

# Evaluation of Phase II of the Medicare Advantage Value-Based Insurance Design Model Test

## First Three Years of Implementation (2020–2022)

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RAND Health Care

PR-A1881-2  
September 2023

Prepared for the Centers for Medicare & Medicaid Services  
Center for Medicare & Medicaid Innovation

Under Research, Measurement, Assessment, Design, and Analysis Contract Number  
75FCMC19D0093, Order Number 75FCMC20F0001

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## About This Project Report

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This report presents RAND Corporation researchers' findings from their evaluation of Phase II of the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model test, initiated by the Center for Medicare & Medicaid Innovation (Innovation Center), for the first three years of implementation. This model allows participating MA parent organizations (POs) to offer supplemental benefits and financial and nonfinancial incentives to beneficiaries, hospice benefits (an MA Hospice Benefit, palliative care, Transitional Concurrent Care, and hospice supplemental benefits), and Wellness and Health Care Planning through their MA plans. Some benefits may be targeted to beneficiaries with certain chronic conditions or based on beneficiaries' socioeconomic status measured by qualification for the Medicare Part D low-income subsidy (LIS) or by dual eligibility for Medicare and Medicaid in territories where LIS is not available.

In this report, we describe findings from interviews with representatives of participating POs, in-network and out-of-network hospices, and beneficiaries. We also report initial findings on the estimated association between VBID and a variety of key outcomes. Data availability to assess outcomes varied given lags in encounter data run-out periods and pandemic-related changes to data reporting that affected some 2020 outcomes. For most plan-level outcomes, we analyzed data for 2020, 2021, and 2022. For most beneficiary-level outcomes, including utilization and health outcomes, we analyzed data for only one postimplementation year—2020. For contract-level outcomes—namely, the Star Rating—we analyzed data for 2021, because of coronavirus pandemic-related adjustments that affected reporting in 2020. We analyzed outcomes including enrollment, care quality, health outcomes, bids, premiums, and costs to the Centers for Medicare & Medicaid Services (CMS). A separate appendix provides additional information on primary data collection and analysis, statistical approach, and other material. The results will be useful to multiple audiences, such as policymakers, health plans, and researchers interested in insurance benefit design.

This research was funded by the Innovation Center under Research, Measurement, Assessment, Design, and Analysis Contract Number 75FCMC19D0093, Order Number 75FCMC20F0001, for which Julia Driessen is the contracting officer's representative. It was carried out within the Payment, Cost, and Coverage Program in RAND Health Care.

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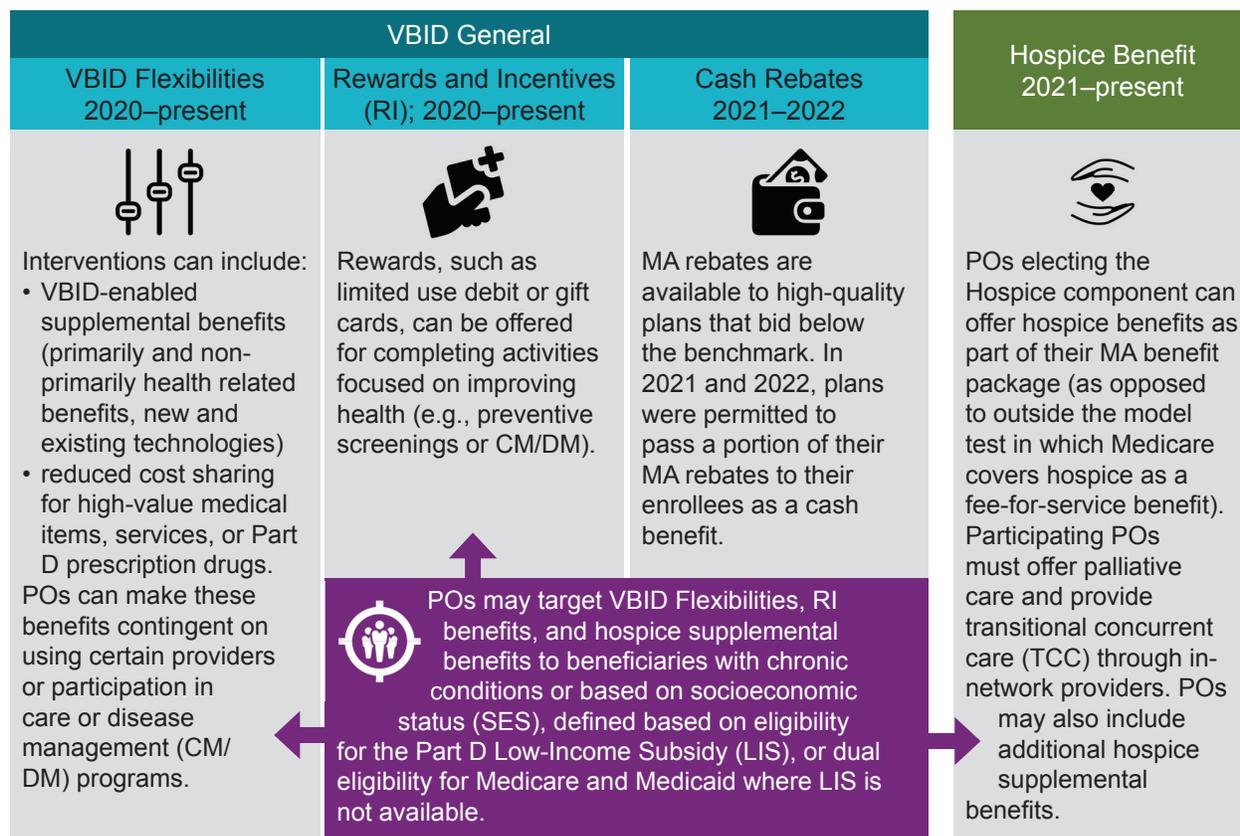
## Acknowledgments

We thank Julia Driessen at CMS for her guidance and support as we developed this report, as well as the CMS Office of the Actuary and Acumen, LLC, for providing critical data. Alison Poole and Robert Lang of Wakely Consulting Group contributed expertise related to CMS bidding processes and actuarial issues. We are also indebted to our reviewers and expert advisers, including Melissa Aldridge, Betsy Q. Cliff, Beth Ann Griffin, Paul Koegel, and Jeanne Ringel. We are grateful to Lynn Polite for excellent administrative assistance.

# Summary

In January 2020, the Centers for Medicare & Medicaid Services (CMS) began a new phase of a voluntary Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model test to enable participating MA insurers, known as parent organizations (POs), to offer one or more innovative benefit design options in eligible MA plans. The concept of VBID originated in employer insurance plans and has traditionally aimed to align patients’ out-of-pocket costs with the clinical value of the services that they use, such as by reducing copayments for statins for people with high cholesterol. Within MA, CMS expanded the traditional definition of VBID to encompass a greater range of options, shown in Figure S.1. Broadly, the goal of the model is to increase beneficiaries’ engagement in their care; encourage the use of high-value treatments, services, and providers; and promote healthy behavior. By encouraging healthier behaviors and recommended care, the model aims to improve care quality, enhance beneficiary health, and reduce health spending.

**Figure S.1. VBID Model Test Components**



The model allows participating POs to target reduced cost sharing, supplemental benefits, or Rewards and Incentives (RI) to enrollees on the basis of their chronic condition status or SES. Both reduced cost sharing and RI enable POs to offer incentives to beneficiaries who use high-value services, such as preventive screenings and recommended medications. VBID-enabled supplemental benefits can include options that are designed to encourage healthy behaviors or promote health, such as healthy food cards or transportation to medical appointments. In 2021 and 2022, the model also allowed POs to share MA rebates directly with enrollees as cash or monetary transfers (this option was discontinued in 2023). Beginning in 2021, the model enabled participating POs to offer hospice benefits as part of their MA benefit package. At CMS' request, we distinguish the Hospice Benefit component of VBID from other parts of the model test, which we refer to as VBID General.

All participating POs must offer a Wellness and Health Care Planning benefit, focused on advance care planning, to all enrollees in participating plans. Aside from this, POs can pick and choose the VBID benefits they wish to offer from the menu of options described in Figure S.1, and they have substantial flexibility regarding the types of interventions they offer. For example, POs can choose which chronic conditions they target, which services or treatments receive reduced cost sharing, the types of supplemental benefits provided, and so forth. POs can choose to offer VBID in any or all of their MA plans that meet eligibility criteria based on size, length of existence, and performance; interventions can also vary across plans.

RAND researchers are conducting a multiyear evaluation of the VBID Model test using a mixed-methods approach that involves surveys and interviews with participating POs, hospices, and beneficiaries and quantitative analyses of the relationship between VBID implementation and a variety of outcomes, including costs, quality, use of high-intensity services, and beneficiary health outcomes using difference-in-differences (DD) regressions. We evaluate VBID General and Hospice Benefit components of the model separately. This report presents results from the second annual evaluation of Phase II of the model test. (Phase I of the model test ran from 2017 through 2019 and involved a more limited range of benefit design options, similar to the VBID Flexibilities options described in Figure S.1.)

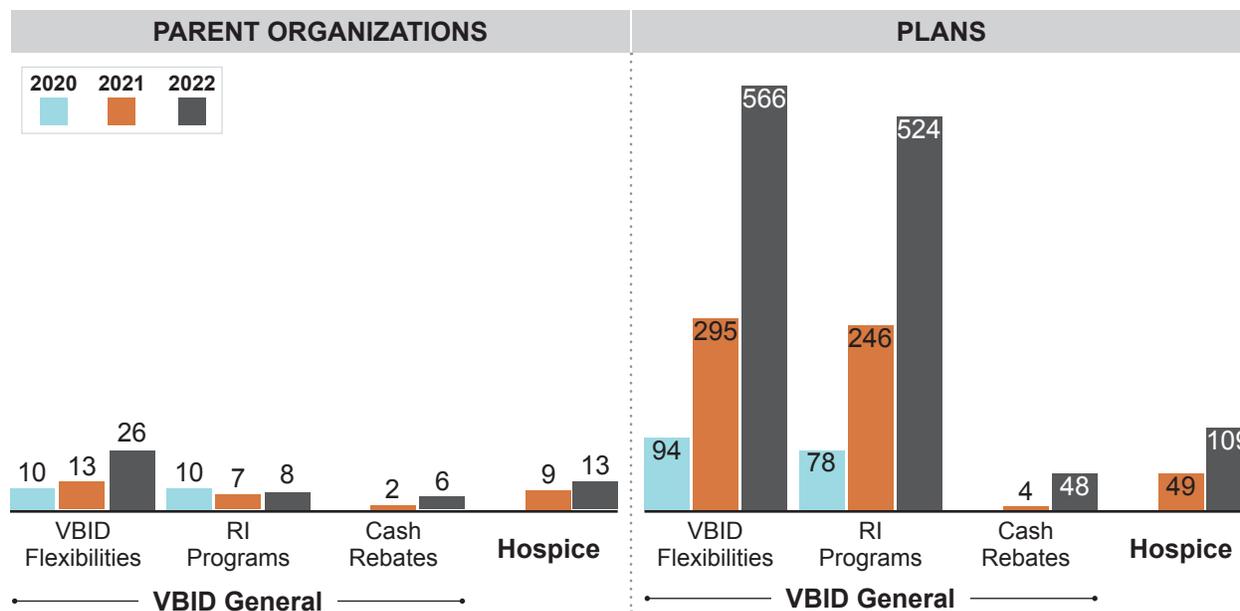
## Model Participants and Interventions

Participation in the model grew dramatically over time, with the number of participating POs more than doubling between 2020 and 2022 (from 14 to 34) and the number of participating plans increasing by nearly sevenfold (from 137 in 2020 to 933 in 2022). Relative to nonparticipants, POs participating in VBID General were more likely to be located in areas with high MA penetration and lower median income, and POs participating in the Hospice Benefit component were more likely to be large, national organizations.

