.

One bill was introduced in the Senate and the other one in the House. Along with co-sponsors, Senators Johnny Isakson and Mark Warner introduced the Care Planning Act of 2015 (S.1549). Included in the legislation was Medicare coverage for people with serious life-threatening or progressive illnesses, including services for advance illness planning, care coordination services, discussions about treatment options, and beneficiary preferences. House Representative Earl Blumenauer, along with 59 co-sponsors, introduced the Personalize Your Care Act of 2013 (H.R. 1173), legislations
that included both Medicaid and Medicare coverage for advance care planning discussions between health care professionals and patients.

**What are advance directives and are health care facilities required to keep records of them?**

Advance directives are the written instructions that show the beneficiary’s health care wishes. These instructions help guide the decisions that need to be made should the patient not be able to communicate for himself or herself. Advance directives are a result of the advance care planning process. A living will is a common type of advance directive. The living will includes directions for the patient’s preferred medical treatment should they become incapacitated. It may also designate the person who will have the medical power of attorney in such an instance. Advance directives are part of state regulations. The forms that are required for formal advance directives will vary depending on the state. According to studies, four in ten Americans who are 65 years old or older don’t have advance directives. Furthermore, they haven’t written down their preferences for end-of-life care.

There are differences in demographics when it comes to the people who have advance directives. Hispanics and African Americans have lower rates of having advance directives when compared to white people. People with lower levels of completed education and lower incomes also have less of a possibility of having advance directives. According to research, there are multiple factors that are instrumental in these differences: cultural differences; religious differences; communication challenges, particularly between patients and medical professionals; distrust of the health care system and medical systems; and lack of awareness of advance directives. Requirements for Medicare advance care
directives at health care facilities were included in the 1991 Patient Self-Determination Act. This law said that medical facilities, including skilled nursing facilities and hospitals, had to ask each person, when they were admitted, if they had an advance directive. The answer had to be included in the patient’s file.

While the presence or lack thereof of an advance directive had to be recorded, facilities cannot require patients to create advance directives prior to providing care. Additionally, Medicare beneficiaries aren’t required to have advance directives before receiving treatment. Surveys have shown that people receiving long-term care in a facility, including a hospice facility or a nursing home, are more likely to have advance directives.

**Does Medicare provide insurance for hospice care and how many Medicare beneficiaries actually use hospice care?**

Yes, Medicare provides insurance for hospice care. This is useful for terminally ill beneficiaries who don’t want to seek out curative treatment. Medicare has a comprehensive benefit covering a variety of hospice services, including counseling, nursing care, palliative medications, and five days of respite care to assist a caregiver. Often, hospice care is provided in the patient’s home. Medicare beneficiaries who opt for hospice care have little or no cost-sharing liability when it comes to a majority of hospice services. In order for a beneficiary to qualify for hospice care, the physician has to verify that it’s expected that the patient will die within six months, assuming the illness runs a natural course. If the patient lives beyond that six months, it’s possible that hospice coverage will continue if both the hospice team and the
physician certify the criteria for eligibility again. Of the Medicare beneficiaries who died in 2013, 47% used hospice care. This rate has more than doubled since 2000, when the rate was 23 percent. The rate of hospice coverage will increase with age. The highest rate of hospice patients are people aged 85 and older.

Additionally, hospice use is more common among women than men, as well as among white beneficiaries than beneficiaries of any other ethnicity or race. Hospice coverage makes up 10% of regular Medicare spending in a beneficiary’s last year of life. Note that Medicare Advantage plans don’t cover hospice care and that if a Medicare Advantage beneficiary receives hospice care, the coverage will fall under normal Medicare. Experts, including researchers, policy maker and patient advocates, feel that there are a number of benefits to hospice care, particularly when it comes to offering proper end-of-life care for Medicare beneficiaries.

However, there have been many questions about the increase in for-profit hospice companies. There have been differences cited regarding the on average care needs of patients served compared to the patients who are served by non-profit companies.

What is palliative care and is it covered by Medicare?

