



POLICY RECOMMENDATIONS FOR MEDICARE HOSPICE BENEFIT RELATING TO PATIENTS WITH ADRD

**Evan Sangster (Rebecca Utz, Katherine Supiano & Margaret Clayton)
Department of Social and Behavioral Science**

INTRODUCTION

Hospice is a form of team-delivered health care that provides palliative (rather than curative) care to terminal patients -defined as having 6 months or less to live- and their families. Palliative care focuses on the management of symptoms and on increasing the overall quality of life of a patient. Hospice is generally covered by the Medicare hospice benefit which lays out the rules and regulations that hospice providers must follow in order to maintain licensure as well as the criteria that must be met for a patient to be deemed terminally ill. These criteria were formed by the Centers for Medicaid and Medicare (CMS) in the 1980's and catered primarily to cancer patients which has been the predominant patient population served by hospice. However, within recent years patients with Alzheimer's disease and related dementias (ADRD) have come to make a larger proportion of that population. This growing proportion is accompanied by the fact that patients with ADRD experience a much less predictable prognosis and trajectory when compared to patients with cancer. Imposing these criteria onto ADRD patients which was originally designed for cancer patients has resulted in an increased rate of "live discharge" across the country. Live discharge occurs when a hospice patient outlives eligibility and is thus disqualified from Medicare coverage, most commonly as a result of the patient failing to meet hospice eligibility criteria set forth by CMS.

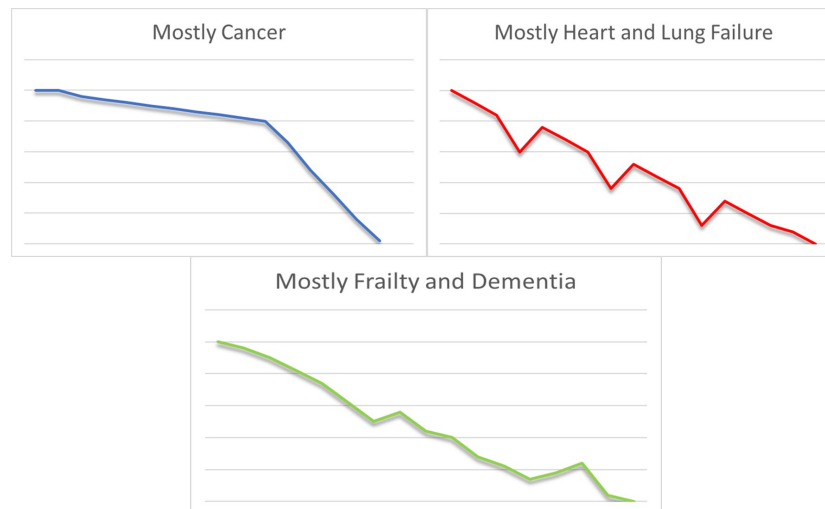


Figure 1. Three common end of life disease trajectories
Figure adapted from: Lynn, Joanne and David M. Adamson,
Redefining and Reforming Health Care for the Last Years of Life.

Live discharge has many unintended consequences. Live discharge generates feelings of abandonment, loss of security -especially for the families of the patients who must now provide the care-, loneliness, uncertainty, anger and frustration, and physical decline (Watson Campbell, 2015). Furthermore, one third of patients who are discharged from hospice alive go on to pass away within 6 months of their discharge (Kutner et al., 2004).

The conditions of participation/eligibility were benchmarked towards cancer patients. They are therefore not appropriate for patients with ADRD and other diseases with similar trajectories (Russell et al., 2017; Dolin et al., 2017; Taylor et al., 2008). Given the growing utilization of hospice and the increasing proportion of hospice patients with ADRD, it's imperative to consider alternative policies that will better suit this population.

