MEDICARE ACO USE OF PALLIATIVE CARE CONSULTS AND HOSPICE

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Background

- The accountable care organization (ACO) model incentivizes providers to deliver efficient health care services.
- Hospice is included in the Medicare ACO model's expenditure calculation, used to determine savings and penalties.
- Hospice and palliative care have demonstrated clinical and financial value but nonetheless are still characterized by highly variable utilization.

Objectives

- Characterize the utilization of palliative care consults and hospice election in Medicare ACOs
- Examine how the use of these services is associated with provider network characteristics and quality measures.

Data & Methods

- 50% sample of beneficiaries aligned with Medicare's largest ACO model, the Medicare Shared Savings Program (MSSP), in 2014
- Identified palliative care consults via ICD-9 code V66.7 in Medicare inpatient, outpatient, and carrier claims
- Identified hospice election via Medicare Beneficiary Summary File
- Calculated ACO-specific intensity of each service as number of ACO's beneficiaries receiving each service as a proportion of their decedents in calendar year
- Examined association with inclusion of a hospice or palliative care specialist in the ACO's network, and the 33 Medicare ACO quality measures

Results

Intensity of Usage

- Wide range in utilization of both palliative care consults and hospice.

Measure	Definition	Mean	SE	Min	5%-ile	Median	95%-ile	Max
Palliative care intensity	# of aligned beneficiaries receiving palliative care consults / # of aligned decedents	0.26	0.09	0.02	0.11	0.26	0.42	0.48
Hospice intensity	# of aligned beneficiaries electing hospice /# of aligned decedents	0.47	0.11	0.00	0.26	0.48	0.64	0.79

Correlation of Intensity with ACO Provider Network Characteristics and Quality Measures

MSSP Provider Network			
Measure	Mean based on inclusion of HPM specialist: Yes	Mean based on inclusion of HPM specialist: No	P-val
Palliative care intensity	0.32	0.24	<0.0001
Hospice intensity	0.48	0.47	0.43

- Inclusion of a hospice or palliative care specialist was statistically significantly associated with the hospice intensity measure, but not with palliative care intensity.
- Findings preserved in regression adjusting for patient cohort demographics, chronic disease, and other ACO characteristics.

MSSP Quality Measures			
Measure	F-test of all quality measures	P-val	Significant individual measures
Palliative care intensity	1.10	0.34	Functional status
Hospice intensity	1.19	0.23	Influenza and pneumococcal vaccinations

- Collectively, measures were not jointly significant in explaining palliative and hospice care intensity.
- A small number of individual measures were statistically significantly associated with these intensities.
- Model adjusted for ACO characteristics, patient cohort demographics and chronic conditions.

Discussion

- Substantial variation in how MSSPs are approaching hospice and palliative care
  - Despite the financial accountability of MSSPs for hospice care, little evidence that they have systematically approached this service line.
- Underscores concern that serious illness care is not sufficiently captured in the MSSP quality metrics
  - Lack of serious illness indicators may incentivize MSSPs to look elsewhere
- May also reflect limited knowledge of hospice and palliative care on the part of MSSPs, which to this point have largely focused on streamlining acute and post-acute care.
- Limitations include the limited insight into palliative care in the Medicare claims data, and the fact that in 2014 many MSSPs were relatively newly formed. Furthermore these 'intensity' measures are only one way of capturing per capita utilization of these services.
- Next steps: Further qualitative probe of how MSSPs are thinking about serious illness care, more robust quantitative analysis of how the MSSP model influenced utilization of palliative and hospice care.

Conclusions

The intersection of high-value but underused services, such as hospice and palliative care, with a reimbursement model that rewards such care suggests that these services would be used more intensively in the MSSP model, but we do not yet see evidence of this happening in a systematic way.

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