Medical News & Perspectives | QUICK UPTAKES

Despite Big Buildup, Few Benefit From Medicare's Advance Care Planning Coverage

Mary Chris Jaklevic, MSJ

In 2016 Medicare launched a much-anticipated advance care planning (ACP) benefit that pays physicians to counsel patients about living wills, advance directives, and end-of-life care options. During the ACP process clinicians can help patients determine the type of care they would want in a medical crisis or at the end of life and reassure them that their preferences will be observed. Numerous medical and patient advocacy organizations backed the Medicare initiative, asserting that compensation for physicians would encourage proactive end-of-life care discussions. These conversations are associated with patients receiving care that respects their wishes as well as fewer in-hospital deaths and more hospice use.

However, the benefit isn't being widely used. An analysis of outpatient claims published in *Health Affairs* found that although ACP billing increased steadily during the first 4 years, only 2.9% of beneficiaries overall had an ACP claim in 2017, including 4.7% who were older than 85 years and 7.2% of beneficiaries who ultimately died that year. Compared with previous studies, the researchers' data showed smaller differences in the odds between White patients and Black and Hispanic patients having ACP discussions, but the differences were still significant.

A Fraught History

The push for ACP Medicare reimbursement had a rocky start. Provisions to authorize the payments and promote end-of-life planning were dropped from the Affordable Care Act after health reform opponents charged that the legislation would create heartless "death panels" to arbitrate who lives or dies. PolitiFact deemed the death panel claim 2009's "lie of the year."

The Obama administration revived the idea in 2015 with a proposal to adopt ACP billing codes. That year an Institute of Medicine report, Dying in America, mentioned financial support for ACP along with the development of quality standards for such discussions among its key findings and recommendations. In a letter of support to US Department of Health and Human Services Secretary Sylvia Mathews Burwell, 66 organizations—including the AARP, the American Medical Association, and the American Academy of Palliative and Hospice Medicine—noted that ACP was already part of physician quality reporting. The codes took effect on January 1, 2016.

iStock.com/LPETTET

What's Covered

Medicare pays $86 for 16 to 30 minutes of ACP as a stand-alone service at any outpatient visit, subject to a 20% co-payment, with an additional $75 for up to a half hour of additional counseling. To encourage ACP prior to a serious illness, the co-payment is waived if the service occurs during an annual wellness visit. No limit has been set on the number of ACP claims a beneficiary can have. But to avoid a co-pay, the discussions have to take place during an annual wellness visit, which Medicare covers only once a year.

Physicians, nurse practitioners, and physician assistants of any specialty may bill for the service, and they should offer a patient or surrogate an opportunity to decline the discussion. Medicare does not require that counseling lead to the completion of an advance directive, a legal document often called a "living will."

A Trickle of Claims

Previous studies found low utilization, even for patients considered to have great need:

- Less than 1% of Medicare beneficiaries in New England were represented among 26 522 ACP claims filed in the region during 2016, the inaugural year.
- Among beneficiaries aged 65 years or older who were seriously ill or frail, 5.2% had a billed ACP discussion in 2017, compared with 2.3% of those who didn't have extensive medical needs. Among patients younger than 65 years with dual eligibility for Medicare and Medicaid, 2.7% with end-stage kidney disease and 1.3% of those with a disability had a billed ACP discussion.
- In a large practice that educated physicians in ACP billing and gave them a small financial incentive for ACP documentation, 5.4% of 113 612 hospitalized patients aged 65 years or older had a billed ACP conversation. The figure rose to 8.3% among patients whose physician answered "no" to the question: "Would you be surprised if the patient died in the next year?" Data covered the first 3 months of 2017.

- ACP claims among beneficiaries who died within a given year rose from 3.3% in 2016 to 5.8% in the first 3 quarters of 2017, according to national claims data. Internists billed for 48% of claims and family physicians billed for 28% in 2016.

Scrutinizing Outpatient Claims

For the *Health Affairs* study, researchers examined outpatient claims for beneficiaries who were continuously enrolled in fee-for-service Medicare from 2016 to 2019, including enrollees younger than 65 years who qualified for Medicare due to a disability. That amounted to 133 million beneficiary-years. They captured whether patients had been diagnosed in the previous 12 months with a medical condition that conferred a greater risk of dying, such as cancer, a heart attack, or Alzheimer disease.

Among the findings:

- The number of ACP claims rose from 17 000 in January 2016 to 120 000 per month in 2019. In 2018, the last year with complete data, 3.7% of beneficiaries had a claim. About half occurred during a wellness visit.
- Except for hypertension, all the newly diagnosed conditions analyzed were associated with greater rates of claims. Patients with a hip fracture had the highest rate, 7.4%. Next were those with lung cancer.
- Dual-eligible beneficiaries, most of whom have low incomes, had higher rates of ACP claims than more affluent beneficiaries.
- Overall, the likelihood of having an ACP claim was similar for Black beneficiaries and their White counterparts. Among patients with an ACP claim, Black and Hispanic patients were less likely to have had the counseling at an annual wellness visit, which does not incur a co-pay.

Some Caveats

This study didn't capture ACP discussions that occurred in institutional settings such as hospitals, skilled nursing facilities, or with hospice personnel or in the home. In addition, it didn't capture conversations that were too short to be billable or conversations that weren't billed. Some clinicians may not be aware of ACP billing codes or have them integrated into their billing systems, the researchers noted. In addition, some patients may have completed advance care directives on their own or with an attorney. The analysis didn't include Medicare beneficiaries who were enrolled in Medicare Advantage plans.

Getting to Greater Adoption

Ultimately, it's hard to say what the optimal rate of ACP billing should be, lead author Makayla Palmer, PhD, an assistant professor in economics at the University of Nevada in Las Vegas, said via email. However, she added, "Most experts would agree that ACP should be revisited as health status changes or individuals receive new diagnoses." Given that 5% of the Medicare population dies each year, she said, "it would not be unrealistic to expect annual ACP rates to be considerably higher" than what the study found.

Given public interest in ACP—which COVID-19 has boosted in some regions—the researchers said health care organizations should address barriers to ACP in the outpatient setting, where it can occur before health issues arise. In some cases, institutional changes may be needed to incorporate ACP into the physician workflow; machine learning mortality predictions accompanied by behavioral nudges to clinicians and nurse navigators have been found to increase ACP.

In addition, Medicare might have to increase reimbursement rates to encourage ACP discussions, the researchers wrote, noting that current payments might be insufficient to motivate physicians to engage in training that could enhance their skills. ■

Note: Source references are available through embedded hyperlinks in the article text online.