There was marked growth in plan-level participation across all types of VBID interventions (Figure S.2). In 2022, VBID Flexibilities and RI were the most commonly offered interventions

at the plan level, with fewer plans offering Cash Rebates or the Hospice Benefit component. Relative to VBID Flexibilities interventions, RI interventions became more narrowly concentrated within a small subset of POs over time, with the majority of 2022 RI interventions (91%) offered by a single PO. In 2022, 43.6% of VBID General plans were dual eligible special needs plans.

**Figure S.2. Summary of Interventions Offered by POs and Plans in 2022**



While plans participating in VBID General were more likely to target enrollees based on chronic conditions than SES, over time, the share of plans targeting enrollees based on SES increased (from 22.6% in 2020 to 42.6% in 2022). In VBID Flexibilities plans, there was also marked growth in the share of plans offering supplemental benefits (rising from 36.1% of VBID Flexibilities plans in 2020 to 59.5% in 2022) and the share of plans offering Part D cost-sharing reductions (rising from 54.3% of VBID Flexibilities plans in 2020 to 80.8% of VBID Flexibilities plans in 2022). In 2022, over 40% of VBID General plans offered both reduced cost sharing and supplemental benefits, explaining why the percentages can sum to more than 100. While VBID Flexibilities plans could condition benefits receipt on beneficiaries' completion of participation requirements, the share of VBID Flexibilities plans adopting this strategy declined over time, from 67.0% in 2020 to 30.2% in 2022. By 2022, fewer than 7% of targeted beneficiaries enrolled in VBID Flexibilities plans faced participation requirements.

Participation in VBID was voluntary, and POs and plans serving beneficiaries in Puerto Rico accounted for a large share of participants implementing both Cash Rebates and the Hospice Benefit component. For example, four of the six POs and nearly half of the plans that offered Cash Rebates operated in Puerto Rico in 2022. Similarly, two of the 13 POs and about one-

quarter of VBID-participating plans that offered the Hospice Benefit component in 2022 served beneficiaries in Puerto Rico.

## Findings Related to VBID General

### *Implementation Experiences*

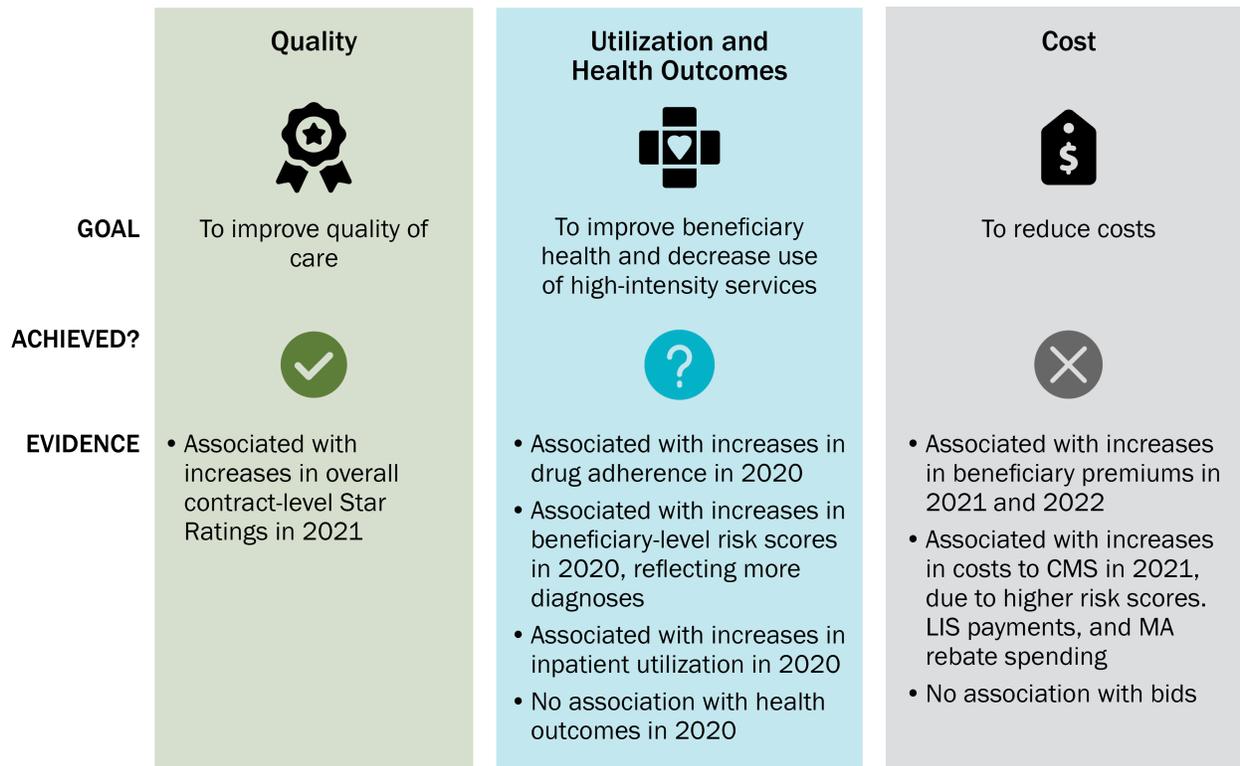
PO representatives continued reporting that VBID General implementation was not too burdensome and did not pose major challenges in 2022. Indeed, three-quarters of POs (15 of 20) implementing VBID General interventions that shared their implementation experiences during the interview felt that implementation was either “a small lift” or “relatively easy.” These POs include those that continued their VBID participation without changing their interventions, as well as the new model participants that offered Part D interventions that targeted beneficiaries based on SES or offered Cash Rebates to all plan beneficiaries.

Moreover, PO representatives generally reported fewer implementation challenges in 2022 than in 2021 and felt that some of the previously reported challenges had diminished. Of the five POs that considered implementation to be “a major lift,” four were new VBID participants and one was rejoining the model test. Model-related data-reporting requirements and working with vendors were the biggest VBID General implementation challenges, which PO representatives rated as “moderate” on the pre-interview survey.

### *Outcomes*

Figure S.3 shows the evidence we have accumulated to date on the association between VBID General and expected outcomes, grouped into three broad categories: quality of care, utilization and health, and cost. In many cases, these findings were based on limited years of data. For example, data on beneficiary-level outcomes, such as adherence and utilization, were limited to 2020. The results to date suggest that VBID General interventions are achieving the goal of improving health care quality and adherence to recommended care. However, based on data available and the outcomes we considered, we have yet to find any evidence of overall improvements in health status or cost outcomes. In fact, VBID General implementation was associated with increases in risk scores, inpatient stays, beneficiary premiums, and costs to CMS in some years. These findings may change in future years, as more data become available.

**Figure S.3. Evidence of Associations Between VBID General and Selected Outcomes**



### Quality of Care

Star Ratings are composite measures of health plan quality that are reported at the contract level and range from 1 to 5, with 5 being the highest level. A contract is a group of health plans offered by the same PO and subject to the same agreement with CMS.

- VBID General was associated with a 0.31 point (8.0%) improvement in Star Ratings for contracts that included at least one participating plan ( $p < 0.01$ , 95% confidence interval [CI]: 0.24 to 0.38).
- The association between VBID General participation and Star Ratings remained statistically significant in sensitivity analyses that limited the sample to contracts with high VBID participation.

This analysis focused on the 2023 Star Ratings, which used measurement data from 2021. Measurement data for 2020 were not consistently reported because of the coronavirus pandemic. For example, some measures that are typically incorporated into the Star Rating were not collected in 2020; in other cases, Star Ratings were reported using prior-year rather than 2020 data.

## *Adherence and Prevention*

Targeted beneficiaries in VBID General plans had small increases in drug adherence in 2020 relative to comparators. Notably:

- VBID General was associated with a 1.4 percentage point increase in adherence to noninsulin diabetes medications ( $p < 0.01$ , 95% CI: 0.9 to 1.9 percentage points); this implies that roughly 687 additional enrollees may have been adherent in 2020.
- VBID General was associated with a 0.7 percentage point increase in adherence to hypertension medications ( $p < 0.01$ , 95% CI: 0.3 to 1.0 percentage points), implying that roughly 824 additional enrollees may have been adherent in 2020.
- VBID General was associated with a 1.6 percentage point increase in adherence to statin medications ( $p < 0.01$ , 95% CI: 1.3 to 2.0 percentage points), implying that roughly 2,286 additional beneficiaries may have been adherent in 2020.

These findings suggest that VBID General was associated with improved quality and adherence, though the number of beneficiaries who had improved adherence was very small. These small effects in part reflect that relatively few plans participated in VBID General in 2020, and hence just under 260,000 beneficiaries were targeted by the model in that year. Because model participation increased over time, the number of beneficiaries becoming adherent could increase in future years, assuming that estimated associations remain stable.

## *Health Outcomes, Risk Scores, and Utilization*

- VBID General was associated with a 0.07 point (6.8%) increase in targeted beneficiaries' risk scores ( $p < 0.01$ , 95% CI: 0.069 to 0.079), which reflect expected medical spending given a beneficiary's health conditions.
- VBID General was associated with an 11.9% increase in inpatient stays among targeted beneficiaries ( $p < 0.01$ , 95% CI: 10.1% to 13.7%). The magnitude and statistical significance of this effect was similar in sensitivity analyses that excluded hospital stays that included a coronavirus diagnosis.
- Aggregate changes in measures of health status estimated using the Health Outcomes Survey, including Physical Component Summary and Mental Component Summary scores, activities of daily living, and instrumental activities of daily living, were small and not statistically significant.

VBID General interventions often aim to increase interactions with providers, which, in turn, may lead to more diagnoses and increase risk scores. Similarly, the increase in inpatient stays could reflect latent need for hospital-based treatments or other delayed care that is discovered through increased interactions with providers. These results are for 2020, because utilization and health outcomes data for 2021 and 2022 were not final as of the time of this writing (early 2023). Because the coronavirus pandemic may have affected utilization and diagnoses in 2020, we controlled for coronavirus case rates in our models. In sensitivity analyses, we found that VBID General was associated with increases in inpatient admissions even after excluding admissions

with a coronavirus diagnosis. Nevertheless, it is important to revisit these results in subsequent years to determine whether patterns change as the pandemic recedes.

### *Cost Outcomes*

We analyzed several cost outcomes, including Medicare Advantage-Part D (MAPD) bids and costs to CMS, which reflect total payments made by CMS to MA plans, accounting for risk adjustment, quality payments, reinsurance, and subsidies for low-income beneficiaries. We also estimated the association between VBID General implementation and beneficiary premiums.

- In 2021, VBID General was associated with an increase in costs to CMS of \$44.26 per member per month (PMPM) (3.3%;  $p < 0.01$ , 95% CI: \$25.93 to \$62.58). The change in costs to CMS for 2020 was not statistically significant. Data were not available for 2022 at the time of this writing.
- VBID General was associated with an increase in MAPD premiums of \$2.25 (9.1%) PMPM in 2021 ( $p = 0.01$ , 95% CI: \$0.48 to \$4.03) and \$1.33 (5.7%) PMPM in 2022 ( $p = 0.01$ , 95% CI: \$0.39 to \$2.27). There was no statistically significant change in 2020.
- VBID General was associated with an \$11.86 PMPM increase in the cost of mandatory supplemental benefits (MSBs) in 2021 ( $p < 0.01$ , 95% CI: \$7.65, \$16.06) and a \$16.15 increase in 2022 ( $p < 0.01$ , 95% CI: \$12.93, \$19.37).

