In 2021, the Centers for Medicare & Medicaid Services (CMS) began testing the value-based insurance design model in 9 Medicare Advantage organizations providing plans in 206 counties nationwide. Under this model, which will become more widespread in the future (anticipated to increase to 15 Medicare Advantage organizations providing plans in 461 counties in 2022), hospice services are paid for and overseen by Medicare Advantage, unlike the existing structure that carves out hospice services from Medicare Advantage. In the carve-out approach, when Medicare Advantage enrollees elect hospice, their hospice benefits are provided under traditional Medicare coverage and are not overseen by the Medicare Advantage plan.

Proponents of the Medicare Advantage carve-in suggest it has the potential to reduce fragmentation, produce new opportunities for coordination, and create new programs for patients at the end of life by consolidating accountability under Medicare Advantage. However, older adults, and particularly those with serious illness, whose end-of-life experiences would be shaped by Medicare Advantage under the carve-in, may potentially be at risk to receive lower-quality care because of the incentives to control the costs of care in Medicare Advantage plans. This Viewpoint summarizes some of these concerns and outlines the possible implications of the Medicare Advantage hospice carve-in for end-of-life care if existing trends continue.

Who Will Be Affected by the Hospice Carve-In?
Enrollment in Medicare Advantage has increased substantially over time to an estimated 42% of Medicare beneficiaries in 2021. According to a 2021 report (based on 2017 Medicare data) from the Government Accountability Office, among an estimated 454,097 beneficiaries in Medicare Advantage plans at 12 months prior to death, 45.4% were carved out of the plan when they enrolled in hospice. An estimated additional 20,749 (or 4.6%) disenrolled from Medicare Advantage during the last year of life. This compares with a disenrollment rate of 1.7% among individuals who were not in their last year of life who were enrolled in Medicare Advantage in 2017. As a result, Medicare Advantage plans were only responsible for the end-of-life care of approximately 50% of Medicare Advantage beneficiaries during the 12 months prior to death. Even though Medicare Advantage plans will be accountable for the quality and costs of care for hospice enrollees under the carve-in, the plans will not be accountable for individuals who disenroll from Medicare Advantage during the last 6 months of life without enrolling in hospice.

The Medicare Advantage hospice carve-in has the potential to shift end-of-life care delivery for a large number of Medicare beneficiaries. This could have a range of possible beneficial and harmful outcomes for this high-need, vulnerable population as well as their caregivers.

Potential for Both Improved and Worsened Care
Under the Medicare Advantage Hospice Carve-In
The Medicare Advantage hospice carve-in could be advantageous to patients if it facilitates development of innovative approaches to end-of-life care. Hospice is an important service to meet and support the symptom management needs of patients at the end of life. Despite this, the hospice model of care, which is limited to individuals with a prognosis of 6 months or less and to those who forego life-prolonging therapies, is a poor fit for many people at the end of life. Individuals with unpredictable trajectories of illness, such as those with dementia, may have difficulty qualifying for and remaining enrolled in hospice until the end of life. Other individuals may desire treatments that reduce symptoms, such as transfusions for patients with hemato logic malignancies, but these types of transfusions are considered life-prolonging treatments. The hospice carve-in could allow Medicare Advantage plans greater flexibility to develop hospice-like programs to provide palliative support services for patient populations not eligible or interested in hospice, as well as to provide concurrent life-prolonging or curative therapies along with hospice in some situations.

