

Concurrent Care: Improving Access to End of Life Treatments

Authorized within §3140 of the *Patient Protection and Affordable Care Act (ACA)*, the *Medicare Hospice Concurrent Care Demonstration Program* (Demonstration Program) may expand certain treatment options for Medicare patients seeking “end of life” care. Under current Medicare coverage policies, patients must choose between either *curative treatment options* or *hospice care*. However, through the Demonstration Program, HHS will evaluate the impact on patient care and quality of life, as well as the cost-effectiveness of reimbursing facilities for both *curative treatment options* and *hospice care*.¹

Medicare requires beneficiaries to forgo any curative treatment, i.e., treatment that is given with the intent of curing a particular condition, as a qualifier for providing coverage for hospice services, which has been “...*the acknowledged gold standard for those at the end of life and their families*.”² Medicare originally began covering hospice services in 1983, i.e., “...*primarily because Congress saw it as cost-effective, and, generally speaking, foregoing expensive curative treatment in favor of less-intensive hospice services will reduce overall costs*.”³ Restrictions limiting access between these two treatment options not only have the potential to create financial tensions for patients and their families when seeking end of life treatment,⁴ but may also “...*cause[s] confusion likely resulting in healthcare professionals’ failure to recommend hospice as soon as they could*.”⁵ Additionally, asking patients from certain cultures to choose “*comfort*” or palliative care to the exclusion of life-prolonging treatment may be in conflict with their cultural beliefs, thereby creating an access barrier to hospice care.⁶

The Demonstration Program is set to take place over a three year period, at no more than 15 hospice programs (located in both urban and rural areas) that will allow patients to receive hospice concurrently with other curative treatment(s) without incurring out of pocket expenses.⁷ Following the Demonstration Program, the Secretary of HHS must arrange for an independent evaluation to be submitted to Congress regarding the effect of providing concurrent care, specifically, whether the “...*demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program*.”⁸

Proponents of the Demonstration Program advocate that eliminating the dichotomy between hospice and curative treatment will improve patient care and quality of life, while also lowering healthcare expenditures.⁹ A 2012 study published in the *Journal of the American Geriatrics Society*, and funded by the Alzheimer’s Association and the National Institute on Aging, found that patients with advanced dementia in the last 90 days of life who received hospice care in addition to skilled nursing care required fewer aggressive treatments and were typically at lower risk of hospital death.¹⁰ The Alzheimer’s Association study also found that without concurrent care treatment options, there were also certain financial incentives for unnecessary care to be provided to Medicare beneficiaries, due to providers attempting to offset typically lower Medicaid per diem rates by over treating Medicare beneficiaries in order to receive higher Medicare per diem rates.¹¹

While CMS has yet to set a start date for the Demonstration Program, some private payors, e.g., Aetna and UnitedHealthcare, have offered concurrent care options for several years.¹² In 2010, approximately 1.58 million patients in the U.S. received hospice care, of which 1.03 million died while under hospice care, which represented 41.9 percent of all U.S. deaths that year. Of those patients discharged from hospice care, a large percentage of these patients left a hospice program to pursue curative treatments. In 2010, 82.7 percent of hospice patients were 65 or older, and a majority of patients (38.9 percent) were over the age of 85.¹³ As the baby boomer population continues to age, the need for hospice care will likely increase, making quality and cost effective treatments a necessity. While pediatric patients account for less than one percent of hospice patients,¹⁴ a concurrent care amendment to the Medicaid program and the *Children’s Health Insurance Program (CHIP)*, which was mandated under the ACA, also took effect in 2010, allowing for both hospice and curative reimbursement to be available for children seeking hospice care.¹⁵

1 “Patient Protection and Affordable Care Act” Pub. L. 111-148, 124 STAT. 440-441. (March 23, 2010).
 2 “Forced to Choose: Exploring Other Options” By Paula Span, New York Times, December 3, 2012, <http://newoldage.blogs.nytimes.com/2012/12/03/forced-to-choose-exploring-other-options/> (Accessed 1/4/2013).

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- 3 “Health Care Reform at the End of Life: Giving with One Hand but Taking with the Other” By Kathy L. Cerminara, American Society of Law, Medicine and Ethics, 2013, http://www.aslme.org/print_article.php?aid=460404&bt=ss#_ft1 (Accessed 1/7/2013).
- 4 Span, 2012.
- 5 Cerminara, 2013.
- 6 *Ibid.*
- 7 Pub. L. 111-148 (March 23, 2010).
- 8 *Ibid.*
- 9 Cerminara, 2013.
- 10 “Influence of Hospice on Nursing Home Residents with Advanced Dementia Who Received Medicare-Skilled Nursing Facility Care Near the End of Life” by Susan Miller, Julie Lima, and Susan Mitchell, *Journal of the American Geriatrics Society*, Vol. 60, Is. 11 (Nov. 2012), p. 2035-2041.
- 11 *Ibid*, p. 2036.
- 12 “Medicare Will Experiment With Expansion Of Hospice Coverage” By Michelle Andrews, Kaiser Health News, September 7, 2010, <http://www.kaiserhealthnews.org/features/insuring-your-health/medicare-hospice-coverage-expansion.aspx> (Accessed 1/28/2013).
- 13 “NHPCO Facts and Figures: Hospice Care in America” National Hospice and Palliative Care Organization 2011 Edition, 2012, p. 4, 6.
- 14 *Ibid*, p. 6.
- 15 Pub. L. 111-148, 124 STAT 293 (March 23, 2010); “Letter from CMS to State Health Officials Regarding Hospice Care for Children in Medicaid and CHIP” By Cindy Mann, Director of the Center for Medicaid, CHIP and Survey & Certification, to State Health Officials, SMD # 10-018, September 9, 2010.



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