The increase in costs to CMS reflects that risk scores and MA rebate payments increased among VBID General plans relative to similar comparators, leading to a net increase in CMS spending. We found no statistically significant changes in MAPD bids. The increase in MAPD premiums, which was primarily driven by growth in Part D premiums, is borne by enrollees, including enrollees who were not targeted by the VBID General intervention, and by CMS, which pays Part D premiums for enrollees with LIS status. MSBs are services that are not covered by traditional Medicare, such as dental benefits and meal delivery, and must be paid for with beneficiary premiums or MA rebates. Notably, the increase in the premium was much lower than the increase in MSB costs, indicating that plans found a way to economize or buy down MSB costs with MA rebates rather than passing these costs on to beneficiaries.

## Findings Related to Hospice Benefit Component Implementation

### *Implementation Experiences*

Participating POs had different perspectives on the ease of Hospice Benefit component implementation, with POs new to VBID Hospice in 2022 reporting greater challenges than POs that also participated in 2021, the first year of the Hospice Benefit component.

Participants described the model's administrative processes as "moderately" challenging, particularly regarding claims processing. Hospices agreed that claims processing and adjudication with POs was time-consuming and resource-intensive and noted that their payments were often delayed, placing a strain on cash flow. In-network hospices also described challenges

in identifying beneficiaries eligible for Transitional Concurrent Care (TCC) and noted that the variability in POs' eligibility requirements and services offered for TCC and hospice supplemental benefits increased administrative burden for hospices that participate in more than one PO's network.

POs generally considered the process of hospice network building to be moderately challenging but rated the process of negotiating hospice payment and ensuring network adequacy to be only slightly challenging, perhaps because most did not renegotiate contract terms with their in-network hospices from 2021 to 2022. While the vast majority of sampled in-network and out-of-network (OON) hospices indicated their intent to continue or begin contracting with participating POs, some hospices expressed reservations about reimbursement rates below that of traditional Medicare Hospice, and some expected that expansion of the model would reduce financial viability of hospices and decrease access to hospice care.

Like POs, hospices experienced fewer implementation challenges as they gained experience with the model, suggesting that there is a learning curve to effective implementation.

### *Outcomes*

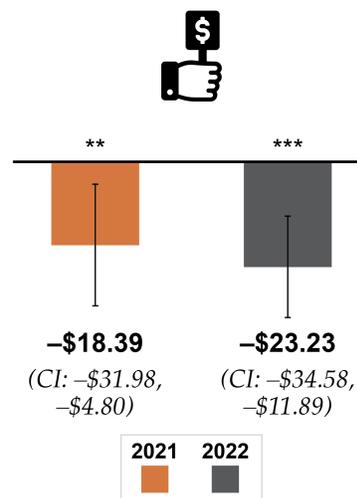
In 2022, 1,168 hospices provided care to at least one VBID beneficiary; approximately one in five were in-network hospices. In-network hospices tended to be larger and were more likely to be part of a chain than OON hospices. Hospice care experiences, assessed as a summary of measure scores from the Consumer Assessment of Healthcare Providers and Systems Hospice Survey, were similar among in-network hospices and other hospices in POs' service areas.

In 2022, palliative care utilization was lower than most POs expected when they applied to participate in the model; very few beneficiaries used TCC or hospice supplemental benefits, and the proportion of VBID beneficiaries receiving hospice care was similar to previous years. For 2021, the first year in which the Hospice Benefit component was implemented, we analyzed a variety of hospice outcomes, including hospice enrollment, average length of stay, probability of live discharge, transfers to another hospice, revocation of hospice status, number of professional visits in the last two days of life, and hospice care experiences. Only the hospice care experiences outcome was statistically significant at conventional levels (2.59 points higher among VBID beneficiaries,  $p = 0.02$ , 95% CI: 0.39 to 4.79), indicating that caregivers of VBID beneficiaries who died while receiving hospice care reported experiences that were, on average, more positive than those reported by caregivers of beneficiaries enrolled in comparison plans. Because nearly one-quarter of POs that volunteered to participate in the Hospice Benefit component in 2021 served beneficiaries in Puerto Rico, a large share (55%) of beneficiaries enrolled in plans participating in the Hospice Benefit component in 2021 were located in Puerto Rico. Therefore, we could not fully account for underlying differences between hospice-eligible and comparison beneficiaries in our analysis. As more POs from the mainland volunteer to participate in the Hospice Benefit component over time, we anticipate that the participating and

comparison groups will become more similar, which should improve our ability to estimate model effects.

We also assessed the relationship between PO participation in the Hospice Benefit component and plan-level financial outcomes, including MAPD bids and premiums for 2021 and 2022 and MAPD costs to CMS for 2021 (2022 data were not available at the time of this writing). We found an association between Hospice Benefit component implementation and reductions in MAPD bids (PMPM) in both years (Figure S.4). We also found a statistically significant increase in MSB costs in 2021 (\$12.18 PMPM,  $p = 0.01$ , 95% CI: \$2.72 to \$21.63), which fell and became marginally significant in 2022, and a marginally significant decline in MAPD premiums in 2021 ( $-\$4.49$ ,  $p = 0.07$ , 95% CI:  $-\$9.37$  to  $\$0.39$ ). As with the beneficiary-level analyses, the substantial differences between Hospice Benefit component participants and nonparticipants made it challenging to identify a suitable group of comparison plans; therefore, some caution is warranted in interpreting the estimates.

**Figure S.4. Association Between Hospice Benefit Component Participation and MAPD BIDS**



NOTE: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively.

## Strengths and Limitations of Evaluation

Our evaluation has strengths and limitations that readers should consider when interpreting results (Table S.1). We combined our quantitative estimates with perspectives of POs, hospices, and beneficiaries to provide context and to better understand the mechanisms underlying the results. We also used state-of-the-art statistical methodologies to estimate the relationship between VBID and outcomes. However, despite rigorous methods, the voluntary nature of the model prevents us from fully ruling out the possibility that unmeasured differences between VBID participants and comparators affected results. POs could also design their own interventions within broad parameters set by CMS, resulting in a wide variation among implemented interventions. Additionally, the model was launched at a time when the health system faced unprecedented challenges due to the coronavirus pandemic. Many outcomes assessed in this report were measured only for 2020, which may be an unrepresentative year.

**Table S.1. Strengths and Limitations of Evaluation**

Evaluation Strengths	Evaluation Limitations
<ul style="list-style-type: none"> <li>• Combines qualitative and quantitative data to identify and explain VBID impacts</li> <li>• Uses survey and interview data to explain PO, hospice, and beneficiary experiences</li> <li>• Adjusts for differences between VBID participants and comparators using rigorous statistical methods (entropy balancing and DD models)</li> <li>• Addresses bias due to both observable and unobservable differences between groups</li> <li>• Controls for time trends common to both VBID and comparison groups</li> <li>• Analyzes multiple outcomes to gain a comprehensive picture of effects</li> </ul>	<ul style="list-style-type: none"> <li>• Uses data from a voluntary model that allowed participants to design their own interventions</li> <li>• Cannot fully rule out unmodeled differences between VBID and comparison groups, given voluntary participation</li> <li>• Analyzes beneficiary-level outcomes for 2020 only and Star Ratings for 2021 only</li> <li>• Model implementation coincides with coronavirus disease 2019 (COVID-19) pandemic</li> <li>• Lacks clinical data, such as lab results, that could help clarify impact on health outcomes</li> <li>• Most 2021 Hospice Benefit component participants are located in Puerto Rico, which limits generalizability</li> </ul>

## Summary and Next Steps

Our analysis suggests that VBID General implementation was associated with higher Star Ratings in 2021 and small improvements in beneficiary adherence in 2020, but we have not yet detected improvements in beneficiary health outcomes or reductions in costs to CMS. In fact, VBID General was associated with increases in risk scores and inpatient stays among targeted beneficiaries in 2020 and increases in MAPD costs to CMS in 2021. In sensitivity analyses exploring the underlying reason for the association with increased cost to CMS, we found that higher risk scores, MA rebates, and LIS payments all played a role. We also found an association between VBID General implementation and higher MAPD premiums in 2021 and 2022. This result was driven by higher Part D premiums, which are paid for by CMS when beneficiaries are LIS-eligible.

Beneficiary uptake of the Hospice Benefit component has been low to date, and we found little evidence that the model affected beneficiary-level measures of hospice enrollment, care patterns, or care experiences in the first year of implementation (2021). Nevertheless, we found a negative association between participation in the Hospice Benefit component and plan bids, which may reflect the expectation among POs (and their actuaries) that participation would reduce seriously ill beneficiaries’ utilization of costly acute care services, such as inpatient stays. However, bids are set prospectively, based on expectations which may change over time.

Our report focuses on the first three years of the model test (2020 through 2022), and some outcomes could only be evaluated for 2020. CMS recently extended the model through 2030. Our interviews identified that POs and hospice providers face a “learning curve” as they implement the model, suggesting that results may change as the model matures. Initial implementation of the model also coincided with the coronavirus pandemic. While we controlled for COVID-19 case rates and conducted sensitivity analyses to ensure that our inpatient findings were not driven by coronavirus admissions, the pandemic likely complicated the impact of

VBID. For example, incentives to use preventive care and to interact with high-value providers may have been muted in 2020 and 2021 because of beneficiaries' concerns about coronavirus exposure. Outcomes may change as additional years of data become available.

## Abbreviations

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ACP	advance care planning
ADLs	activities of daily living
BDI	Benefit Design Innovations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CI	confidence interval
CM	care management
CM/DM	care management or disease management
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
COVID-19	coronavirus disease 2019
DD	difference-in-differences
D-SNP	dual eligible special needs plan
ED	emergency department
FFS	fee-for-service
HCC	Hierarchical Condition Category
HOS	Health Outcomes Survey
IADLs	instrumental activities of daily living
LIS	low-income subsidy
MA	Medicare Advantage
MAPD	Medicare Advantage-Part D
MCS	Mental Component Summary
MSB	mandatory supplemental benefit
MTM	Medication Therapy Management
NOE	notice of election
OACT	Office of the Actuary
OON	out-of-network
OOP	out-of-pocket
OTC	over-the-counter
PBM	pharmacy benefit manager
PBP	plan benefit package
PCP	primary care provider
PCS	Physical Component Summary
PDE	prescription drug event
PDP	Prescription Drug Plan
PDSS	Part D Senior Savings

PHRSBs	Primarily Health-Related Supplemental Benefits
PMPM	per member per month
PO	parent organization
RI	Rewards and Incentives
ROI	return on investment
SES	socioeconomic status
SSBCI	Special Supplemental Benefits for the Chronically Ill
SNAP	Supplemental Nutrition Assistance Program
TCC	Transitional Concurrent Care
UF	Uniformity Flexibility
VBID	Value-Based Insurance Design
WHP	Wellness and Health Care Planning