However, given the motivation of Medicare Advantage plans to control costs, there is some concern that Medicare Advantage enrollees could possibly be at risk for worsened end-of-life care under the carve-in without rigorous regulations and quality measurement. Profit-maximizing behavior by some for-profit hospice programs has been shown to affect the quality of care for patients and families in numerous ways, including providing a narrower range of services to patients, use of less-skilled clinical staff, selection of patients with needs met by lower-skilled workers over longer enrollment periods, and higher rates of disenrollment from hospice and filed and substantiated complaints made to hospice oversight agencies. If cost-controlling and profit-maximizing approaches are adopted, Medicare Advantage plans could possibly produce similar effects. Medicare Advantage plans may reduce access to hospice for patients anticipated to have high costs and needs; may restrict Medicare Advantage networks to lower-quality, lower-cost hospice facilities; or may reduce supports, such as home health or hospice visits, at the end of life.
Even in the absence of Medicare Advantage plan involvement in hospice, existing evidence has raised concerns around the experiences and quality of care received by patients with serious illness enrolled in Medicare Advantage plans. Older adults with higher care needs and higher treatment costs are more likely to leave Medicare Advantage plans. According to a study of 2,119 nationally representative decedents in Medicare, the family and friends of patients enrolled in Medicare Advantage plans reported worse quality for end-of-life care compared with the quality reported by the family and friends of patients enrolled in traditional Medicare. The hospice carve-in will substantially increase the number of individuals under the care of Medicare Advantage plans at the end of life, potentially including them in the same Medicare Advantage networks and practices associated with these lower-quality ratings.

How to Help Ensure High-Quality Care for Individuals at the End of Life Affected by the Medicare Advantage Hospice Carve-In

In 2021, for the second consecutive year, the Medicare Payment Advisory Commission stated, “the current state of quality reporting in [Medicare Advantage] MA is such that the Commission can no longer provide an accurate description of the quality of care in MA.” To safeguard individuals at the end of life, quality measurement in Medicare Advantage must be bolstered. Rates of hospice enrollment and hospice use patterns, such as disenrollment from hospice and skilled care visits (nursing, physician), during the last days of life will be essential to track and report.

Given that the quality of care at the end of life is shaped by patient goals and values as well as by the nature of communication between patients and clinicians, claims-based measures cannot fully capture the quality of end-of-life care, therefore, surveys of bereaved family and friends are equally important. Although these surveys are routinely given to family and friends of individuals who die in hospice, extending the survey to family and friends of all who die could provide additional data to help improve the quality of Medicare Advantage plans. The Veterans Health Administration currently surveys surrogates following the death of all veterans who die at Veterans Affairs facilities as a standard quality measure and these surveys appear to align with health care processes that are thought to improve care.

Special attention needs to be focused on the population of patients who leave Medicare Advantage plans, given their high levels of illness and health care use at the end of life. Even though Medicare Advantage does not directly oversee the care of these patients after they have left the program, it is important to assess why they are leaving. Medicare Advantage plans could be monitored for rates of disenrollment from the plans at the end of life and could be held accountable for the costs and quality of end-of-life care for patients who were enrolled at any time within the last year or the last 6 months of life compared with only holding plans accountable for patients still enrolled in the plan at the time of death.

In addition, given the flexibility of Medicare Advantage plans to offer expanded benefits, such as caregiver support and transportation assistance, innovative Medicare Advantage plans may generate important data about how to improve the care of older adults with serious illness who do not choose hospice. The Medicare Advantage carve-in could support case studies of plans that develop unique approaches to meeting the care goals of these patients while supporting them at home, thus improving quality while reducing or stabilizing costs. These novel models could guide innovation to improve the care of this population within traditional Medicare.

Conclusions

The Medicare Advantage hospice carve-in has the potential to shift end-of-life care delivery for a large number of Medicare beneficiaries. This could have a range of possible beneficial and harmful outcomes for this high-need, vulnerable population as well as their caregivers. It is important that the CMS and researchers, health systems, and hospices carefully monitor the hospice carve-in through both expanded and novel assessments of quality of end-of-life care and consider the experience of the multiple populations potentially affected by these changes. Even though Medicare Advantage plans are incentivized to reduce the costs of care, the CMS should ensure that these plans are appropriately incentivized to deliver high-quality care at the end of life.

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ARTICLE INFORMATION

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