Framing the Challenges and Opportunities for Financing and Payment Innovation

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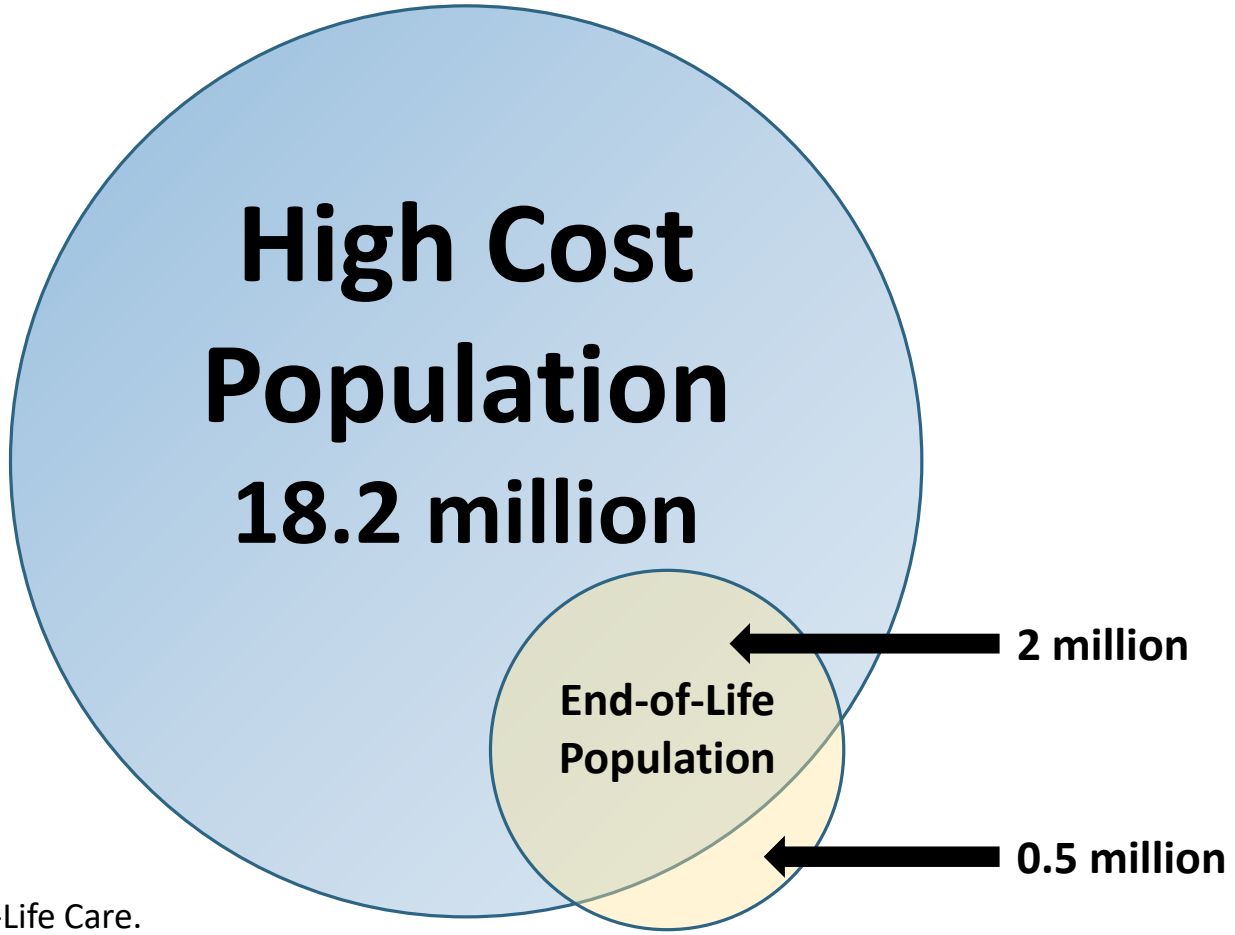
Most with High Health Care Spending Are Not at EOL

- High cost population not all at EOL
  - Not all at EOL are high cost
- Around 40% persistently high cost from year-to-year
  - People with chronic conditions and functional limitations
- Many with serious illness live with their conditions for extended period of time



SOURCE: Aldridge MD and AS Kelly. The Myth Regarding the High Cost of End-of-Life Care. *Am J Public Health*. 2015 December; 105(12): 2411–2415. PMCID: PMC4638261