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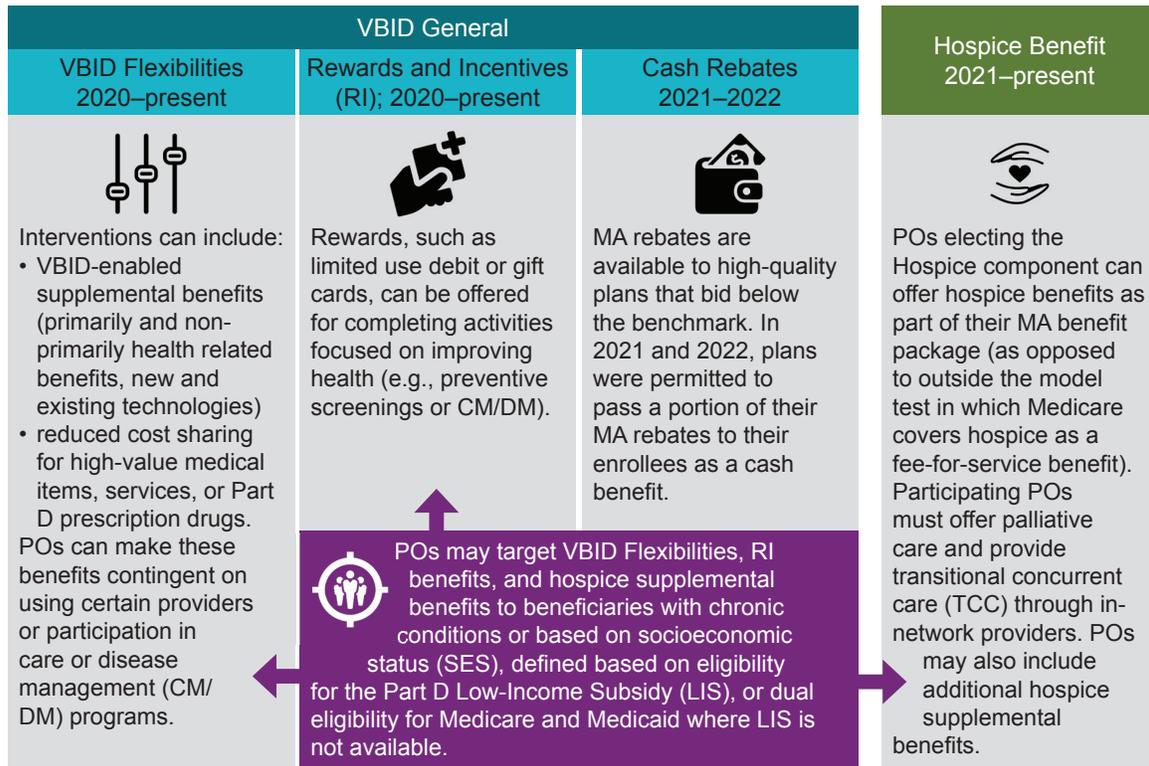
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# Chapter 1. Introduction

Implemented in January 2020, Phase II of the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model enables participating MA parent organizations (POs) to offer a variety of benefits to MA enrollees. Broadly, VBID benefits can be separated into two components (Figure 1.1). First, VBID General interventions encourage beneficiaries to use high-value care and engage in healthy behaviors through such interventions as reduced cost sharing for high-value services, Part D drugs, and providers; care management or disease management (CM/DM) programs; supplemental benefits; and Rewards and Incentives (RI)—for example, restricted-use gift cards to encourage healthy behavior. These options can be targeted to specific enrollees based on chronic condition status or socioeconomic status (SES). In 2021 and 2022, VBID General also included a Cash or Monetary Rebates (“Cash Rebates” in this report) option that allowed plans to share MA rebates directly with enrollees. Second, the Hospice Benefit component enables MA plans to offer palliative care, Transitional Concurrent Care (TCC), hospice supplemental benefits, and the full Medicare Hospice Benefit to enrollees. Outside the model, Hospice benefits are “carved out” of MA and provided under fee-for-service (FFS) Medicare.

**Figure 1.1. VBID Model Test Benefits**



All POs participating in either VBID General or the Hospice Benefit component must also offer Wellness and Health Care Planning (WHP) services, such as advance care planning (ACP) and/or annual wellness visits, to all beneficiaries in their VBID-participating plans. Phase II of the VBID Model test built off a prior version offered from 2017 through 2019 (Phase I). In March 2023, the Centers for Medicare & Medicaid Services (CMS) announced that the model would be extended through 2030 (CMS, 2023).

RAND Corporation researchers are evaluating Phase II of the VBID Model test along multiple dimensions. This report is the second annual report for Phase II of the VBID Model test, covering implementation experiences in 2022 and the impact of the model for 2020 through 2022, as data permitted. We assessed most beneficiary-level outcomes for 2020 only, most plan-level outcomes for 2020 through 2022, and contract-level outcomes (Star Ratings) for 2021. The differences in years reflect differences in data availability, described in more detail below and throughout the report. The remainder of this chapter provides an overview of the model test and its participants, the research questions addressed in this report, a summary of the evaluation methods, and a synopsis of the report structure. This overview of the model test draws heavily on text originally written for our prior report (Khodyakov et al., 2022); any repetition is intentional, to save interested readers from the need to toggle between documents.

## Model Test Overview

As briefly described above, the VBID Model offers POs a range of benefit design options that aim to promote patient- and family-centered care; increase beneficiary choice and access to high-quality, timely, and clinically appropriate care; and reduce the cost of care. POs can enter one or more plans into the model test, provided they meet eligibility requirements described in CMS' request for applications. In general, the model is available to all coordinated care plans and special needs plans that meet specified length-of-existence and plan performance criteria.

### *VBID General*

VBID General includes VBID Flexibilities, RI, and Cash Rebates. Although Cash Rebates, if offered, were required to be provided to all of a plan's enrollees, other VBID General subcomponents may be targeted based on enrollees' chronic conditions or SES, defined as being eligible for the Part D low-income subsidy (LIS) or being dually eligible for Medicare and Medicaid in territories where LIS is not available. (As described in more detail below, many VBID participating plans were located in Puerto Rico.) The option to target benefits based on SES is a unique feature of the VBID Model and could lower barriers to care related to affordability concerns and help plans to better address unmet social and medical needs.

### *VBID Flexibilities*

Through VBID Flexibilities, participating POs may offer reduced cost sharing for high-value medical services, high-value providers, and/or outpatient prescription drugs. They can also offer supplemental benefits, including supplemental benefits that are not permitted outside of the model test. As described above, both reduced cost-sharing and VBID-enabled supplemental benefits can be targeted based on beneficiaries' chronic conditions or SES; they can also be made contingent on meeting requirements, such as engaging with a care manager. VBID-enabled supplemental benefits can be primarily health-related (for example, blood pressure cuffs or over-the-counter [OTC] items) or non-primarily health-related (for example, transportation to nonmedical destinations). Supplemental benefits must have a reasonable expectation of improving or maintaining the health or overall function of the targeted beneficiary. VBID-enabled supplemental benefits may also incorporate coverage for new and existing technologies and medical devices approved by the U.S. Food and Drug Administration, including those not covered under traditional FFS Medicare (for example, continuous glucose monitoring devices for beneficiaries with diabetes). High-value care could include, for example, endocrinologist visits for those with diabetes or statin use for those with high cholesterol.

### *Rewards and Incentives Programs*

To encourage activities that promote health, prevent illness and injury, and encourage efficient use of health care resources, POs may establish RI programs that offer extra benefits to enrollees through, for example, gift or grocery cards. Outside the model test, POs may offer such programs to their entire enrollee population (for example, to encourage broadly recommended care, such as vaccines or preventive screenings). As part of the model test, however, POs may design targeted RI programs to specifically focus the incentives on certain groups of their enrollees. POs could propose to align the value of the RI offered with the value of the expected benefit of the encouraged service or activity (rather than simply the cost of the service), up to an annual limit of \$600. Some restrictions apply; for example, POs may not use RI to reward beneficiaries for not taking Part D covered drugs, nor can they make rewards contingent on achieving a certain outcome.

### *Cash Rebates*

MA plans can receive rebates if the bid they submit to CMS to cover the cost of benefits falls below a regional benchmark based on estimated spending for a beneficiary enrolled in traditional FFS Medicare. Typically, CMS requires that the MA rebates received as part of the bidding process be passed back to enrollees as supplemental benefits, reductions in cost sharing, or lower premiums. In 2021 and 2022, the VBID Model test allowed plans to share some or all of their MA rebates with enrollees by passing them back as direct monetary

transfers. POs that offered Cash Rebates were required to provide this benefit to all enrollees in the participating plan.

### *Hospice Benefit Component*

Starting in 2021, POs could participate in the Hospice Benefit component, which allowed them to offer the Medicare Hospice Benefit within MA. The Hospice Benefit component is designed to consolidate overall financial responsibility and accountability for the cost, quality, and outcomes of MA enrollees who enter hospice, to improve care coordination, and to reduce care fragmentation (Driessen and West, 2018; Medicare Payment Advisory Commission, 2020).

In addition to “carving in” the current Medicare Hospice Benefit into MA-covered benefits, POs participating in the Hospice Benefit component must provide access to palliative care services for seriously ill enrollees who are not eligible for, or prefer not to receive, hospice services. POs must also make individualized TCC services—related to an in-network hospice enrollee’s terminal illness and related conditions—available to those who are eligible for hospice, meet PO-developed TCC eligibility criteria, and wish to receive both curative care (that is, treatment that has the intent of curing illness or preventing further decline) and hospice services. Concurrent curative and hospice care is typically not available to Medicare beneficiaries outside the model.

POs may also offer hospice supplemental benefits, which could include a range of items and services that extend beyond Medicare hospice care, such as additional respite care and access to additional in-home services. Hospice supplemental benefits can be targeted based on SES or chronic conditions and may be limited to beneficiaries choosing in-network hospices. By including palliative care and TCC services, the Hospice Benefit component is designed to encourage smoother and timelier transitions to hospice when appropriate and preferred, thereby promoting use of services that are aligned with beneficiary needs and preferences and reducing use of avoidable acute care services.

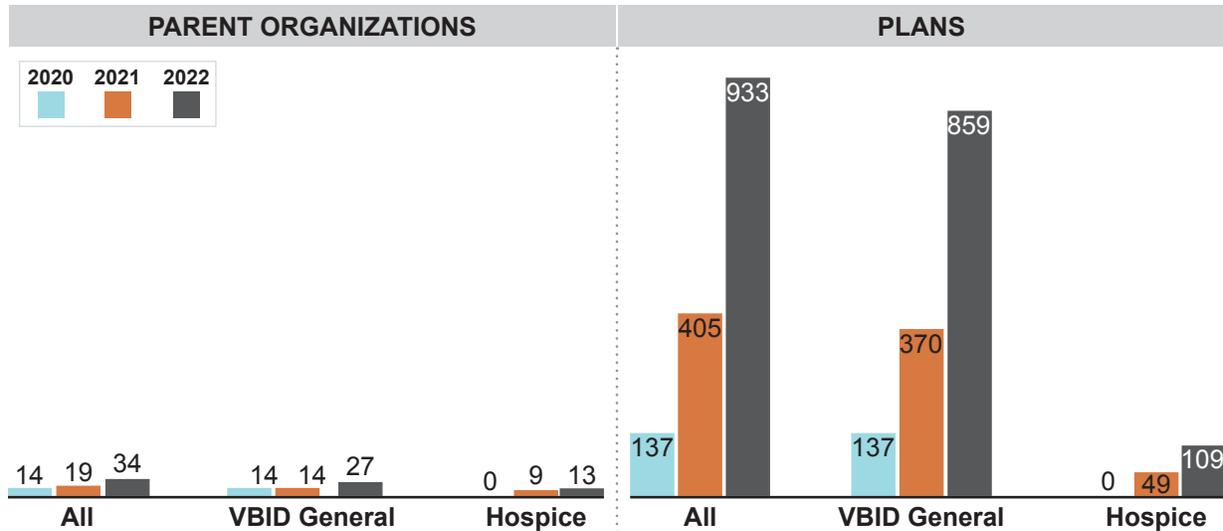
### *Wellness and Health Care Planning Requirement*

POs must offer all VBID plan enrollees timely access to WHP services aimed at improving access to ACP services, including discussions with patients and their family members about care preferences and completion of advance directives. POs are also encouraged to promote the use of annual wellness visits and invest in infrastructure that can help them track the receipt of ACP services. Requiring POs to offer WHP services to all beneficiaries in their VBID-participating plans is expected to (1) improve timeliness of ACP activities; (2) encourage care preferences discussions between beneficiaries and their providers during annual wellness visits, as well as the sharing of these conversations’ outcomes with family members; (3) facilitate sharing of ACP documents across sites of care; and—ultimately—(4) improve the value and quality of care for beneficiaries by aligning care with their preferences and goals.