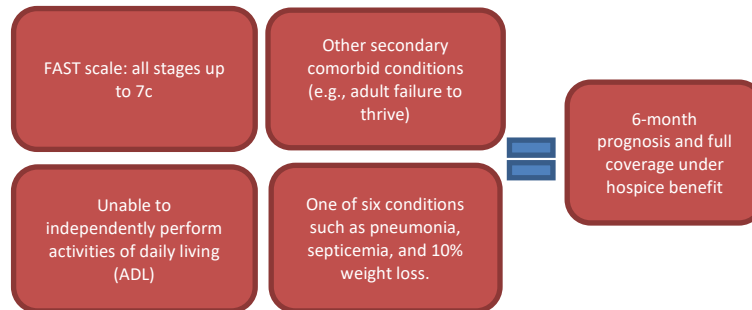


Figure 2. Current eligibility guidelines for patients with ADRD

METHODS

The CDC Polaris Policy Process was used as a template for these policy recommendations. We performed an analysis of the CMS policies and regulations for the hospice benefit focusing primarily on the language associated with hospice eligibility. Using this analysis, a thorough literature review, and insight gained from interviews healthcare professionals in the fields of hospice and geriatrics, we generated three policy recommendations. The aim of these recommendations was to provide more coverage for patients with ADRD while limiting the cost expenditures incurred by CMS.

POLICY RECOMMENDATIONS

Alternative #1 – Partial Coverage

We suggest partial financial coverage under the Medicare hospice benefit for patients who meet several criteria but may not meet all of the recommended criteria for a 6-month prognosis. This alternative policy would provide the much-needed hospice support for patients who would otherwise utilize more expensive hospital resources. An example of how this may look is presented below. This would result in better health outcomes for the patient and less spending in general for the healthcare system.

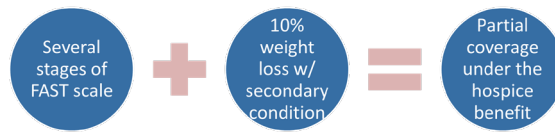


Figure 3. Suggested eligibility guidelines for partial coverage under the hospice benefit

Alternative #2 – New Flow Chart

This is a flowchart representing a new possible approach to determining hospice eligibility for patients with ADRD. This decision-making process uses the guidelines created by the National Hospice and Palliative Care Organization (NHPCO) to allow for better care of more complex patients such as those with ADRD. The ADEPT (mentioned below) is an assessment that has been deemed as more accurate than current hospice eligibility guidelines in some crucial elements (Mitchell, et al., 2011, NCBI). Meanwhile, the FAST scale, which is currently used to determine hospice eligibility, was found to be an unreliable predictor of a 6-month prognosis (Brown et al., 2012).

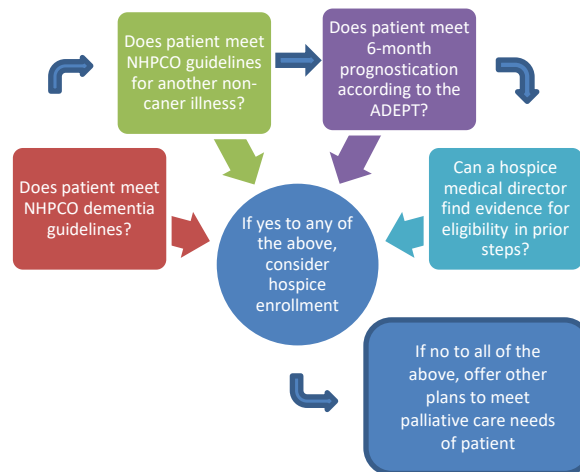


Figure 4. A suggested approach for determining Medicare hospice benefit eligibility for patients with dementia

Figure has been adapted from: Jayes, R., Arnold, R., & Fromme, E. (2012). Does This Dementia Patient Meet the Prognosis Eligibility Requirements for Hospice Enrollment? *Journal of Pain and Symptom Management*.

Alternative #3 – Financial Needs Factor and Goals of Care

We suggest that clinicians responsible for certifying terminal illness be permitted to factor in the financial needs of the patient and the available caregiver support when determining hospice eligibility. Patients who are discharged alive frequently still require involved care. This care may

be provided by a private home health agency or by family and loved ones with these options requiring either significant funds or working less hours on the part of the family to provide the needed care themselves. Furthermore, we suggest that the patient's goals of care be factored in when determining eligibility. In a study looking at goals of care, dying at home was observed more often in people who were receiving care that aligned with their goals. Dying at home and thus aligning care with the goals of the patient was associated with better pain management, communication, and greater quality of life (Khandelwal et al., 2017). These alternative policies would again improve health outcomes for the patient by giving them access to high quality care and equipment. This would result in increased costs for CMS but net savings overall.