Medicare's Role in Shaping Care for Serious Illness

- Medicare covers a range of acute and post-acute services
- Hospice Benefit primary mechanism for financing EOL care
  - Encompasses a broad array of palliative and supportive services
  - Limited to individuals with a terminal diagnosis
- Substantial gaps between coverage and needs
  - High cost sharing
  - Gaps in coverage (e.g., LTSS)
  - Limited palliative care coverage outside of hospice

Medicare's Importance in Financing EOL Care

- Prominent role of Medicare in shaping U.S. EOL care
  - Around 80% who die each year are Medicare beneficiaries
- Share of program spending for people at EOL relatively steady
- Important to look beyond aggregate numbers
  - Around 2/3 hospitalized at EOL
- Many of same challenges impacting EOL care affect the care of those with serious illness and – indeed – all Medicare beneficiaries

How Other Payers Finance Care for Serious Illness

Medicaid and private insurance often follow Medicare's lead

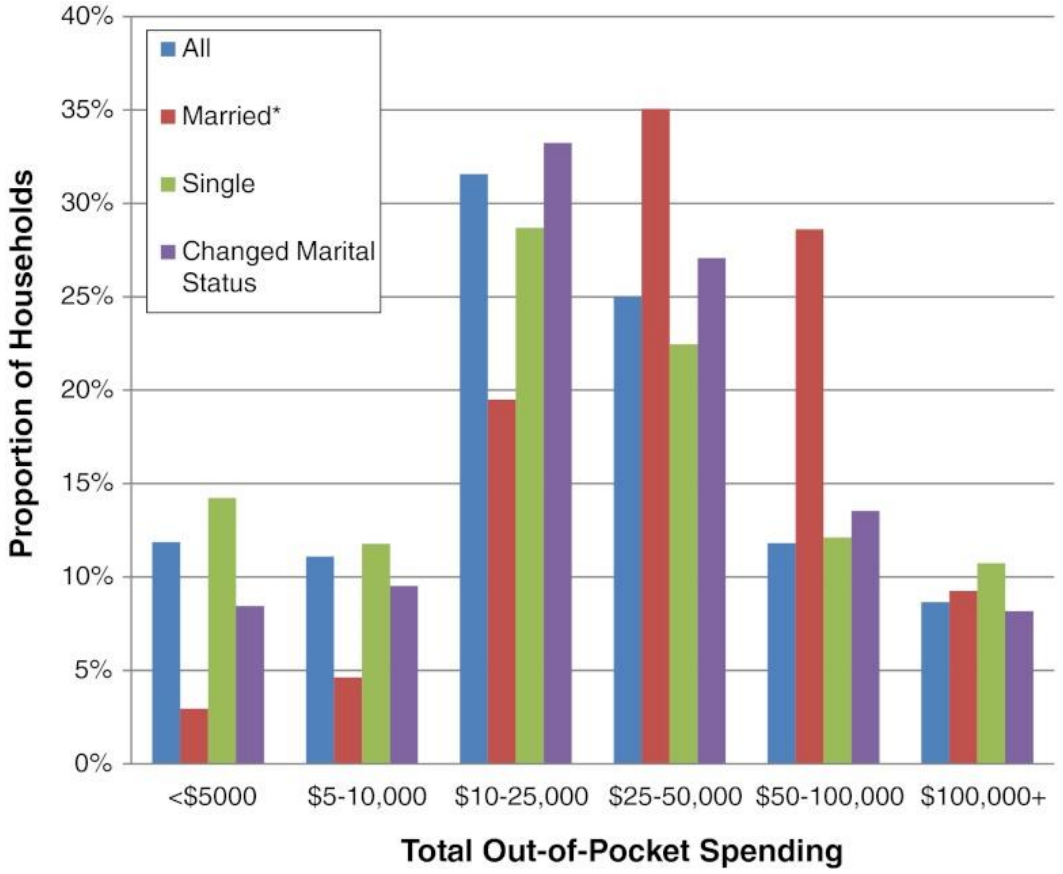
- Commercial plans have explored alternate approaches, including earlier palliative care integration and broader hospice benefit
- Like Medicare, commercial plans tend *not* to cover LTSS but some have experimented with targeted social supports
- Hospice and palliative care *not* included in 10 essential health benefits but benchmark plans in all states typically include
- Use of high-deductible health plans (HDHPs) has increased in recent years