## Model Participants

Thirty-four POs participated in the MA VBID Model test in 2022; these POs entered 933 plans into the model test (Figure 1.2). The number of participating POs and plans has increased dramatically since the start of Phase II of the VBID Model in 2020. Specifically, the total number of participating POs more than doubled, from 14 to 34, between 2020 and 2022, and the number of participating plans increased by more than sevenfold, from 137 to 933. Between 2021 and 2021, the number of plans participating in VBID General roughly doubled (from 370 to 859), as did the number of plans participating in the Hospice Benefit component (from 49 to 109).

**Figure 1.2. PO and Plan Participation in VBID Over Time**



SOURCE: RAND analysis of participating plan intervention data.

NOTE: The plans have been crosswalked to their 2022 IDs. Appendix H (available in a separate document) provides details on the crosswalking methods. POs and plans may offer more than one intervention; therefore, the numbers in the graph do not add to the total number of participating POs and plans in each year. We omitted two plans from these counts that participated in VBID General in 2022 because they had no enrollment.

The 933 plans entered into the VBID Model in 2022 covered more than 7 million beneficiaries (Table 1.1). Twenty-seven POs participated in VBID General across 859 plans with more than 6.6 million enrollees; 13 POs participated in the Hospice Benefit component across 109 plans with more than 1 million enrollees. Six POs offered both VBID General and Hospice Benefit components. Most POs participating in VBID General ( $N = 26$ ) chose the VBID Flexibilities option, while eight offered RI programs and six provided Cash Rebates. Because plans may offer more than one intervention, beneficiaries may be exposed to more than one VBID subcomponent. Among the 6.6 million beneficiaries enrolled in plans offering VBID General, 4.5 million (about 68%) were in a plan that offered VBID Flexibilities, and 3.7 million (56%) were in a plan that offered RI. Less than 5% of beneficiaries in plans participating in VBID General were offered Cash Rebates.

**Table 1.1. VBID Participation Among POs and Plans, 2022**

	Parent Organizations	Plans	Total Enrollment
VBID General	27	859	6,605,303
VBID Flexibilities	26	566	4,511,305
RI	8	524	3,694,178
Cash Rebates	6	48	317,353
Hospice	13	109	1,025,093
Total	34	933	7,178,820

NOTE: Total enrollment represents enrollment as of July 1, 2022, and includes all plan enrollees, whether or not they were targeted for VBID interventions.

Since 2019, CMS has made several other value-based initiatives available to all POs outside of the VBID Model (text box), enabling them to offer additional benefit flexibility to their enrollees. Because VBID participants often implement these initiatives together with various model test components, we mention these initiatives throughout the report as appropriate.

#### Other Value-Based Initiatives

- **Uniformity Flexibility (UF):** allows MA plans to offer reduced cost sharing or supplemental benefits to beneficiaries based on chronic disease status; these flexibilities apply only to medical items and services, not drugs.
- **Special Supplemental Benefits for the Chronically Ill (SSBCI):** an opportunity for MA plans to offer additional benefits targeted at beneficiaries who are chronically ill.
- **New Primarily Health-Related Supplemental Benefits (PHRSBs):** an expansion in the definition of *supplemental benefits* that allows additional primarily health-related benefits, such as adult day care or home-based palliative care, to be offered to beneficiaries.
- **Part D Senior Savings (PDSS):** a model test that allows Medicare Advantage-Part D (MAPD) plans to offer beneficiaries with diabetes a fixed, maximum \$35 per-month copayment for their insulin; participating plans also have the option of offering a Part D RI program to beneficiaries with prediabetes or diabetes.

## Methods Overview

This report examines the first three years of Phase II of the VBID Model by integrating observations from both primary (qualitative) and secondary (quantitative) data. Our mixed-methods approach incorporates the perspectives of POs, hospices, and beneficiaries with quantitative data on such outcomes as enrollment, utilization, and costs. While the impact of the VBID implementation on key outcomes is determined based on the quantitative data modeling, we use qualitative data to contextualize quantitative findings; identify potential mechanisms through which the model might have affected outcomes of interest; and explain what POs, hospices, and beneficiaries think about the impact that the VBID Model had on them. As such, our mixed-methods approach combines objective quantitative estimates of the

model's impact with more-subjective assessments of its outcomes from the perspectives of key stakeholders.

Both approaches have strengths and limitations. The qualitative analyses provide perspectives of stakeholders who were involved in the model test and reflect their on-the-ground experiences with the model. However, the qualitative assessments rely on self-reported data and therefore are subject to a range of biases. While the quantitative analyses provide a more uniform, data-driven approach to assessing outcomes, they depend heavily on data quality and require statistical assumptions. For example, the difference-in-differences (DD) methods that we use throughout this report require an assumption that trends in outcome variables would evolve similarly for VBID participants and weighted comparators in the absence of the intervention. Because both approaches have advantages and disadvantages, we triangulated the results by looking at the congruence between quantitative and qualitative results to provide more-comprehensive responses to the research questions.

Table 1.2 shows the research questions addressed in this report and the years analyzed for each question. Some outcomes are relevant for only VBID General or the Hospice Benefit component. The timing of data release affects which years can be analyzed for each outcome. For example, because premiums are developed prospectively, premium data for a given year are available before that year begins, whereas MA encounter data for the same year are not finalized until 18 to 24 months after the year ends. In addition, data collection for certain quality measures was complicated for 2020 because of the coronavirus disease 2019 (COVID-19) pandemic. In analyzing Star Ratings, it is important to distinguish the year in which the Star Ratings were publicly reported (the display year) from the year in which the data were measured (the measurement year). For the 2022 display year, which reflects data measured in 2020, CMS reverted to prior-year data to generate component measures if the prior-year data were more favorable than the 2020 data (CMS, 2021a). In addition, CMS did not field the MA & Prescription Drug Plan (PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which informs Star Ratings, in 2020. As a result, we opted not to analyze Star Ratings for the 2020 measurement year.

Readers should bear in mind that the primary data included in this report came from interviews conducted in 2022, but much of the secondary data reflect outcomes from earlier years. Because participants changed over time, their perspectives on the model in 2022 and later years may not always align with experiences from the past. Furthermore, although one of the goals of our evaluation is to estimate the causal effect of VBID on outcomes, this study is not a randomized control trial, and POs may have selectively entered health plans into the model test. Although we have applied state-of-the-art methods to isolate the effect of VBID on outcomes, we avoid using causal language to describe the results.

**Table 1.2. Research Questions Addressed in This Report**

Domain	Research Questions	Analysis Level, 2020	Analysis Level, 2021	Analysis Level, 2022
Implementation	What are POs' implementation experiences with VBID General? Did they vary by intervention?	—	—	PO <sup>a</sup>
Implementation	What did POs need to do to implement the Hospice Benefit component in their plans?	—	—	PO <sup>b</sup>
Implementation	Do in-network hospices need to operate differently under VBID?	—	—	Hospice <sup>b</sup>
Implementation	How do in-network and out-of-network (OON) hospices perceive the Hospice Benefit component of the model test?	—	—	Hospice <sup>b</sup>
Participation	What interventions did POs implement, and what groups of beneficiaries did they target?	—	—	PO <sup>a, b</sup>
Participation	What palliative care, TCC, and hospice supplemental benefits do participating POs offer as part of the model test?	—	—	PO <sup>b</sup>
Participation	Why did hospices join VBID POs' networks?	—	—	Hospice <sup>b</sup>
Participation	How are networks of hospices being built, and what do they look like?	—	—	PO <sup>b</sup>
Participation	How are payment arrangements being handled?	—	—	PO and Hospice <sup>b</sup>
Beneficiary experiences	Were eligible beneficiaries aware of their plan's intervention and how to access it?	—	—	Beneficiary <sup>a, b</sup>
Beneficiary experiences	What was the VBID uptake among targeted beneficiaries?	—	—	Beneficiary <sup>a, b</sup>
Quality	Do Star Ratings change in MA contracts that include participating plans?	—	Contract <sup>t<sup>a, b</sup></sup>	—
Quality	Does participation in the model improve performance on relevant individual quality measures?	Beneficiary <sup>a</sup>	Contract <sup>a</sup>	—
Health	Does the model improve targeted enrollees' overall health status and specific conditions?	Beneficiary <sup>a</sup>	—	—
Health	What, if any, impact does the model have on enrollees' risk scores?	Beneficiary <sup>a</sup>	—	—
Utilization	Does the model result in targeted enrollees consuming fewer high-intensity services, such as emergency department (ED) visits and inpatient admissions?	Beneficiary <sup>a</sup>	—	—
Cost	What is the model's effect on costs to Medicare?	Plan <sup>a, b</sup>	Plan <sup>a, b</sup>	—
Cost	What is the model's effect on MAPD bids?	Plan <sup>a, b</sup>	Plan <sup>a, b</sup>	Plan <sup>a, b</sup>

Domain	Research Questions	Analysis Level, 2020	Analysis Level, 2021	Analysis Level, 2022
Cost	What is the model's impact (if any) on targeted enrollees' and non-targeted enrollees' premiums and on the availability of supplemental benefits for non-targeted enrollees in participating plans?	Plan <sup>a</sup>	Plan <sup>a, b</sup>	Plan <sup>a, b</sup>
Hospice election	How does the Hospice Benefit component of the model impact the decision to elect hospice by enrollees?	—	Beneficiary <sup>b</sup>	Beneficiary <sup>b</sup>
Hospice election	How does the Hospice Benefit component of the model impact the timing of hospice election by enrollees?	—	Beneficiary <sup>b</sup>	—
Hospice experiences	How does the model affect enrollee hospice experience as measured by visits in the last week of life, likelihood of live discharge, transfer, and revocation, among others?	—	Beneficiary <sup>b</sup>	—

NOTE: A dash (—) indicates that the outcome was not analyzed for that year. <sup>a</sup> VBID General. <sup>b</sup> Hospice Benefit component.

### Primary Data

In 2022, we solicited the perspectives of VBID-participating POs, in-network and OON hospices, and beneficiaries on the model and its outcomes. We use these data not only to describe stakeholder thoughts on and experiences with the model test components but also to explain how and why VBID implementation might have affected (or did not affect) key outcomes, which helps us to address key research questions more comprehensively.

To encourage candor among those who participated in this evaluation, we have anonymized all data contained in this report. For example, for POs and hospices, we have assigned placeholder letter names (for example, PO A, PO B, Hospice A, Hospice B) to protect their confidentiality. For continuity purposes, we have also retained the labeling assignments for POs and hospices from previous VBID evaluation reports, where applicable. If relevant, we also note whether a hospice we interviewed was in-network or OON for a VBID-participating PO.

### Parent Organizations

Between June and September 2022, we obtained PO perspectives on the model test via questionnaires and semi-structured small group interviews conducted with individual POs. Of the 35 model test participants,<sup>1</sup> we received questionnaire responses from 32 POs and were able to interview representatives of 27 POs. Our goal was to explore how POs implemented model test components, what implementation challenges they encountered, and what they

<sup>1</sup> For the purposes of primary data collection, we considered two POs that merged in 2022 as separate entities because one of them continued its VBID participation from 2021 and the other joined the model test that year.

thought about the impact of VBID on enrollment, care quality, and cost outcomes in 2022. During the interviews, we used each PO's responses to the questionnaire to help structure the interview. To minimize burden, we held these interviews virtually, at a time convenient to interviewees. Interviews lasted for up to two hours and were often conducted over two sessions. Appendix A provides additional details on PO questionnaires and interviews.

