To: Third Way

From: Avalere Health

Date: December 16, 2014

Re: Estimated Federal Impact of Medicare End-of-Life Policy

Summary

Third Way asked Avalere Health to estimate the Federal cost or savings associated with a Medicare end-of-life care (EOL) policy that would engage beneficiaries and providers in the EOL care decision-making. The proposed policy would provide one-time incentive payment to a Medicare beneficiary to create an advance directive (AD) starting in FY 2015. The policy would also create a separate billing code and reimbursement under Part B fee-for-service (FFS) schedule for EOL care counseling visit.

We estimate this proposal would reduce federal spending by $13.8 billion over the 2015-2024 federal budget window. This amount reflects a combination of an estimated $7.2 billion in new spending on the incentive payments to Medicare beneficiaries for an AD creation and physician payments for EOL counseling visits offset by an estimated $21.0 billion in savings from the reduced EOL Medicare spending due to lower health care utilization by beneficiaries having ADs.

Estimated Change in Federal Spending due to Medicare End-of-Life Policy

$ in billions, by fiscal year

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	**2015-2024**
Costs due to incentive payments & EOL counseling visits	0.8	0.8	0.6	0.5	0.7	0.7	0.6	0.6	0.9	0.9	7.2
Savings from reduced EOL Medicare spending	-1.2	-1.7	-1.8	-1.9	-2.0	-2.2	-2.3	-2.5	-2.6	-2.8	-21.0
Total change in spending	**-0.4**	**-0.9**	**-1.2**	**-1.4**	**-1.3**	**-1.5**	**-1.7**	**-1.9**	**-1.7**	**-1.9**	**-13.8**

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Background

An advance directive (AD) allows individuals to pre-specify their health care treatment preferences for times when they might not be able to express them, including whether they want to forgo or receive aggressive life-sustaining treatment. There are different types of ADs including living will and the durable power of attorney for health care. The creation of the AD is a part of EOL care planning.

Currently, Medicare does not reimburse physicians for having EOL care conversations with their patients. Some private insurers e.g., Blue Cross Blue Shield of New York, already reimburse doctors who help patients with advance care planning.[1] Some states, such as Colorado, also reimburse physicians for advance care planning under the Medicaid program. [2]

The 1990 Patient Self-Determination Act (PSDA) requires health care institutions that receive Medicare and Medicaid reimbursement such as hospitals, nursing homes, home health agencies, hospice providers, health maintenance organizations (HMOs), and other health care institutions to provide patients with the information about their rights regarding medical decision-making, including availability of ADs.[3] This law however, does not apply to individual physicians, clinics and practices, which makes it more difficult to support EOL care discussions and AD creation.

Historically, there has been some legislative efforts to support physicians in talking to their patients about EOL care. One of the policy proposals under the 2009 health care reform would have authorized reimbursements for physician EOL counseling every five years, including advance directives.[4] This proposal was not included in the Affordable Care Act (ACA) of 2010 because of the controversy over potential rationing of medical care and avoidance of the curative treatment at the end of life. Similarly, in November 2010, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to allow "voluntary advance care planning" as an element of the Medicare-reimbursable annual wellness visit established by the ACA.[5] CMS rescinded this rule two months after it was created due to pressure from various constituents. [6]

The proposed policy would provide one-time incentive payment to a Medicare beneficiary, enrolled in either FFS or Medicare Advantage (MA), to create an AD starting in FY 2015. Under the policy, beneficiaries would receive $75 for a creation of an electronic AD and $50 for a creation of a manual AD. No payments would be made for future updates to ADs. The higher incentive payment for the electronic AD is meant to improve portability and accessibility of the document. The policy would also create a separate Healthcare Common Procedure Coding System (HCPCS) billing code and reimbursement under Part B FFS schedule for EOL care counseling visit. The EOL counseling visit will be voluntary and available to a FFS beneficiary every four years.

