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Findings at a Glance

Medicare Care Choices Model

Evaluation of the model's effects on beneficiaries' outcomes from January 2016 to March 2021

MODEL OVERVIEW

The Medicare Care Choices Model (MCCM) tested whether offering eligible beneficiaries the option to receive supportive services at the end of life without forgoing payment for treatment of their terminal conditions (which is required to enroll in the Medicare hospice benefit) improved the quality of care, increased beneficiaries' satisfaction, and reduced Medicare expenditures. Eligible beneficiaries were referred to participating hospices and could voluntarily enroll in the model over a five-and-a-half-year period from January 1, 2016, to June 30, 2021. The model ended December 31, 2021.

PARTICIPANTS

141 hospices participated in MCCM

- 89 hospices (63%) enrolled at least one beneficiary (through September 2020).
- 49 hospices (35%) participated in a one-year model extension (through December 2021).
- Hospices recruited and enrolled beneficiaries and provided them supportive services, including care coordination and case management, round-the-clock access to health care professionals, person- and family-centered care planning, shared decision making, symptom management, and counseling.

6,427 Medicare fee-for-service beneficiaries enrolled in MCCM through September 2020

- About two-thirds of beneficiaries who were referred to MCCM and met model eligibility criteria chose to enroll in the model. Enrollees represent less than 1% of beneficiaries who lived near participating hospices, died, and met the claims-based MCCM eligibility criteria.
- The average beneficiary enrolled in MCCM 185 days (about 6 months) before their death, but post-enrollment survival varied widely from a single day to more than two years.
- 72% of the enrollees had a terminal diagnosis of cancer.
- Just 5 participating hospices enrolled 45% of all beneficiaries in MCCM.

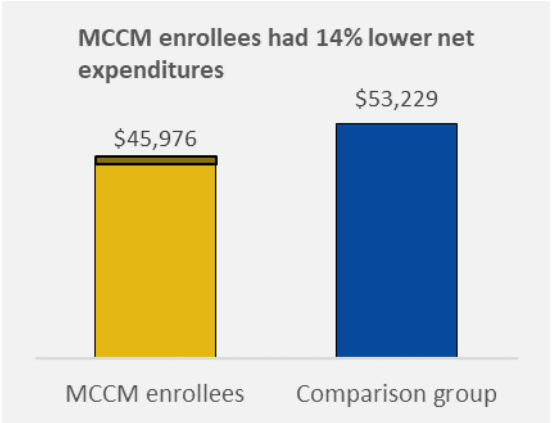
MCCM eligibility criteria

- Diagnosed with cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS
- Expected to live six months or less
- Had at least 1 hospital encounter and 3 office visits in 12 months before enrollment
- Not enrolled in hospice in 30 days before enrollment
- Resided in a traditional home
- Enrolled in Medicare fee-for-service Part A and B in 12 months before enrollment

FINDINGS

Reduced Medicare expenditures

- Net expenditures (Medicare Part A and B expenditures plus MCCM payments) decreased by 14% ($7,254 per MCCM enrollee) from the date of MCCM enrollment through death, relative to a matched comparison group.
- 70% of the savings accrued through increased use of the Medicare hospice benefit. Decreased inpatient spending drove overall reductions in Medicare expenditures.
- Payments to participating hospices for providing MCCM services averaged $1,827 per enrollee (typically $400 per beneficiary per month).



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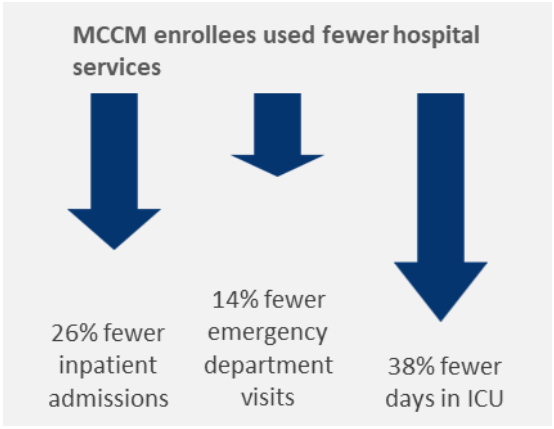
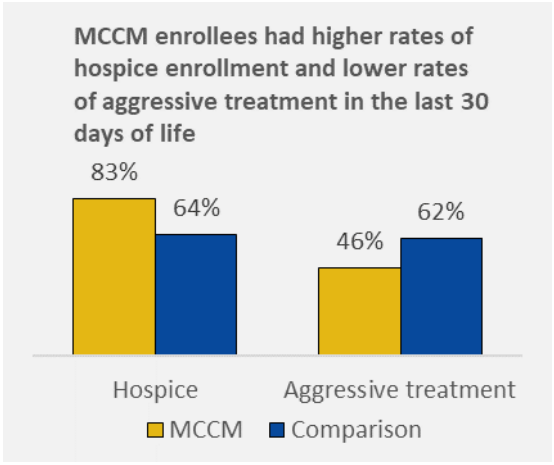
Reduced use of resource-intensive services

- MCCM enrollees had 26% fewer inpatient hospital admissions than matched comparison beneficiaries.
- MCCM enrollees had 14% fewer outpatient emergency department visits and observation stays.
- MCCM enrollees spent 38% fewer days admitted to an inpatient intensive care unit (ICU).



Increased use of the Medicare hospice benefit

- MCCM enrollees were more likely to elect the Medicare hospice benefit before death than matched comparison beneficiaries were (83% versus 64%).
- MCCM enrollees elected the hospice benefit 3 weeks sooner, on average, than those in the comparison group (41 days versus 18 days).



Improved quality of end-of-life care

- MCCM enrollees were less likely to receive an aggressive life-prolonging treatment in the last 30 days of life (46% versus 62%).
- MCCM enrollees spent more days at home (167 days versus 161 days) in the period between enrollment and death.

Subgroup analysis

- Effects of MCCM were similar for beneficiaries with cancer, congestive heart failure, and chronic obstructive pulmonary disease, which suggests that persons with a wide range of terminal conditions might benefit from similar services.
- Early evidence indicates MCCM's effects were largely sustained during the COVID-19 pandemic, which suggests the pandemic did not adversely affect model implementation and fidelity.

KEY TAKEAWAYS

Outcomes generally aligned with the expectations of the model. Specifically, MCCM beneficiaries were more likely to enroll in the Medicare hospice benefit than matched comparison beneficiaries, less likely to use hospital services and other health care services, and more likely to receive better-quality end-of-life care in the period between enrollment in MCCM and death. Decreased use of resource-intensive services, driven by earlier enrollment in the hospice benefit, resulted in lower Medicare expenditures. These findings might not generalize to other settings, however, given the small number of hospices that participated in MCCM and the small percentage of eligible beneficiaries that enrolled.

This document summarizes the evaluation report prepared by an independent contractor.
To learn more about MCCM and to download the Fourth Annual Evaluation Report, visit https://innovation.cms.gov/innovation-models/medicare-care-choices.