### Hospices

Between October and December 2022, we conducted semi-structured small group interviews with representatives of 19 hospices, including those that entered into contracts with POs to be an in-network hospice and those that were OON but in close geographic proximity to model test participants. These interviews explored factors that hospices considered when deciding to participate in PO networks, as well as their experiences negotiating contracts with POs, working with POs to coordinate care for VBID beneficiaries, and delivering Hospice Benefit component services. We also asked in-network hospices to complete a pre-interview questionnaire similar to the one we used during the PO data collection. Each interview lasted for about one hour and was conducted virtually. Appendix A provides additional details on hospice questionnaires and interviews.

### Beneficiaries

Between June and September 2022, we also conducted semi-structured telephone interviews with 150 beneficiaries. These 30-minute interviews were designed to assess beneficiary experiences with, awareness of, and perceived impact of different VBID benefits. Beneficiary interviews were conducted in either English or Spanish, depending on the beneficiary language preference. By design, the majority of interviewees ( $N = 117$ ) were low-income beneficiaries from VBID-participating plans that offered VBID General benefits designed to help them address their health-related social needs. For a portion of our VBID General-focused interviews ( $N = 62$ ), we intentionally sampled LIS-eligible beneficiaries who switched to a VBID-participating plan in 2022 from either a non-VBID plan or FFS Medicare to explore the factors that affected their plan choice. We also interviewed 33 beneficiaries (or their caregivers) who were enrolled in a Hospice-participating plan and received palliative care services. For interviews focused on palliative care services delivered through the VBID Model, we sampled beneficiaries from Hospice-participating plans who received these services at least for eight days in 2021 to ensure that beneficiaries had sufficient exposure to palliative care to recall and describe their experiences. Appendix B provides additional details on beneficiary interviews.

### Data Analysis

PO and hospice questionnaire data were analyzed descriptively to identify the most common responses and the range of perspectives. Our approach to the analysis of all

qualitative data entailed a series of coding steps to process data from the interviews, followed by a thematic analysis. Data coding involved the development of a codebook from an initial set of interview transcripts to identify emerging patterns and then a systematic application of similar codes across subsequent transcripts to pull out common themes. We then analyzed transcripts using thematic analysis techniques to compare and contrast emerging themes, explore variation in implementation experiences by model components and participants, and respond to research questions (Guest, MacQueen, and Namey, 2012). Once all the data were analyzed, we compared our results with the findings reported in our previous report to determine whether and how stakeholders' perspectives on the VBID Model had changed over time. A full description of our primary data collection and analysis methods can be found in Appendices A and B.

### *Secondary Data*

We conducted analyses at the plan, beneficiary, and contract levels to understand VBID's possible effects on key outcomes, drawing on a range of data sets. To analyze outcomes at the plan level, we compared VBID-participating plans with comparison plans that were eligible for VBID (based on plan-type, length-of-existence, and performance requirements) but did not participate. We defined plans at the plan benefit package (PBP) level. We used an entropy-balancing approach to weight comparison plans so that they closely resembled VBID-participating plans along key pre-VBID dimensions, including pre-VBID trends in each outcome variable. We then used DD regression models to assess whether trends in outcomes for VBID participants and the weighted set of comparators diverged after the model was implemented. Our statistical models build on an approach documented by Callaway and Sant'Anna (2021) to address the fact that VBID implementation (and de-implementation, if a plan leaves the model test) occurred at different time periods for different plans. Briefly, we used this method to create separate estimates for a range of plan participation patterns, including participation in 2020–2022, participation in 2021–2022, participation in 2022 alone, and others. We then combined these estimates to calculate the average effect of VBID on outcomes in each calendar year (2020, 2021, and 2022).

Some health plan quality measures, including the Star Ratings, are defined by CMS at the contract level. Contracts are groups of plans offered by the same PO and covered by the same contracting agreement by CMS. Typically, not all plans within a contract participate in the VBID Model. For contract-level analyses, we compared contracts with at least one VBID participant to a weighted set of contracts with no VBID participants, using the same DD approach outlined above. In sensitivity analyses, we restricted the sample to contracts with a threshold-level of beneficiaries in VBID-participating plans (for example, 25%, 50%, and 75%) to address the possibility that the effects of VBID on contract-level outcomes are stronger in contracts with more VBID participants.

For beneficiary-level analyses, we used different approaches for VBID General and Hospice outcomes. When analyzing VBID General interventions, we restricted our sample to beneficiaries and comparators who were enrolled in the same plan from January 1, 2019, through January 1, 2020, enabling us to track trends in outcomes before and after VBID General implementation. About 57% of beneficiaries targeted for VBID General interventions met this criterion. We included months enrolled in the plan in the post-period as a balancing characteristic to ensure that the time period over which the outcome is assessed is balanced for VBID and comparison beneficiaries. Consistent with our prior evaluation (Eibner et al., 2020), we used an “intent-to-treat” approach in which we considered beneficiaries to be treated if they were enrolled in VBID-participating plans and targeted for VBID interventions, regardless of whether they used VBID benefits. Comparators were individuals who enrolled in MA plans that were eligible for VBID but did not join the model test. We then ran entropy-balanced beneficiary-level DD regressions akin to those described at the plan level. The entropy-balancing approach aimed to make the beneficiaries in the comparison group resemble beneficiaries in the VBID-participating group along a variety of characteristics, including health conditions, SES, and other criteria that plans used to target VBID benefits.

A longitudinal approach at the beneficiary level does not work for Hospice analyses, because beneficiaries who elect hospice are not typically observed in the data for more than a year. Rather, most of our Hospice analyses used a cross-sectional approach in which we compared subsets of beneficiaries in VBID-participating and comparison plans over time. The specific subsets may include all health plan enrollees, all decedents, or all hospice enrollees, depending on the research question. More detail on the statistical methods can be found in Appendix C; information on the variables we used in the analysis is reported in Appendix D.

For all outcomes, we conducted separate analyses for VBID General and the Hospice Benefit component. Additionally, for several key outcomes jointly selected by RAND and CMS, we conducted subgroup analyses to better understand effects for subcomponents of VBID General, including VBID Flexibilities overall, interventions targeted based on SES, Part D cost-sharing reductions, interventions with participation requirements, and RI. These results are discussed, where applicable, in the main text and reported in full in Appendix E.

## Report Structure

This report describes the experiences of participating POs, beneficiaries, and hospices, and it analyzes the relationship between VBID implementation and outcomes for 2020 to 2022, depending on data availability. We present separate results for VBID General (Part I) and the Hospice Benefit component (Part II), concluding with a discussion of stakeholder perceptions on potential model expansion and a summary of the overall findings and their limitations (Part III).

A separate volume of appendices provides detail on plan intervention designs, detailed methods descriptions, supplemental results, sensitivity analyses, and subgroup analyses.

## **PART I: VBID GENERAL**

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## Chapter 2. Participants, Interventions, and Implementation Experiences

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### Key Findings

- PO participation in VBID General nearly doubled between 2021 and 2022 by increasing from 14 to 27, with the number of participating plans increasing from 370 to 859.
  - Participants were more likely than nonparticipants to be located in areas with lower median incomes and areas with higher MA penetration. They were more likely to be dual eligible special needs plans (D-SNPs), had a higher proportion of dual- and LIS-eligible beneficiaries, had slightly younger enrollees, and had a smaller proportion of males and non-Hispanic White enrollees.
  - There was growth in all three VBID General subcomponents offered and both types of targeting approaches used. The vast majority of plans with at least one SES-based intervention were D-SNPs.
  - VBID Flexibilities was the most commonly offered VBID General intervention; the number of plans offering Cash Rebates grew at the fastest rate by increasing from four in 2021 to 48 in 2022. Nearly half of plans offering RI interventions in 2022 were located in Puerto Rico.
  - Implementation of reduced cost-sharing interventions doubled in 2022. Part D drug cost-sharing reductions—especially those targeted to low-income beneficiaries—drove this trend. The number of plans offering healthy food benefits more than doubled, making the food benefit one of the most commonly implemented VBID General benefits.
  - As in 2021, PO representatives felt that VBID General implementation was not too burdensome and did not pose major challenges in 2022. Five POs reported that implementation was a major lift, but four of these POs were new or rejoining model test participants. Model-specific data reporting requirements and working with vendors remained the biggest VBID General implementation challenges.
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This chapter uses PO and plan characteristics data to describe 2022 VBID Model participants that implemented VBID General, with a specific focus on the difference between participating and nonparticipating POs and plans. Using model application materials, information from the model implementation and monitoring contractor, and results of PO survey and interview data, this chapter also summarizes the VBID General interventions that model participants implemented in 2022, beneficiary groups they targeted, and implementation barriers they encountered (Appendix A provides details on the PO survey and interviews). In addition, this chapter explains how participants and their VBID General interventions changed between 2020 and 2022. Summaries of 2020–2022 interventions can be found in Appendix F.

### Characteristics of POs and Plans That Implemented VBID General

In 2022, 27 POs implemented VBID General, an increase from 14 in 2021. One 2021 participant did not continue its participation in 2022. Two POs that left VBID before 2021 returned and implemented VBID General in 2022. POs participating in VBID General in 2022 were generally located in areas with higher MA penetration rates, compared with nonparticipating POs (54.1% versus 49.2%,  $p = 0.02$ ), and were in service areas with lower median county income levels (\$29,327 versus \$31,292,  $p = 0.04$ ).

Participating POs entered 859 plans into the model test in 2022, an increase from 370 in 2021.<sup>2</sup> Compared with nonparticipating plans, participating plans were more likely to offer Part D (99.7% versus 89.9%,  $p < 0.001$ ), were more likely to be D-SNPs (43.6% versus 7.3%,  $p < 0.001$ ), and had a higher average out-of-pocket (OOP) maximum amount (\$5,333 versus \$4,989,  $p < 0.001$ ). Likely due to the high proportion of participating D-SNPs, participating plans had a higher proportion of dual-eligible (52.3% versus 20.5%,  $p < 0.001$ ) and LIS-eligible enrollees (54.7% versus 26.8%,  $p < 0.001$ ). Participating plans had, on average, slightly younger enrollees (68.4 versus 71.6,  $p < 0.001$ ), a smaller proportion of male enrollees (43.0% versus 46.6%,  $p < 0.001$ ), and fewer non-Hispanic White enrollees (51.1% versus 61.4%,  $p < 0.001$ ). VBID General participants were more likely to participate in the PDSS model, as well as more likely to implement UF, SSBCI, and/or new PHRSB ( $p < 0.001$  for all except those implementing UF, which was  $p = 0.06$ ). Appendix G provides further detail on these comparisons.

In general, new POs that implemented VBID General cited two main reasons for participating in VBID, which were similar to the ones stated by 2021 model participants. First, representatives from eight new VBID General participants (POs AA, AC, AD, AE, AG, AH, AK, and AP) and two rejoining model participants (POs E and AA) considered VBID an attractive opportunity to offer additional benefits, such as zero-dollar cost sharing for drugs, meal benefits, and Cash Rebates, or offering benefits only to beneficiaries with low SES. Second, representatives of four new participants (POs AD, AG, AK, and AO) reported that VBID offered an opportunity to improve care quality and health outcomes. Other reported reasons included consistency of VBID goals with organizational priorities (PO AH) and the opportunity to address unique needs of beneficiaries with low SES (POs AD, AG, and AK).