Palliative care may be a big part of end-of-life care. Palliative care often helps to manage the symptoms of the patient’s illness or condition. This can provide both the patient and their family with comfort. Palliative care is common for people who are receiving end-of-life care. However, it’s not only restricted to those with a terminal illness. According to the Center of Advance Palliative Care, this care is often used for people who are living with chronic, complex or otherwise serious illnesses, such as heart disease, cancer,
depression or pain. Forty-five percent of Medicare beneficiaries have at least four chronic conditions that may be improved by palliative services. These services may be used instead of or along with curative treatment. Medicare’s hospice benefits covers palliative care for patients who have a terminal illness.

How much does Medicare spend for end-of-life care and which services are included?

Of the seniors who had traditional Medicare and who died in 2011, spending by Medicare was an average of $33,500 per beneficiary. This is four times that of the on average cost-per-capita for seniors who didn’t die in 2011. Additional research has shown that over the past decades, approximately one-quarter of traditional Medicare health care spending is for services for patients who are 65 years old or older and in their last year of life. For the traditional beneficiaries who are 65 years old or older and who die during the year, Medicare’s per-capita spending decreased with age in 2011. Medicare spending throughout the year of death decreases with age after 70 years of age.

This suggests that families, providers and patients could possibly be choosing less costly and less intensive end-of-life treatments as the beneficiary gets older. In 2011, per capita Medicare spending peaked at the age of 70 and $42,933 and decreased by approximately 50%, down to $21,993, by the age of 95. Approximately 50% of the total of Medicare spending for people who died within a given year went toward hospital inpatient expenses; skilled nursing services and hospice care made up about 10% of Medicare spending.
Was Medicare coverage for end-of-life care and/or advance care planning affected by the Affordable Care Act?

No. The finalized Affordable Care Act (ACA) legislation didn’t have any provisions that allowed health professionals, including physicians, to seek out additional Medicare payment for advance care planning consultations. A predecessor bill that was passed by the House (H.R.3200) had provisions that would allow for Medicare reimbursement for advance care planning and programs that would increase awareness of advance care planning. However, these provisions were dropped from the final ACA legislation. There was still a lot of confusion about the ACA once it passed. This confusion can be seen in a survey by the Kaiser Family Foundation, which found that in 2013, approximately 35% of people who were 65 years old or older still believed that there was a panel by the ACA that would make end-of-life decisions for beneficiaries of Medicare.

Does the Institute of Medicine have any recommendations regarding end-of-life care and/or advance care planning?

The Institute of Medicine (IOM) has released a comprehensive report called Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. This report includes five recommendations that strive to increase the quality of end-of-life care and also improve a patient’s ability to choose their own customized treatment plan. IOM recommendations call for the following:
Comprehensive care coverage by the government and private health insurers for patients who have serious advanced illnesses and who are nearing the end of their life.

Development of quality metrics and standards for communication between healthcare providers and patients when it comes to advance care planning, including insurance reimbursement that’s tied to the performance on these standards.

Strengthening of clinical training and licensing/credential requirements for palliative care.

Federal and regulatory action that establishes financial incentives for integrating social and medical services for people who are nearing the end of their life, including electronic health records that include advance care planning.

Efforts to provide widespread information to the public regarding the benefits of advance care planning, including the ability for patients to choose their preferred type of treatment.

How does the public feel about both advance care planning and Medicare’s role in end-of-life planning?

Overall, the public is in support of health professionals discussing end-of-life planning with patients. The public also supports Medicare and private insurance covering these conversations. According to a recent survey by the Kaiser Family Foundation, 9 in 10 adults, 89 percent, say that doctors should be discussing end-of-life treatment issues with their patients. However, only 17% of adults say that they’ve had a similar discussion with their health care provider. Of adults who are 65 years old or older, 27% have had an end-of-
Of the adults who have not had an end-of-life discussion with their doctor, 50% have said that they want to. Eighty-one percent of adults say that Medicare should cover these discussions, which can be compared to the 83% of people who prefer private insurance coverage for end-of-life treatment discussions.