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[1] http://www.nytimes.com/2014/08/31/health/end-of-life-talks-may-finally-overcome-politics.html?_r=0
[2] Ibid.
[3] Patient Self Determination Act, 42 U.S.C. §§1395cc(f), 1396a (1990). http://thomas.loc.gov/cgi-bin/query/z?c101:H.R.4449.IH:
[4] America's Affordable Health Choices Act of 2009, http://www.gpo.gov/fdsys/pkg/BILLS-111hr3200ih/pdf/BILLS-111hr3200ih.pdf
[5] Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule. http://www.gpo.gov/fdsys/pkg/FR-2010-11-29/html/2010-27969.htm
[6] Medicare Program; Amendment to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-01-10/pdf/2011-164.pdf

Data Sources

We used the following data sources to develop our estimate:

- Medicare FFS and MA population 2015-2024 estimates, CMS' Office of the Actuary (OACT) Part A February 2014 Baseline[7]
- Medicare age distribution, Medicare & Medicaid Statistical Supplement, 2013 edition, Chapter 2: Medicare Enrollment[8]
- Physician Fee Schedule Search[9]
- Projected Consumer Price Index for Urban Consumers (CPI-U), Congressional Budget Office (CBO) March 2014 Baseline: Medicare[10]
- Medicare historical and projected spending growth, 2014 Medicare Trustees Report[11]
- The Census Bureau population mortality projections[12]
- Murphy SL, Xu JQ, Kochanek KD. "Deaths: Final data for 2010." National vital statistics reports; vol 61 no 4. Hyattsville, MD: National Center for Health Statistics. 2013.[13]
- Rao, Jaya K. et al. "Completion of Advance Directives Among U.S. Consumers." American Journal of Preventive Medicine, Volume 46 , Issue 1 , 65 – 70.[14]
- Anne Wilkinson, Neil Wenger, Lisa R. Shugarman. "Literature Review on Advance Directives." RAND Corporation. Prepared for Office of Disability, Aging and Long-Term Care Policy Office of the Assistant Secretary for Planning and Evaluation (ASPE). June 2007[15]
- Paul Terry, David R. Anderson. "The role of incentives in improving engagement and outcomes in population health management: An evidence-based perspective." StayWell Health Management research Department. 2011[16]
- Ronnie L. Tan. "Medicare Beneficiaries' Use of Computers and Internet: 1998-2005." Health Care Financing Review. Winter 2006-2007. Volume 28, Number 2[17]
- Gell NM, Rosenberg DE, Demiris G, Lacroix AZ, Patel KV. "Patterns of Technology Use Among Older Adults With and Without Disabilities." Gerontologist. December 2013.[18]
- Teno J, Lynn J, Wenger N, et al. "Advance directives for seriously ill hospitalized patients: effectiveness with the patient self-determination act and the SUPPORT intervention." J Am Geriatr Soc. 1997;45:500–7.[19]

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[7] Files received by Avalere from the CMS' Office of the Actuary.
[8] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2013_Section2.pdf
[9] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=1&CT=0&H1=99211&H2=99212&H3=99213&H4=99214&M=5
[10] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf
[11] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf
[12] http://www.census.gov/population/projections/data/national/2012/summarytables.html
[13] http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf
[14] http://www.ajpmonline.org/article/S0749-3797(13)00521-7/fulltext.
[15] http://aspe.hhs.gov/daltcp/reports/2007/advdirlr.pdf
[16] http://staywell.com/wp-content/uploads/2012/11/StayWell-Health-Management-incentives-white-paper.pdf
[17] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/06-07Winpg45.pdf
[18] http://www.ncbi.nlm.nih.gov/pubmed/24379019
[19] http://www.ncbi.nlm.nih.gov/pubmed/9100721

- Emanuel LL, Barry MJ, Stoeckle JD, Ettelson LM, Emanuel EJ. "Advance directives for medical care–a case for greater use." N Engl J Med 1991; 324(13):889–895.[20]
- Morrison RS, Morrison EW, Glickman DF, "Physician reluctance to discuss advance directives." Arch Intern Med. 1994;1542311- 2318.[21]
- Nicholas L, Langa KM, Iwashyna TJ, Weir DR. "Regional Variation in the Association Between Advance Directives and End-of-Life Medicare Expenditures." *JAMA.* 2011;306(13):1447-1453.[22]
- Stevenson DG1, Ayanian JZ, Zaslavsky AM, Newhouse JP, Landon BE, "Service use at the end-of-life in Medicare advantage versus traditional Medicare." Med Care. 2013 Oct;51(10):931-7.[23]