High Out-of-Pocket Costs for Those with Serious Illness

Gaps in Medicare and limited reach of Medicaid → high OOP costs

- Between 2002-2008, average OOP costs in five years before death: $38,688
  - 90th percentile of OOP costs: $89,106
- NH care accounts for half of OOP spending for those in the top quartile
- High Rx costs also substantial factor
- Even with coverage, many struggle to pay medical bills

Distribution of Out-of-Pocket Spending in the Last 5 Years of Life



Source: Kelley, A., McGarry, K., Fahle, S., Marshall, S. M., Du, Q., & Skinner, J. S. (2013). Out-of-pocket spending in the last five years of life. *Journal of General Internal Medicine*, *28*(2), 304–309. http://doi.org/10.1007/s11606-012-2199-x

Payment Silos Highlight Need for System Redesign

Beneficiaries' service needs currently fragmented by:

- Payer type and benefit
  - inpatient and outpatient (Medicare Parts A and B)
  - post-acute rehabilitative (Medicare SNF and home health)
  - end-of-life (Medicare hospice)
  - long-term services and supports (Medicaid/out-of-pocket)
- Provider type/setting
  - MDs, hospitals, nursing homes, home health, and hospice

Implications can be higher costs and worse outcomes:

- Few incentives to coordinate care across settings
- Perverse incentives within settings
  - hospitalization of NH residents

What about Hospice?

- Primary government-financed mechanism for EOL care
- Eligibility policy serves to target/limit the benefit's use
  - Dependent on prognosis *and* on election to forgo curative therapies
- Has grown – and changed – substantially over its 30+ year history
  - Around half of Medicare decedents use benefit before death
- Serves as an escape hatch but benefit structure arguably mismatched with some of current use
- PLUS – As noted above, many with serious illness are not at the EOL

The Need for Integrated Care

- People with serious illness have interconnected needs
- In context of policy, we often talk about needs separately
  - Reflects Medicare's fragmented approach
- *Dying in America* → piecemeal reforms won't be effective
- Committee argued for different mix of medical and social services
  - Caregiver training and support, home modifications, meals/nutrition, and transportation
- Important caveat: Increased spending alone unlikely to be feasible

Serious Illness and Alternative Payment Models

- Many innovative financing and delivery strategies aim to rationalize and improve care for people with serious illness
  - Primary care and care management based models
  - Bundled payment demonstrations
  - Accountable Care Organizations
  - Managed care
- Financial incentives and accountability must be aligned to foster patient-centered care
- Also important for palliative care and hospice to be included in models to the extent feasible

Key Financing Challenges – 1

- Medicare and other types of insurance do not cover all service needs for people with serious illness
- The lack of LTSS coverage prominent but other needs also can pose a substantial burden
  - Medicaid offers a limited safety net

Implications:

- Substantial OOP costs, especially for those living with serious illness over extended period
- Scrutiny focused on ensuring appropriate use as opposed to high quality care

Key Financing Challenges – 2

- Hospice offers well-defined alternative but has limitations
  - Prognosis standard clinically arbitrary and practically difficult to follow
  - Requirement to forgo disease-modifying therapies enforces an artificial distinction and impedes timely enrollment

Implications:

- Very short hospice stays
- Limited access to palliative care, especially in the community

Key Financing Challenges – 3

- With exception of ACOs, hospice generally excluded from integrated financing and delivery demonstrations
  - FAI, BPCI, and PACE
- Hospice has always been "carved out" of Medicare Advantage

Implications:

- Carve-out ensures access to hospice provider of choice
- But approach has potential tradeoffs:
  - Lessens MA plans' incentives to bolster their own expertise
  - Creates incentive for plans to cede responsibilities for EOL care

Key Financing Challenges – 4

- As system focuses on value, there are few established quality measures to hold providers accountable for serious illness care
- Provider performance standards need to bolster these approaches, not undermine them
  - None of 33 performance measures in ACO contracts relate to EOL care

Implications:

- Providers and plans are not always attuned to providing high quality palliative and EOL care – can be viewed as outside of scope or expertise

Final Thoughts

- Medicare plays key role in financing serious illness care in the U.S.
- Important gaps and limitations are increasingly visible
- Transition of payment and delivery toward value is an opportunity for palliative care and hospice (and patients)
- However, progress will be limited if these services are excluded or de-emphasized
- Continued development of quality measures and flexible delivery models will help support push toward improved care