

MODEL OVERVIEW

The six-year Medicare Care Choices Model (MCCM) tested whether offering eligible fee-for-service Medicare beneficiaries the option to receive supportive and palliative care services through hospice providers without forgoing payment for the treatment of their terminal conditions (which is required to enroll in the Medicare hospice benefit) improved beneficiaries' quality of life and care, increased their satisfaction, and reduced Medicare expenditures.

PARTICIPANTS



CMS accepted 141 Medicare-certified hospices to participate in MCCM.

- Participating hospices tended to be larger than hospices nationally and were more often a nonprofit organization.
- Significant attrition occurred over time, partly because of low payments and challenges recruiting eligible beneficiaries. Only 89 hospices (63%) enrolled a beneficiary and only 44 (31%) participated for all six years.
- Enrollment was highly concentrated: just 5 hospices enrolled 46% of all MCCM enrollees, which limits generalizability.



7,263 Medicare beneficiaries enrolled in MCCM.

- All qualified for hospice and met other eligibility criteria, including having cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS.
- Less than 1% of eligible beneficiaries who lived in participating hospices' market areas enrolled. MCCM enrollees disproportionately had cancer, used more health care services, were non-Hispanic and White, were not dually eligible for Medicaid, and lived in non-rural areas.
- Lengths of enrollment varied widely, with a median of about 2 months. About 89% of enrollees died before the model ended.

FINDINGS



Enrollees received supportive and palliative care services through MCCM.

- Enrollees received 2.6 encounters per week with MCCM staff (on average among all model enrollees), provided mostly by clinically trained staff, often in person and at home.
- Through MCCM, hospice staff provided a range of services they identified as critical to keeping enrollees from seeking care in an emergency department and preventing hospitalizations.
- MCCM hospices reported delivering high-quality services per CMS-defined metrics, such as achieving high rates of comprehensive assessments and symptom screening and management for pain, shortness of breath, and emotional well-being among all model enrollees.
- Surveyed MCCM enrollees and caregivers reported high levels of satisfaction with shared decision making, receiving care consistent with their wishes, and quality of life.
- Interviewed hospice staff identified (1) implementing a “no wrong door” referral policy, (2) gaining enrollees' trust, (3) engaging enrollees in ongoing education, and (4) giving enrollees someone to call after hours as keys to their success.

Commonly provided MCCM services

- Assessment of health and health-related social needs
- Care coordination and case management
- Round-the-clock access to health care professionals
- Person- and family-centered care planning
- Shared decision making
- Symptom management
- Education and counseling

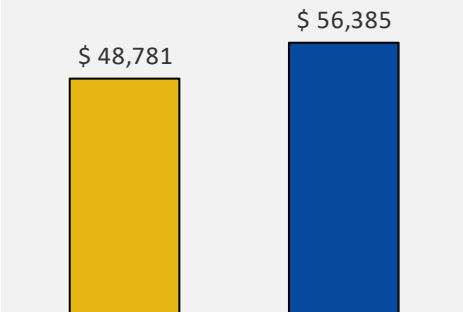
Findings at a Glance



MCCM reduced Medicare expenditures and use of acute care services.

- Among enrollees who died before the model ended, net expenditures (Medicare Part A and B expenditures plus MCCM payments) decreased by \$7,604 per MCCM enrollee (13%) between enrollment and death, on average, relative to a matched comparison group.
- Inpatient admissions decreased by 26%. Reduced inpatient expenditures drove overall Medicare savings.
- Outpatient emergency department visits and observation stays decreased by 12%.

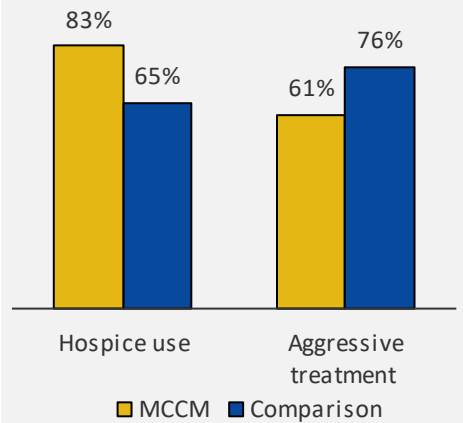
Deceased MCCM enrollees had 13% lower net Medicare expenditures.



For many enrollees, MCCM served as a stepping stone to the Medicare hospice benefit, not a long-term alternative.

- Deceased MCCM enrollees were 18 percentage points more likely to use the Medicare hospice benefit before death than matched comparison beneficiaries (83% versus 65%) and spent more than twice as many days in hospice (42 versus 19 days).
- About half the Medicare Part A and B savings were due to MCCM enrollees entering hospice earlier and more often than comparison beneficiaries.

Deceased MCCM enrollees used hospice more and fewer received aggressive treatments in the last 30 days of life.



MCCM improved the quality of end-of-life care.

- Deceased MCCM enrollees were less likely than comparison beneficiaries to receive an aggressive life-prolonging treatment in the last 30 days of life (61% versus 76%).
- MCCM enrollees who died spent more days at home than comparison beneficiaries before death (183 versus 178 days).



MCCM's effects were widespread, although larger for certain beneficiary subgroups.

- MCCM's effects varied by the length of time enrollees lived after enrollment, but not by terminal illness.
- MCCM improved outcomes for deceased enrollees from underserved communities. Notably, it reduced, but did not eliminate, disparities in the rates of hospice use among non-White or Hispanic (versus non-Hispanic White) enrollees and Medicare-Medicaid dually eligible (versus non-dually eligible) enrollees.
- Virtually all MCCM hospices with at least one enrolled beneficiary had the intended effects on beneficiaries' outcomes.

KEY TAKEAWAYS

Some terminally ill Medicare beneficiaries will accept supportive and palliative care services if they do not have to forgo payment for the treatment of their terminal conditions. By providing supportive services and increasing use of Medicare's hospice benefit, participating hospices achieved MCCM's goals of improving enrollees' quality of life and care, attaining high satisfaction, and reducing Medicare expenditures and acute care service use. These findings point to the importance of transforming care delivery to improve terminally ill beneficiaries' and caregivers' experiences and reduce costly usage that might be inconsistent with beneficiaries' preferences. Although there are concerns about the generalizability of these findings, MCCM is a promising approach to increasing hospice use.

This document summarizes the evaluation report prepared by an independent contractor.

To learn more about MCCM and to download the Fifth Annual Evaluation Report, visit <https://innovation.cms.gov/innovation-models/medicare-care-choices>.