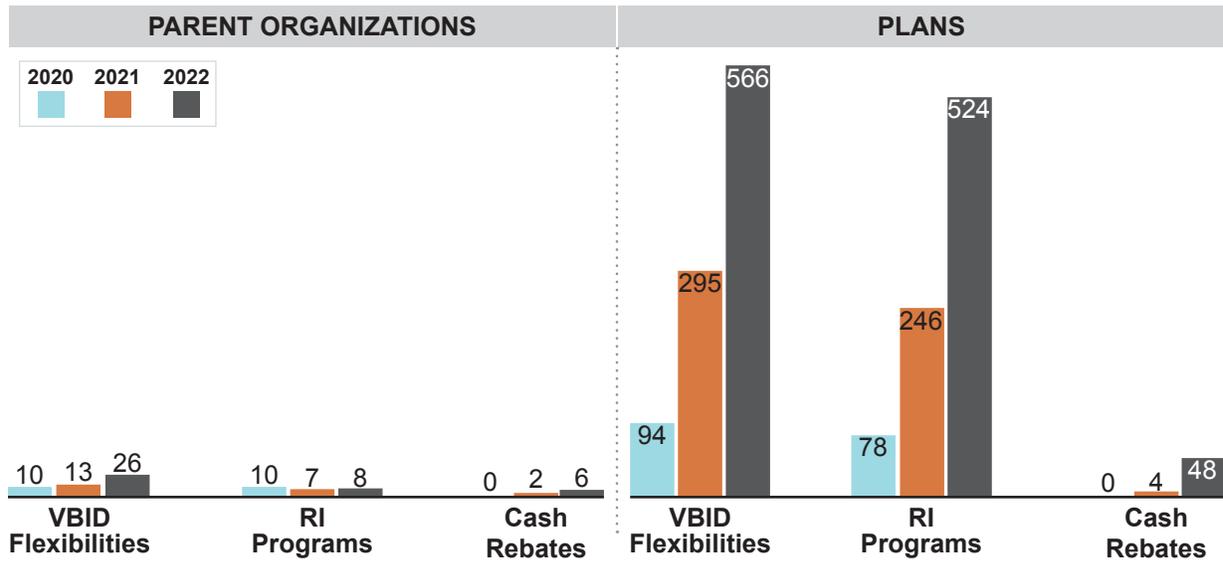
## VBID General Subcomponents Implemented

Figure 2.1 summarizes the number of POs and plans that implemented different VBID General subcomponents. Between 2020 and 2022, there was marked growth in the number of participating plans across all three VBID General subcomponents; VBID Flexibilities was the most commonly offered option in all years. In 2022, 26 POs (or 96.3% of all VBID General POs) and 566 plans (65.9% of all VBID General plans) implemented VBID Flexibilities. While a comparable number of plans offered VBID Flexibilities and RI (566 versus 524), RI plans were concentrated in a smaller number of POs, with one PO (PO P) accounting for more than 90% of all RI plans. Relatively few plans and POs offered Cash Rebates, yet offerings of this VBID General subcomponent grew from four plans located in one geographic region in 2021 to 48 plans located in several regions (5.6% of VBID General plans) in 2022.

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<sup>2</sup> The number of plans participating in 2021 differs from our prior report (Khodyakov et al., 2022) because some plans merged between 2021 and 2022. For the purposes of this report, we treat merged plans as a single observation. We define plans at the PBP level, not at the PBP-segment level.

**Figure 2.1. Number of POs and Plans with VBID General Subcomponents, 2020–2022**



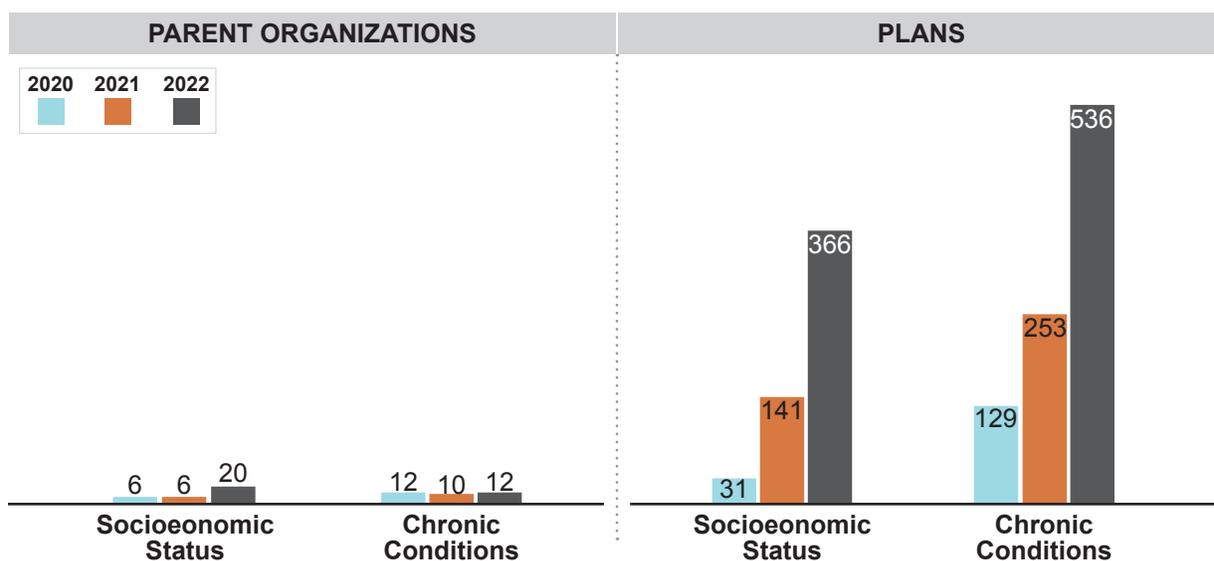
SOURCE: RAND analysis of participating plan intervention data.

NOTE: The plans have been crosswalked to their 2022 ID. Appendix H provides details on the crosswalking methods. POs and plans may offer more than one intervention; therefore, the numbers in the graph do not add to the total number of participating POs and plans in each year. We omitted two plans from these counts that participated in VBID General in 2022 because they had no enrollment. Plans with new technology interventions are included in the VBID Flexibilities category.

### *Beneficiary Targeting*

POs could offer VBID Flexibilities and RI programs only to certain types of beneficiaries in their VBID-participating plans. Figure 2.2 shows the number of POs and plans implementing different interventions targeted to beneficiaries with a chronic condition or based on SES. Twelve POs offered VBID General interventions targeting chronic conditions in 536 plans in 2022. PO P accounted for 89% of the plans with the interventions targeting chronic conditions in 2022. This PO was also largely responsible for the increase in the number of plans targeting a chronic condition from 2021 to 2022. In interviews, the main rationales cited for implementing chronic condition–focused interventions were similar to those mentioned in previous years and included the desire to improve the management of specific chronic conditions to reduce costly downstream consequences, such as ED visits or inpatient stays.

**Figure 2.2. Number of POs and Plans with Targeted Group, 2020–2022**



SOURCE: RAND analysis of participating plan intervention data.

NOTE: The plans have been crosswalked to their 2022 ID. Appendix H provides details on the crosswalking methods. Plans may have more than one intervention with more than one targeted group (or no targeting for the Cash Rebates); therefore, the numbers in the graph do not add to the total number of participating plans in each year.

More than twice as many POs targeted beneficiaries based on SES in 2022 than in 2020 or 2021. The number of plans with SES-based targeting increased from 31 in 2020 to 141 in 2021 and 366 in 2022. Ninety-three percent of the plans with at least one SES-based intervention in 2022 were D-SNPs (compared with 97% in 2021; data not shown). It is worth noting that some interventions that used SES-based targeting were implemented in non-D-SNPs, and some D-SNPs offered interventions to beneficiaries with certain chronic conditions.

Although VBID General participants could target VBID Flexibilities and RI interventions to beneficiaries identified based on chronic conditions or SES, the vast majority of POs and plans offering RI targeted their interventions based only on chronic conditions. Only one PO offered RI interventions to low-income enrollees in only one plan in 2020, and no POs targeted RI interventions based on SES in 2021 or 2022. In contrast, in all three years, POs offering VBID Flexibilities targeted beneficiaries based on both chronic conditions and SES. While more POs offered reduced cost-sharing VBID Flexibilities interventions than VBID-enabled supplemental benefits to low-income beneficiaries in 2022 ( $N = 16$  versus 12, respectively; data not shown), the number of plans that offered these interventions to beneficiaries identified based on SES was roughly the same ( $N = 296$  versus 300, respectively; data not shown).

SES-based VBID Flexibilities interventions generally fell into three categories: lower Part D cost sharing, supplemental benefits to assist with activities of daily living (ADLs), and healthy food cards. Similar to the rationale for choosing the chronic condition–focused interventions, the goal of SES-based targeting was to reduce the risk of downstream and

expensive complications stemming from poorly managed chronic conditions. Another commonly cited reason for offering interventions to low-income beneficiaries was competition in benefit offerings among POs in certain local markets. A representative of PO AA, which implemented \$0 cost sharing for Part D generic drugs, explained:

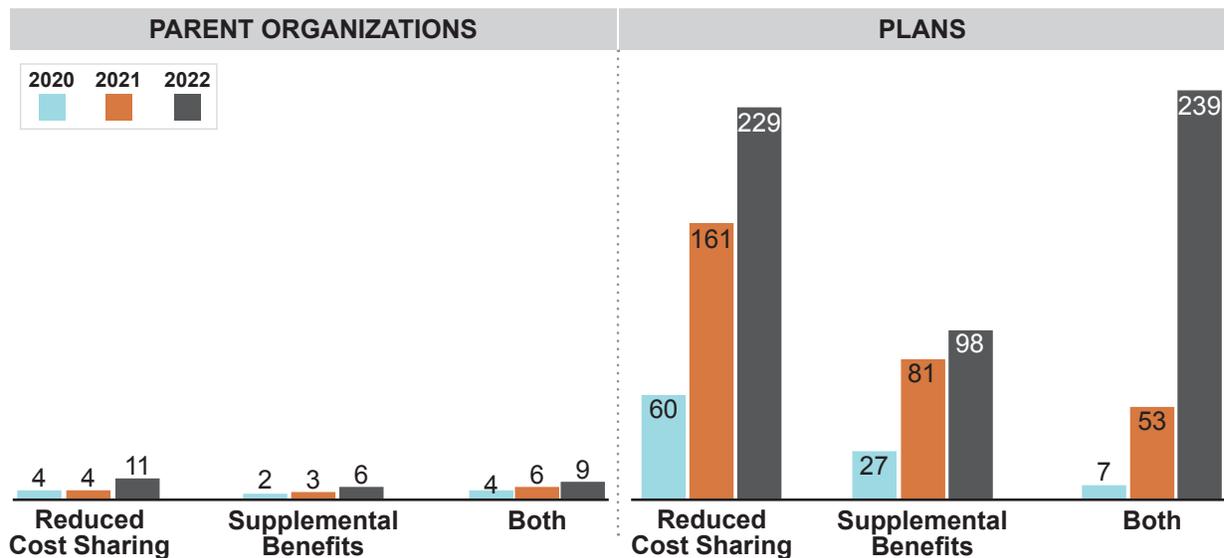
[W]e're starting to see a number of different MAOs [Medicare Advantage Organizations] in both [our] market and nationwide offer this type of benefit. So, we wanted to make sure that [our plan] is basically keeping up with some of the other competitors or staying ahead of some of the other plans.

