JNP

Medicare Payment: Advanced Care Planning

Andréa Sonenberg, PhD, WHNP, and Alsacia L. Sepulveda-Pacsi, DNS, FNP

ABSTRACT

Within a context of an increasing life expectancy and rates of chronic/terminal illnesses, along with technological advances leading to prolonged life, patients' self-determination and quality of life are becoming priorities. Evidence supports that end-of-life (EOL) care, beginning with advance care planning (ACP), leads to greater patient quality of life and satisfaction, cost savings, and provider satisfaction. Alleviating obstacles to EOL care begins with reforming policies to promote ACP. Honoring their professional, moral, and ethical obligations, nurses were instrumental in advocating for the revision to the Medicare payment rule for ACP, improving quality of life and self-determination for the chronically and terminally ill.

Keywords: advance care planning, end-of-life counseling, Medicare reimbursement, primary care, quality of life

Although rates of chronic illnesses and cancer are growing, technological advances are prolonging life at advanced stages of terminal illness. Under these circumstances, for many, end-of-life (EOL) is of lower quality. It is also costly to patients, their families, the health care system, and society as a whole.[1] Therefore, it is expected that Medicare payment for advance care planning (ACP), as approved in the Final Rule,[2,3] will improve patients' quality of life (QOL), patient satisfaction, and self-determination and reduce health care costs. This new policy pays nurses, physicians, and others for ACP. As such, it enables nurses to fulfill their professional, moral, and ethical obligation to better inform patients about EOL choices; provide improved patient-centered care; and assist patients to reach higher levels of comfort, peace, and dignity at EOL. The purpose of this article is to describe the potential benefits of the expanded payment for ACP under the recent Medicare policy (effective January 2016). Additionally, this article will explore the impacts the payment rule change has on nursing practice. With the holistic nursing approach and advanced communication skills, nurse practitioners (NPs) are uniquely positioned, educated, and skilled to guarantee that chronically and terminally ill Medicare beneficiaries receive this critical service to improve QOL and self-determination.

BACKGROUND

Chronic Disease in the United States

In 2001, life expectancy at birth in the US was 76.86 years; in 2013, it was 78.8 years.[4] At that time, heart disease and cancer were the 2 leading causes of death, and technological advances were prolonging life through myriad treatments in the later stages of terminal illness.

Although the rate of growth of Medicare spending has decreased since 2010, a disproportionate amount of this public expenditure is on managing chronic illnesses.[5,6] Medicare cost expenditures for decedents (those who died during hospitalization) in their last year of life is greater than for survivors (those who were able to be discharged), which is primarily attributable to decedents having more inpatient hospitalizations (50.2%) compared with survivors (37.7%).[7] It is projected that, if 90% of all US hospitals had palliative care (PC) programs, the savings would be $5 billion per year for the health care system as a whole.[6] This would be attributable to decreased hospital readmission, increased QOL; decreased depression rates; and patients opting for less expensive care modalities than

more costly medical interventions, including being discharged to die at home.[8–10] Although long-term care facility policies are a primary factor in hospital care use at EOL, research also shows that EOL hospital care is less used by residents of nursing homes who have knowledge of EOL care, thus contributing to further cost savings.[11]

ACP

EOL care begins with ACP, which has several components. ACP begins with providing the patient and family caregivers information on the available life-sustaining treatment options. After this, ACP involves supporting the patient and family in a variety of ways, such as assuring that they have the autonomy to decide what types of treatment they would or would not want should the patient be diagnosed with a life-limiting illness. Other aspects of this support include facilitating patients sharing their personal values with their loved ones and guaranteeing that they complete advance directives in writing that specify what types of treatment they would or would not want should they be unable to speak for themselves.[12]

However, there are obstacles to realizing these options. Although Medicare has reimbursed hospice care (HC) since 1982 and expanded it in 1986,[13,14] the coverage does not routinely pay for PC, which is the other model of EOL care. Other studies conclude that additional barriers exist. Some of these obstacles are 1) poor provider knowledge, diagnostic skills, and communication related to EOL care; 2) limited provider training in EOL counseling and care; 3) limited availability to coordinated care models; and 4) patient fear, lack of knowledge and understanding, and attitudes related to EOL options.[15–17]

Dube et al[15] aimed to assess the prevalence of ACP by NPs, while also identifying their perceptions of barriers and facilitators to providing ACP. One of the first barriers elucidated was the lack of knowledge that institutions accepting payment from Medicare are mandated to provide patients with advance directive information. This obstacle is exacerbated by another barrier to ACP revealed by the study—a significant number of NPs had not had training in EOL. The study results indicate that both barriers and facilitators can be considered either time-related or system-related factors. Before the change in the Medicare payment rule, it was not fiscally feasible for providers to spend time providing nonreimbursable services or being trained to provide those services. The time-related barriers will decrease now that ACP has a reimbursable procedure code associated with it. Finally, through a qualitative aspect to the study, 3 themes were uncovered: lack of knowledge, issues related to practice settings themselves, and language and culture barriers.[15] Each of these contributes to further implications for both nursing education and nursing practice.

EOL and QOL

The Institute of Medicine (now the National Academy of Medicine) has prioritized improving QOL at EOL.[18] Evidence supports that EOL care, when initiated as early after diagnosis as possible, promotes an improved experience for patients and their families. The EOL care options about which patients are informed include PC and HC. Although these 2 models have some commonalities, there is a fundamental difference between the 2. PC is a coordinated multidisciplinary approach with defined standards, a medical specialty with a focus on symptom management and comfort care for those with chronic illness (including cancer, heart disease, general pain, and depression) but who are not necessarily terminally ill.[12,19] The general goal of PC is to improve QOL for both patient and family caregivers. Similarly, HC focuses on symptom and pain management but differs in that it is a care model used solely for those who are terminally ill (having a prognosis of 6 months or less life expectancy). The primary goal of HC is optimal QOL and a patient's and family's choice of the patient's death with dignity, without any aim to improve life expectancy.

In its 2014 report "Dying in America: Improving Quality and Honoring Individual Preferences near the End of Life," the Institute of Medicine[18] recommends 5 areas of reform related to EOL care. These are 1) delivery of person-centered, family-oriented EOL care; 2) clinician–patient communication and ACP; 3) professional education and development; 4) policies and payment systems to support high-quality EOL care; and 5) public education and engagement. In addition to improving