In many cases, the end-of-life period is marked by a long series of burdensome health care transitions. In 2015, nearly 29% of decedents who were enrolled in the traditional Medicare program received intensive care during the last 30 days of life—an increase from 24% in 2000—and 11% experienced these health care transitions in the last 3 days of life. Previous research using interviews of bereaved family members and friends of decedents found that health care transitions in the last 3 days of life were associated with more unmet needs, higher rates of concern, and lower ratings of quality of care than when such transitions were absent, especially when the transition was between a nursing home and a hospital. Proper handling of these transitions at the end of life involves careful care management. Some would argue that the Medicare Advantage program would be better suited to this role than traditional Medicare.

In the Medicare Advantage program, plans are paid on a capitated basis to cover the needs of enrollees each year. This gives plans a strong incentive to manage the care of enrollees, particularly in terms of reducing avoidable burdensome health care transitions. Medicare Advantage plans may be in a position to provide care management services that are not available to beneficiaries enrolled in traditional Medicare plans, allowing patients to transition from nursing homes to home settings, where family members of descendants tend to report better end-of-life experiences. Medicare Advantage plans can implement incentives to improve advanced care planning, which can play an important role in improving end-of-life care. These plans also have been granted flexibility to cover a range of home-based palliative care services. Hospice care, which has been associated with improved end-of-life quality of care, has been carved out of the Medicare Advantage benefits, incentivizing the referral of potentially costly beneficiaries to hospice by Medicare Advantage plans. Despite these opportunities, the current study from Ankuda et al provides the first evidence to date that Medicare Advantage plans may have some room for improvement.

Ankuda et al found that, compared with decedents who were enrolled in traditional Medicare plans, the loved ones of decedents enrolled in Medicare Advantage plans were more likely to report that care was not excellent, and that they were not kept well informed in the last month of the decedent's life. This dissatisfaction can be reflected in enrollment as well; between January 2017 and December 2017, the Medicare Advantage disenrollment rate was approximately 2% among all beneficiaries, but was 4% among those who had died. Sicker Medicare Advantage enrollees appeared to disenroll from the program at much higher rates than those of healthy enrollees. However, such disenrollment complicates the comparison of end-of-life outcomes between traditional Medicare and Medicare Advantage enrollees, and it is unclear how disenrollment may impact the perceived quality of care.

What might be the reason for these poor experiences? Ankuda et al suggest that it could be owing to narrow the network designs that many Medicare Advantage plans have, which may restrict enrollees from getting care from their preferred health care facilities and limit care to lower-quality facilities. These facilities may be understaffed and may not be able to provide the necessary attention to patients with the greatest needs. Another possibility could be that Medicare Advantage plans may enforce a detailed care protocol that might not be flexible enough to incorporate a patient’s needs. For instance, if an enrollee’s religious beliefs preclude the use of a specific treatment modality at the end of life, a plan may not agree to cover the treatment without a lengthy process of
prior authorization. In general, prior authorization requirements may induce additional stress and delays in access to health care services at the end of life.

No matter what the reasons, ensuring access to high-quality care at the end of life is of the utmost importance given the impending implementation of the Medicare Advantage carve-in model of hospice service coverage starting in 2021. This model may lead to a larger share of enrollees in the Medicare Advantage program and will require detailed monitoring to ensure that quality standards for end-of-life care are met by plans. Whether Medicare Advantage enrollees will have adequate access to high-quality hospice care in this new model will also necessitate scrutiny. Given that previous research has found that Medicare Advantage enrollees tend to be admitted to lower-quality hospitals and nursing homes, it will be critical to ensure that they are not preferentially referred to lower-quality hospice facilities that may save money for the plan at the cost of providing fewer visits and lower-quality end-of-life care.

Medicare Advantage plans are in a unique position to offer high-value end-of-life benefits to enrollees that are unavailable in traditional Medicare plans, and the care management that these plans offer may reduce burdensome health care transitions. As Medicare Advantage plans enter this next frontier in care management, careful monitoring measures are warranted to ensure that this potential advantage is met.

ARTICLE INFORMATION
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