CONCLUSION

Providing an alternative to loss of coverage, a new way of approaching eligibility, and factoring in the financial needs of the patient while respecting their end-of-life goals will foster greater quality of care in patients with ADRD. These policies may be used exclusively or in conjunction with one another. These and other policy recommendations which aim to provide better coverage for this patient population will most likely result in higher costs incurred by CMS due to higher number of hospice enrollments. However, it is well documented that hospice utilization saves money for the patients, Medicare, and the healthcare system as a whole (Huang et al., 2020; Kelley et al., 2013; Obermeyer et al., 2014). With both the prevalence of live discharge and the proportion of hospice patients with ADRD increasing, these recommendations should be considered and adjusted to best fit the needs of the growing elderly population.

REFERENCES

- Brown, M. A., Sampson, E. L., Jones, L., & Barron, A. M. (2012). Prognostic indicators of 6-month mortality in elderly people with advanced dementia: A systematic review. *Palliative Medicine*, 27(5), 389–400. <https://doi.org/10.1177/0269216312465649>
- Dolin, R., Hanson, L., Rosenblum, S., Stearns, S., Holmes, G., & Silberman, P. (2017). Factors Driving Live Discharge From Hospice: Provider Perspectives. *Journal of Pain and Symptom Management*, 53(6), 1050–1056. <https://doi.org/10.1016/j.jpainsymman.2017.02.004>
- Huang, Y., Wang, Y., Chi, C., Hu, W., Lin, R., Shiao, C., & Tang, W. (2020). Differences in medical costs for end-of-life patients receiving traditional care and those receiving hospice care: A retrospective study. *PLOS ONE*, 15(2), e0229176. <https://doi.org/10.1371/journal.pone.0229176>
- Jayes, R., Arnold, R., & Fromme, E. (2012c). Does This Dementia Patient Meet the Prognosis Eligibility Requirements for Hospice Enrollment? *Journal of Pain and Symptom Management*, 44(5), 750–756. <https://doi.org/10.1016/j.jpainsymman.2012.08.004>

- Kelley, A., Deb, P., Du, Q., Aldridge Carlson, M., & Morrison, R. (2013). Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number Of Different Lengths-Of-Stay. *Health Affairs*, 32(3), 552–561.
<https://doi.org/10.1377/hlthaff.2012.0851>
- Khandelwal, N., Curtis, J. R., Freedman, V. A., Kasper, J. D., Gozalo, P., Engelberg, R. A., & Teno, J. M. (2017). How Often Is End-of-Life Care in the United States Inconsistent with Patients' Goals of Care?. *Journal of palliative medicine*, 20(12), 1400–1404.
<https://doi.org/10.1089/jpm.2017.0065>
- Kutner, J., Meyer, S., Beaty, B., Kassner, C., Nowels, D., & Beehler, C. (2004). Outcomes and Characteristics of Patients Discharged Alive from Hospice. *Journal of the American Geriatrics Society*, 52(8), 1337–1342. <https://doi.org/10.1111/j.1532-5415.2004.52365.x>
- Lynn J, Adamson D. Redefining & Reforming Healthcare for the Last Years of Life. 2006.
- Mitchell, S., Miller, S., Teno, J., Kiely, D., Davis, R., & Shaffer, M. (2010). Prediction of 6-Month Survival of Nursing Home Residents With Advanced Dementia Using ADEPT vs Hospice Eligibility Guidelines. *JAMA*, 304(17), 1929.
<https://doi.org/10.1001/jama.2010.1572>
- Obermeyer, Z., Makar, M., Abujaber, S., Dominici, F., Block, S., & Cutler, D. (2014). Association Between the Medicare Hospice Benefit and Health Care Utilization and Costs for Patients With Poor-Prognosis Cancer. *JAMA*, 312(18), 1888.
<https://doi.org/10.1001/jama.2014.14950>
- Russell, D., Diamond, E., Lauder, B., Dignam, R., Dowding, D., Peng, T., Prigerson, H., & Bowles, K. (2017). Frequency and Risk Factors for Live Discharge from Hospice. *Journal of the American Geriatrics Society*, 65(8), 1726–1732.
<https://doi.org/10.1111/jgs.14859>
- Watson Campbell, R. (2015). Being Discharged from Hospice Alive: The Lived Experience of Patients and Families. *Journal of Palliative Medicine*, 18(6), 495–499.
<https://doi.org/10.1089/jpm.2014.0228>