What Do Gaps Between Patient Preferences and Covered Benefits in Medicare Tell Us About End of Life Policy?”

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Answer

- If patient well being and quality of life are key, we need to alter the benefits covered by Medicare (hint: cover long term care)

- The answer raises a question:
  - Could we do this without breaking the bank?
Maybe, And Why It is Time to Try

- Policy Consensus: need higher value in spending
- Unclear who defines value or how?
- Benefit to patient > cost
- For the elderly/Medicare
  - Easiest way to increase value is cover LTC
  - Can we trade low value for high value?
  - Would patients do this with more choice?

Our research suggests maybe
Remainder of the Talk

- Context
- CHAT Study
- Ongoing CMMI Community based palliative care demo
Key Point from IOM Report

- Focus on preferences of “the delivery of person-centered, family-oriented end-of-life care”
- Working out what that means
  - ~8 in 10 deaths nationally occur in Medicare beneficiaries
  - If change is needed, it will have to come to Medicare
Policy Developments

- IMPACT Act passed
- CMS concurrent hospice demo (Medicare Care Choices Demo)
- MedPac/Congressional Discussion
  - Changes to Medicare payment?
  - Will hospice be put into Medicare Advantage?
Context

- Medicare: align benefits w/patient preferences & cost
- Big picture: Medicare unsustainable, even with recent slowdown in cost inflation (Baby boomer + inflation)
- What can be done?
  - National coverage decisions v political reality

Ask Patients?
Convergence

- Shift to patient centered concern
- Thaw in end of life policy; changes may be plausible again
Recent Research in Oct ‘14 JCO

- Identified gap between what Medicare covers (benefits) and the preferences of patients with cancer and their caregivers
- Gaps show willingness to reallocate finite $ to “quality of life” care
  - Concurrent palliative care
  - Home based LTC
  - Unrestricted cash

Big Q?: how to have a national conversation?
Key Point

- Patients + caregivers were reallocating finite $$ from medical care toward quality of life maximizing benefits
## Preferences for non covered benefits

<table>
<thead>
<tr>
<th>Benefits covered by Medicare</th>
<th>Round 1</th>
<th>Round 4</th>
<th>P</th>
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</thead>
<tbody>
<tr>
<td><strong>Treatment for cancer—no. (%)</strong></td>
<td></td>
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<td>0.045</td>
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<tr>
<td>Basic</td>
<td>28 (6.4)</td>
<td>15 (3.4)</td>
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</tr>
<tr>
<td>Intermediate</td>
<td>174 (39.5)</td>
<td>172 (39.2)</td>
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</tr>
<tr>
<td>High</td>
<td>186 (42.3)</td>
<td>217 (49.4)</td>
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<tr>
<td>Advanced</td>
<td>51 (11.6)</td>
<td>34 (7.7)</td>
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<td><strong>Primary Care—no. (%)</strong></td>
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<td>Basic</td>
<td>396 (90.0)</td>
<td>405 (92.3)</td>
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<tr>
<td>Not selected</td>
<td>44 (10.0)</td>
<td>34 (7.7)</td>
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<tr>
<td><strong>Drugs—no. (%)</strong></td>
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<tr>
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<td>90 (20.5)</td>
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<tr>
<td>Intermediate</td>
<td>328 (74.5)</td>
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<td><strong>Benefits not covered by Medicare</strong></td>
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<td><strong>Cash—no. (%)</strong></td>
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<tr>
<td>Basic</td>
<td>124 (28.2)</td>
<td>114 (26.0)</td>
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</tr>
<tr>
<td>Intermediate</td>
<td>43 (9.8)</td>
<td>52 (11.8)</td>
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<tr>
<td>High</td>
<td>38 (8.6)</td>
<td>24 (5.5)</td>
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<tr>
<td>Not selected</td>
<td>238 (54.1)</td>
<td>249 (56.7)</td>
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<td><strong>Home care—no. (%)</strong></td>
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<tr>
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<td>146 (33.2)</td>
<td>163 (37.1)</td>
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<td>119 (27.0)</td>
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<td>185 (42.1)</td>
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<td>70 (15.9)</td>
<td>44 (10.0)</td>
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<tr>
<td>Not selected</td>
<td>80 (18.2)</td>
<td>63 (14.4)</td>
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</table>
Key Findings

- 18% of participants choose all 3 non-covered benefit types (cash, concurrent palliative, home based LTC)
- Allocated mean 15.5 (sd 4.3) of 50 stickers toward these 3 (range 7-24)
- Intermediate to high cancer care level, 7 stickers
- Key predictor: African Americans v White OR 1.91 [1.14-3.23]
Conclusions & Limitations

- **Patient-reported outcomes and preferences are legitimate, important evidence sources**
  
  “Patients living with cancer may be the ones most ready to make difficult choices and trade-offs”

- **Cancer patients and their caregivers may value quality of life care more than current policy indicates**
  
  “The willingness to allocate finite resources toward home-based LTC and concurrent palliative care shows these uncovered services address strongly felt needs”

- **This study measured theoretical choices**
  
  “Patient and caregiver endorsements do not necessarily reflect the decisions they would make in real life, and the options we offered presented stark choices, whereas the Medicare program does not”
Big question: can a “national conversation” be held that is similar to what done in this exercise?

A flexible benefit package allowing less chemotherapy, etc. and more in flexible resources focused on QOL broadly defined could be acceptable/preferable and could save money

Cancer likely hardest area to have this conversation

Need prospective way of addressing costs
CMMI Demo

- Four Seasons Hospice & Duke
- Center for Medicare and Medicaid Innovation Round 2 Grant
  - Community based palliative care
  - 12 counties in N.C.
  - N~8,000 patients, 3 years
  - Earlier exposure: improve QOL + reduce costs?
Key Intellectual Exercise

- Non experimental inference
- Money savings: “as compared to what?”
- More data better
  - Looking for new partners
Biggest Questions?

- Is it scalable?
- Key policy issue
  - If identify the $ size of the bundle, who will hold it?
  - Incentive set needed that will work across many markets
  - Need clear policy goal first
Policy Framework

- Allow elderly more choice
  - Flexible $ for LTC
  - Start with dual eligibles
- Have cost control targets that trigger new financing if not met
  - Part A payroll tax (Give adult children a stake in cost control)
  - Part B premium (Give beneficiaries a stake in cost control)

Looking for a way to test flexible $ for LTC