Assumptions and Methodology

Estimated Cost of Incentive Payments to Create Advance Directive

We first estimated that approximately 46 percent Medicare beneficiaries, regardless if they are in the in the fee-for-service (FFS) or managed care (MA) program, currently have an AD in place. We based this estimate on the national survey results indicating that 51 percent of community-dwelling adults age 65 or more had an AD in 2009-2010, and 21 percent of those less than 65 years old.[24] We adjusted those findings to reflect age distribution among Medicare beneficiaries. Further, our estimate is in line with the findings of a population poll among all-payer representative sample where approximately 50 percent of people 60 or over reported having some version of an AD.[25]

We assumed among Medicare beneficiaries who currently do not have an AD, 50 percent will create the document due to the incentive payment offered. We estimated this AD use rate based on the review of the two types of the topic-relevant studies. Behavioral economics studies indicate high (upwards to 90 percent) response rates to financial incentives provided by employers for the creation/completion of health assessment documents.[26] Conversely, studies focusing specifically on AD programs indicate 30-45 percent AD adoption rates based on comprehensive interventions that involve education, phone calls, follow-up, etc. (but no financial incentives).[27]

Further, we assumed an even split between beneficiaries who will create electronic vs. manual AD based on the research indicating that a little over 40 percent of Medicare beneficiaries use

[20] http://www.nejm.org/doi/full/10.1056/NEJM199103283241305#t=article
[21] http://archinte.jamanetw ork.com/article.aspx?articleid=619540
[22] http://jama.jamanetw ork.com/article.aspx?articleid=1104465
[23] http://www.ncbi.nlm.nih.gov/pubmed/23969590
[24] Rao, Jaya K. et al. "Completion of Advance Directives Among U.S. Consumers." American Journal of Preventive Medicine , Volume 46 , Issue 1 , 65 – 70. http://www.ajpmonline.org/article/S0749-3797(13)00521-7/fulltext.
[25] AARP Bulletin Poll "Getting Ready to Go" Executive Summary. January 2008. http://assets.aarp.org/rgcenter/il/getting_ready.pdf
[26] Paul Terry, David R. Anderson. "The role of incentives in improving engagement and outcomes in population health management: An evidence-based perspective. " StayWell Health Management research Department. 2011. http://staywell.com/wp-content/uploads/2012/11/StayWell-Health-Management-incentives-white-paper.pdf
[27] Anne Wilkinson, Neil Wenger, Lisa R. Shugarman. "Literature Review on Advance Directives." RAND Corporation. Prepared for Office of Disability, Aging and Long-Term Care Policy Office of the Assistant Secretary for Planning and Evaluation (ASPE). June 2007. http://aspe.hhs.gov/daltcp/reports/2007/advdirlr.pdf

internet and this figure has remained constant over the years.[28] We assumed that an additional, small portion of beneficiaries would be provided assistance to create an online AD. We also assumed the initial amounts of incentive payments ($50 for manual and $75 for electronic AD) will increase according to CPI-U under the most recent CBO baseline.[29]

In each subsequent year we estimated a portion of Medicare beneficiaries who will create an AD given the available incentive payment. Our ongoing Medicare population estimates account for new enrollment and mortality. We estimate that by 2024, over 90 percent of Medicare beneficiaries will have an AD.

Estimated Cost of Provider Payments for EOL Counseling Visit

Under the policy Medicare will cover and separately reimburse physicians for a voluntary EOL counseling visit for a FFS beneficiary every four years. We estimate half of the beneficiaries who create an AD due to the incentive payment will have an EOL counseling visit. This assumption is based on the research indicating that approximately half of people with an AD talked to a physician about it or expressed the desire to have EOL conversation with a physician.[30] Further, we took into consideration evidence of physicians' reluctance to discuss EOL care due to the barriers other than compensation, such as lack of knowledge and time constraints.[31]

We assumed the new code for the EOL counseling visit will be reimbursed at the level similar to the current evaluation and management HCPCS code '99213'. The Part B physician fee schedule national non-facility payment amount for '99213' is $78 in 2014.[32] In addiiton, the reimbursement for EOL counseling visit will be subject to annual updates based on the Sustainable Growth Rate (SGR).

