

Managed Care Can Make a Difference: The Need for Care at the End of Life

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The recent Institute of Medicine (IOM) report, "Crossing the Quality Chasm,"¹ highlights the deficiencies of the American healthcare system's management of increasing number of patients with chronic disease. The report suggests these deficiencies result from the increasing complexity of science and technology, poorly organized health systems, and constraints on exploiting the revolution in information technology. As patients with chronic or subacute diseases near the end of life, they have even greater need for thoughtful management of their care that is continuous and patient-centered, and that anticipates the patients' needs and those of their caregivers. A Report of the National Task Force on End-of-Life Care in Managed Care² states that health system inadequacies noted by the IOM have led to many patients dying in pain and discomfort, too many technologies imposed on patients to merely prolong the dying process, lack of continuity of care, too little attention to the depression and emotional suffering of patients and their families, heavy burdens on caregivers, and a sometimes devastating impact on the financial well-being of the surviving family members.

Patients, families, and physicians face a wide range of difficult choices when deciding about care near the end of life. As medical therapies and technologies have advanced, more people are living with complex illnesses and more options are available, both aggressive and conservative. A number of US organizations, including the Institute of Medicine,³ have made efforts to increase the awareness of the public, professional community, and health plans of the need for a more

global and formal approach to managing the care of people near the end of life. States have created task forces, a range of professional specialty organizations from the American Academy of Hospice and Palliative Medicine to the American Nursing Association have begun efforts to improve the skills and awareness of professionals in the management of these patients, and foundations have funded task forces and white papers on end-of-life care.

One of the major challenges to providing excellent end-of-life care is the lack of a system or formal structure to evaluate and meet patients' needs that considers hospice as an appropriate option for care. Managed care plans provide a coordinated and well-organized system of care to patients throughout their illnesses. Health plans provide the infrastructure lacking in the healthcare system as a whole. Health plans encourage patients to identify a primary care provider who can help coordinate care, provide advice, and serve as an advocate, especially when patients are seeing a number of specialty and subspecialty physicians. Health plans also use information technology to identify patients needing preventive care, disease management, or case management services. Health plans particularly focus on those patients who can benefit from a coordinated, multidisciplinary approach to care such as patients with complex, chronic illnesses requiring a broad range of services. Once these patients are identified, health plans provide case managers to help patients get the care they need, navigate through healthcare and health plan systems, coordinate services, and manage cost. The same case manager may follow a patient throughout the course of an illness, providing more continuity of care than any other individual healthcare professional involved in the patient's care. Many patients who are being followed by health plan case managers should consider hospice care as an option as the natural course of their illness progresses.

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Managed Care and the Use of Hospice

Many organizations and advocacy groups have suggested hospice services are underutilized. While there is no gold standard, data such as interviews with families, length of stay in hospice, and Congressional reports on Medicare utilization of hospice suggest many more patients would benefit from referral to hospice care and referral should occur earlier in the course of their illness. The article by Virnig et al⁴ in this issue of the *Journal* analyzes and compares the use of hospice care in fee-for-service and managed care Medicare plans. The authors find enrollees in managed care plans use hospice significantly more often than do patients in fee-for-service Medicare. This is particularly true for populations using less hospice care than average, such as people with lower incomes and minorities. The authors' hypothesis is that the different financial incentives for managed and fee-for-service Medicare are the driving force behind the variation in use.

The role of economic incentives is a complex one. On the surface the incentive to maximize revenue in fee-for-service healthcare should encourage providers not to refer patients to hospice. The services in hospice are generally lower cost and are provided primarily at home or in a skilled nursing facility. Most hospice patients forego the more aggressive and costly therapies sometimes applied at the end of life. On the other hand, managed care plans would appear to have no such disincentive to hospice referral. The costs of hospice care for the health plan's Medicare members are paid directly by Medicare. The health plan is only paid for, and is only at financial risk for non-terminal illness costs and its administrative costs once the patient enters hospice. The financial incentive for health plans is more complex than this simple contrast with fee-for-service care, however.

Managed care plans do not all receive the same capitation payment for Medicare members. The financial incentives for health plans vary based on geographic location, the level of the capitation payments from Medicare, and the cost of hospice care. The rate of Medicare payment in the counties with high reimbursements is twice that of the lowest counties. Given this wide range, one might think if the economic incentives were the main driver of hospice use, significant differences would exist between areas with low payments—where the incentive to refer to hospice is higher—and those with high payments, where a financial incentive to

retain the patient may exist. The authors found no difference in rates across the United States, with rates of referral and length of stay in hospice being consistent across the counties evaluated regardless of the reimbursement rates. Even if the financial incentive for plans were more straightforward, the Medicare Rights Center found that health plan staff do not know about the details of the financial implications and simply see the selection of hospice as the loss of a covered member.

To complicate matters further, financial incentives for patients in fee-for-service Medicare may drive them to choose hospice care to obtain more comprehensive services at lower personal cost. Fee-for-service patients who choose hospice are eligible for a broader range of services than is available under standard Medicare and with a smaller co-payment. In addition, drugs related to the patients' terminal illness that are not covered under traditional Medicare are covered under hospice.

While it is hard to rule out economic incentives as an important driver, other reasons could contribute to higher managed care enrollee use of hospice. The case management services described above increase the likelihood hospice care will be presented to patients and their families. Case managers and many primary care physicians often provide care and support for patients with chronic and fatal diseases and so are more comfortable and skilled in addressing the issues and options available near the end of life. These professionals have ongoing relationships with patients and their families, making it easier to have an open and frank discussion of options for care at the end of life. In the absence of case management or other formal care management programs, these discussions may not occur in the non-managed care sector. Physicians treating patients near the end of life have trouble predicting life expectancy and tend to overestimate the time left for patients.⁵ Physicians frequently do not have the communications skills or time to address the issues patients and families need to consider near the end of life.⁶ Patients may be under the care of a number of physicians, such as oncologists, radiation therapists, surgeons, and primary care physicians, each of whom thinks the other is addressing end-of-life issues with the patient. In these instances, it is the case manager who can work with the patient, the family and other caregivers, the treating physicians, and the health plan to develop a care plan to most effectively meet the patient's needs and wishes.

Other personal and structural issues may explain the difference in referral rates. Managed care plans refer many patients with serious illnesses to centers of excellence. These centers frequently offer more coordinated and comprehensive care than is available elsewhere. Physicians and patients participating in managed care plans may be more open to considering alternatives and a range of choices at the end of life.

The study by Virnig and colleagues raises important questions about the differences between fee-for-service and managed care enrollees in Medicare. The choices patients make near the end of life are intensely personal and should be made with the widest possible range of options and most informed process. While financial incentives play a role in the choices for all participants, further study should also elucidate the other factors of the healthcare system contributing to the patient's decisions as well as the personal factors that drive them. Ultimately, both traditional and managed care Medicare should be

structured to allow patients to make the choices best meeting their needs.

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