

CMS Perspective:

Medicare Care Choices Model (MCCM)

Third Annual Evaluation Report

October 2020

For information on the model and to download the independent evaluation report discussed in this document, please visit

<https://innovation.cms.gov/innovation-models/medicare-care-choices>



**U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicare & Medicaid Innovation
Research and Rapid Cycle Evaluation Group & Patient Care Models Group
2810 Lord Baltimore Drive, Suite 130
Baltimore, MD 21244**

Only half of all beneficiaries use hospice services at the end of life, according to data reported by the Medicare Payment Advisory Commission (MedPAC). Of those who do choose hospice, many elect the Medicare hospice benefit (MHB) less than a week before death—too late to experience the full benefit of hospice care.

Launched in 2016, MCCM tests the effect of allowing eligible beneficiaries the option to receive supportive services from participating hospices while continuing to receive treatment for their terminal condition through fee-for-service Medicare. Participating hospices receive \$400 per beneficiary per month to cover the supportive care and care coordination services they provide to enrolled beneficiaries. This model aims to improve quality of life and beneficiary and family satisfaction with care at the end of life, inform new payment approaches for the Medicare program, and reduce Medicare expenditures.

Preliminary impact results indicate that total Medicare expenditures decreased by 25%, generating \$26 million in gross savings and \$21.5 million in net savings for 3,603 beneficiaries who enrolled in MCCM and died during the first three years of the model. Net savings amounted to \$6,000 per MCCM decedent, largely driven by reducing inpatient care through increased use of MHB. MCCM enrollees elected the MHB 1 – 2 weeks earlier, on average, than the comparison group. More precise impact results are expected in the coming year as MCCM continues through 2021 and evaluation methods are refined. Future analyses will help validate the results included in this report.

Evaluation findings are critical for determining whether CMS models achieved their stated goals, identifying potential model modifications, and designing future initiatives. CMS has made model modifications as a result of participant feedback and evaluation findings. For example, based on low enrollment during the first year of the model and feedback from participating hospices, CMS relaxed the MCCM eligibility requirements to increase the number of eligible beneficiaries. Specifically, CMS decreased the number of required hospitalizations; broadened the requirements for prior office visits; and reduced the amount of time that eligible beneficiaries had to be in Medicare fee for service prior to enrolling in the model. Also, CMS has implemented strategies to encourage broader participation and enrollment in the model. CMS has provided peer-to-peer provider discussions, educational materials for referring providers, and webinars to help hospices expand their referral networks. As a result of these efforts, and with the start of the second cohort of participating hospices, MCCM enrollment increased from 634 beneficiaries in 2016 to 2,034 beneficiaries in 2018. Continued efforts to increase enrollment remain important as enrollment began to taper down in 2019, and the majority of enrollments come from just 9 of the 85 participating hospices. Increasing the breadth of hospice participation and beneficiary enrollment and continuing to gather information from participant hospices on lessons learned and key operational challenges for future end-of-life models are important objectives of the final year of the model test. During this final year of the model, we will continue technical assistance activities focused on increasing enrollment for participating hospices, and reach out to hospices to identify lessons learned and key considerations for future models.

In addition, most caregivers reported positive experiences in the model, yet caregivers of enrollees who did not transition to MHB reported less satisfaction, while most caregivers were highly satisfied with MCCM. This finding suggests that participating hospices may be struggling to adapt care practices to the needs of beneficiaries who continue to receive life-prolonging treatment after MCCM enrollment. Although 84% of beneficiaries who enroll in MCCM transition to MHB at some point, CMS is exploring how best to support hospices who care for MCCM beneficiaries that do not make that transition, through educational and technical assistance activities, as well as other strategies. A more complete

understanding of how ongoing receipt of curative treatment affects delivery of supportive services will help inform the design of future CMS models and help meet the needs of individuals who prefer not to elect the MHB (and forgo care).

Findings from this report also provide valuable lessons to inform the development of future models that target individuals with serious illness. First, restricting the target population to those with cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and HIV/AIDS has limited the model's reach. MCCM hospice staff and referring providers have recommended extending the model to beneficiaries with other complex conditions, such as end-stage renal disease and neurological diseases like dementia, amyotrophic lateral sclerosis, and Parkinson's disease. Second, MCCM evaluation findings also suggest that individuals with serious illness and their caregivers would benefit from supportive care earlier in the disease trajectory than the six-month prognosis required under MCCM and the MHB. New CMMI models such as Primary Care First, the Medicare Advantage Value-Based Insurance Design (VBID) model, and Direct Contracting intend to serve beneficiaries with a broader range of diagnoses than MCCM and address the needs of individuals who are not necessarily in the last months of life, but may be living with advanced serious illness for several years. For example, the Hospice Benefit Component of the VBID Model builds upon the lessons learned in MCCM and provides flexibilities to test innovative palliative care and transitional concurrent care strategies within Medicare Advantage (MA), alongside including the Medicare hospice benefit in the MA benefit package.

The positive findings outlined in this evaluation report suggest that MCCM and similar models could make a meaningful difference in the quality and cost of end-of-life care. Such efforts could lead to further improvements in care and reductions in spending.