Of note, the American Medical Association (AMA) has already proposed a new billing code for physician discussions regarding EOL planning.[33] The AMA's Relative Value Scale Update Committee (RUC) is currently deliberating on the resources doctors expend when they provide advance care planning to patients and is expected to issue the recommendations to the federal government regarding the appropriate level of reimbursement.

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[28] Ronnie L. Tan. "Medicare Beneficiaries' Use of Computers and Internet: 1998-2005". Health Care Financing review /winter 2006-2007/Volume 28, Number 2. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview /downloads/06-07Winpg45.pdf
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[29] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf

[30] Gordon NP, Shade SB. "Advance directives are more likely among seniors asked about end-of-life care preferences." Arch Intern Med. 1999;159:701-4. http://archinte.jamanetw ork.com/article.aspx?articleid=484989.
Teno J, Lynn J, Wenger N, et al. "Advance directives for seriously ill hospitalized patients: effectiveness with the patient self-determination act and the SUPPORT intervention." J Am Geriatr Soc. 1997;45:500–7. http://www.ncbi.nlm.nih.gov/pubmed/9100721
Emanuel LL, Barry MJ, Stoeckle JD, Ettelson LM, Emanuel EJ. "Advance directives for medical care–a case for greater use." N Engl J Med 1991; 324(13):889–895. http://www.nejm.org/doi/full/10.1056/NEJM199103283241305#t=article

[31] Morrison RS, Morrison EW, Glickman DF, "Physician reluctance to discuss advance directives". Arch Intern Med. 1994;1542311- 2318. http://archinte.jamanetw ork.com/article.aspx?articleid=619540

[32] https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=1&CT=0&H1=99211&H2=99212&H3=99213&H4=99214&M=5

[33] HCPCS 2014 Code : S0257 - *Counseling and discussion regarding advance directives or end of life care planning and dec isions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)*

Medicare Savings From the Increased Adoption of ADs

We projected savings from reduced EOL medical spending as a result of increased adoption of ADs among Medicare beneficiaries. A recent study found that Medicare FFS beneficiaries who lived in high-spending areas and had a treatment-limiting AD had 14 percent lower Medicare spending in the last 6 months of life than beneficiaries without AD.[34] We estimated the same effect on the subset of the deceased Medicare FFS population who would create an AD due to financial incentives offered by the proposed policy.

Using mortality projections from the Census Bureau, we assumed approximately 4.5 to 4.7 percent of the Medicare population used the Census Bureau population mortality projections.[35] The AD study found 30 percent of deceased Medicare FFS beneficiaries lived in high-spending areas and 36 percent of these beneficiaries had a treatment-limiting AD (55 percent had any form of AD). Not surprisingly, beneficiaries living in low-spending areas had a higher AD rates. The study findings are in line with other literature that indicates comparable AD rates among elderly population.[36]

Using recent data from the Dartmouth Atlas of Care, we estimated 2015 Medicare FFS spending per decedent in high-spending areas in last 6 months of life to be $49,230 without an AD and $42,272 with an AD. We applied the reduced spending to the estimated number of decedent Medicare FFS enrollees in high spending areas who would have a treatment-limiting AD due to the new policy.

Since the study did not find a difference in spending during the last 6 months of life for Medicare enrollees in non-high spending areas, we did not assume any savings for this portion of the Medicare population.

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[34] Nicholas L, Langa KM, Iwashyna TJ, Weir DR., "Regional Variation in the Association Between Advance Directives and End-of-Life Medicare Expenditures." *JAMA.* 2011;306(13):1447-1453. http://jama.jamanetwork.com/article.aspx?articleid=1104465

[35] http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf

[36] Maria J. Silveira, Scott Y.H. Kim, Kenneth M. Langa, "Advance Directives and Outcomes of Surrogate Decision Making before Death." N Engl J Med 2010; 362:1211-1218 April 1, 2010.
http://www.allianceforlivinganddyingwell.org/media/AdvanceDirectivesOutcomesNEJMApr2010.pdf