### VBID Flexibilities

#### Reduced Cost Sharing

In 2022, reduced cost sharing was the most frequently implemented VBID Flexibilities intervention. The number of POs implementing reduced cost sharing doubled in 2022 (an increase from eight in 2020 and ten in 2021 to 20 in 2022), and the number of plans more than doubled (from 67 in 2020 to 214 in 2021 and to 468 in 2022) (Figure 2.3).<sup>3</sup>

**Figure 2.3. Number of POs and Plans with VBID Flexibilities Interventions, by Intervention Type and Year**



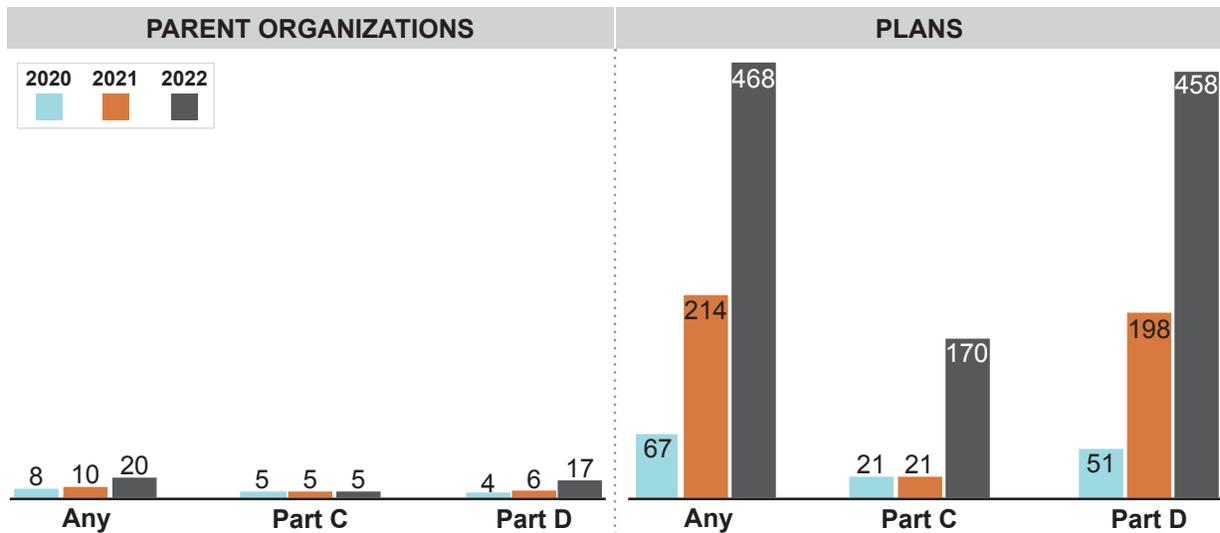
SOURCE: RAND analysis of participating plan intervention data.

NOTE: The plans have been crosswalked to their 2022 ID. Appendix H provides details on the crosswalking methods. Plans may have more than one intervention; therefore, the numbers in the graph do not add to the total number of participating plans in each year.

<sup>3</sup> To calculate the total number of POs and plans implementing reduced cost-sharing interventions, we added the number of POs or plans reported in the “Reduced Cost Sharing” category of Figure 2.3 to the number reported in the “Both” category of the figure.

Of the 20 POs offering some type of reduced cost-sharing intervention in 2022, five offered reduced Part C cost sharing and 17 offered reduced Part D cost sharing (Figure 2.4). There was no change in the number of POs offering reduced Part C cost sharing across the three years, but the number offering reduced Part D cost sharing increased from four in 2020, to six in 2021, and to 17 in 2022. The number of plans offering any reduced cost sharing increased from 67 in 2020, to 214 in 2021, and to 468 in 2022, driven by increases in offering reduced Part D cost sharing. The number of plans with reduced Part D cost-sharing interventions increased from 51 in 2020, to 198 in 2021, and to 458 in 2022, representing 54.3% of plans offering VBID Flexibilities interventions in 2020, 67.1% in 2021, and 80.9% of plans offering them in 2022.

**Figure 2.4. Number of POs and Plans Offering Reduced Cost Sharing, by Type and Year**



SOURCE: RAND analysis of participating plan intervention data.

NOTE: The plans have been crosswalked to their 2022 ID. Appendix H provides details on the crosswalking methods. Plans may have more than one intervention; therefore, the numbers in the graph do not add to the total number of participating plans in each year.

Part D-focused interventions that targeted low-income beneficiaries were particularly widespread in 2022 (295 in 2022 versus 60 in 2021). By offering these interventions, POs hoped to improve overall drug adherence. As a representative for PO N, which lowered Part D drug cost sharing for LIS level 1 and 2 beneficiaries, explained:

It was not only to improve adherence in the drugs that are part of the Part D adherence measures, but really to improve adherence for all maintenance drugs and then to encourage vaccinations, and also to improve member experience at the pharmacy. A lot of our members aren't able to pay for their copays and they forego picking up their medications, even with a small copay that they have.

### *VBID-Enabled Supplemental Benefits*

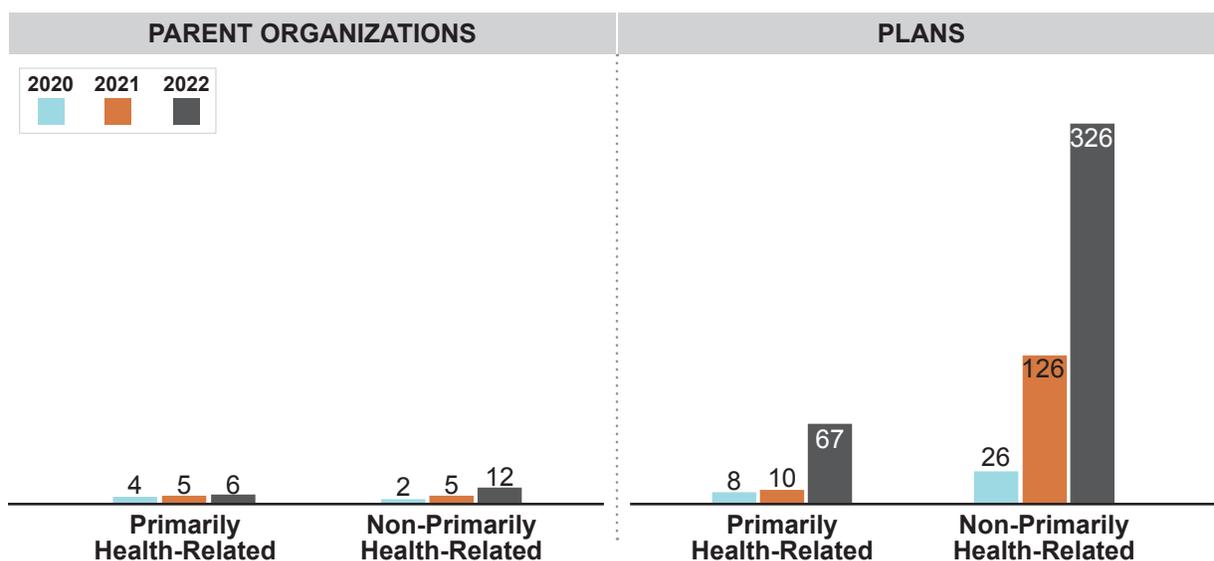
The number of POs offering supplemental benefits as part of the model test increased from six in 2020, to nine in 2021, and to 15 in 2022, and the number of plans increased from 34 to 134 and then to 337 during the same period (Figure 2.3).<sup>4</sup> There was a substantial increase in the number of POs and plans that offered both supplemental benefits and reduced cost-sharing interventions as part of the VBID Model. In 2022, 42% of plans ( $N = 239$ ) implementing VBID Flexibilities interventions offered both VBID-enabled supplemental benefits and reduced cost sharing.

POs often offered multiple supplemental benefits as part of VBID. Figure 2.5 shows a more detailed breakdown of the number of POs and plans that offered supplemental benefits (primarily and non-primarily health-related) as part of their VBID General intervention designs. Although the number of POs offering PHRSBs (for example, OTC items, transportation to medical destinations) increased from four in 2020, to five in 2021, and to six in 2022, the number of plans grew from eight to ten and then to 67 in the same period. Between 2020 and 2022, the number of POs offering non-PHRSBs (for example, healthy food cards, transportation to nonmedical destinations) increased substantially (from two in 2020, to five in 2021, and to 12 in 2022), and the number of plans increased from 26 in 2020, to 126 in 2021, and to 326 in 2022.

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<sup>4</sup> To calculate the total number of POs and plans offering VBID-enabled supplemental benefits, we added the number of POs or plans reported in the “Supplemental Benefits” category of Figure 2.3 to the number reported in the “Both” category of the figure.

**Figure 2.5. Number of POs and Plans Offering Supplemental Benefits, by Type and Year**



SOURCE: RAND analysis of participating plan intervention data.

NOTES: The plans have been crosswalked to their 2022 ID. Appendix H provides details on the crosswalking methods. Plans may have more than one intervention; therefore, the numbers in the graph do not add to the total number of participating plans in each year.

In discussing the value of supplemental benefits, many PO representatives noted that medical services cost sharing for low-income beneficiaries is already low, so supplemental benefits provide additional value. Food cards were particularly popular because POs wanted to reduce access barriers to healthy foods that might reduce exacerbations for certain conditions. Indeed, the number of plans offering healthy food benefits more than doubled between 2021 and 2022 (126 to 295 plans). In-home supports, such as grab bars in bathrooms or companion care services, and transportation benefits also became increasingly common in 2022 because PO representatives felt that these benefits help beneficiaries maintain their independence:

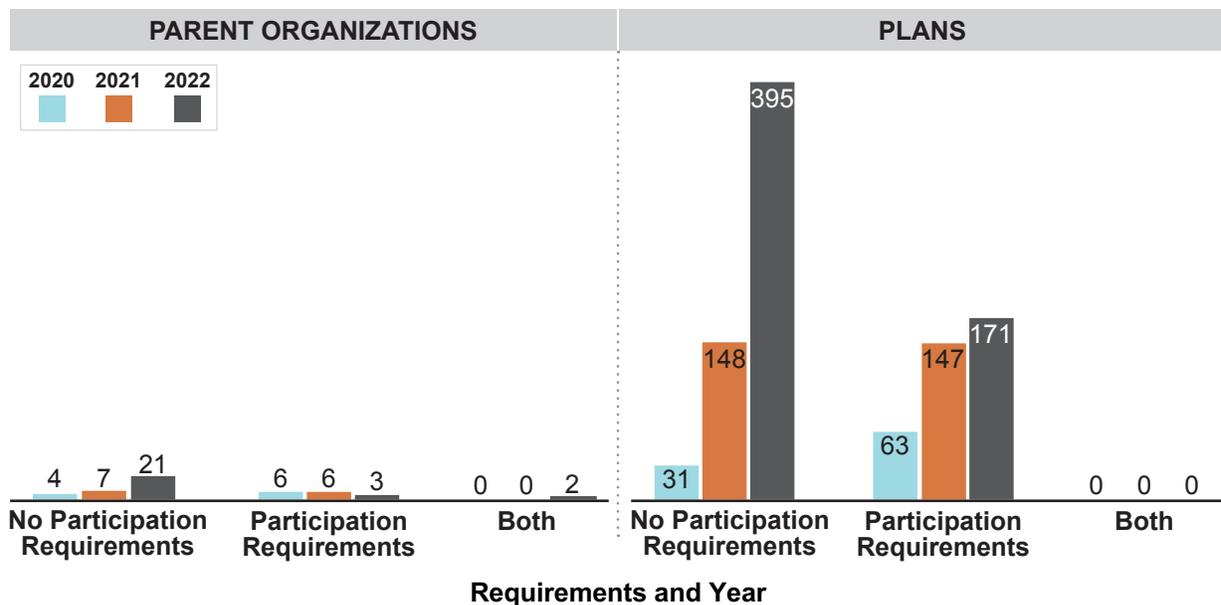
We’ve had members who had offers from family, let’s say, to fill their prescriptions, but refused because they didn’t want to be seen as a burden. So, these types of health plan side interventions help support enrollees in maintaining their dignity and maintaining that autonomy, which, while we haven’t measured it yet, we know from external studies and other research that maintaining that dignity and autonomy is absolutely critical to preserving mental health and a positive outlook. (PO P)

#### *Participation Requirements*

Model participants could make the receipt of their VBID Flexibilities benefits conditional on beneficiaries’ meeting certain participation requirements, such as engagement with a care manager. Over time, there was a decrease in the share of POs and plans offering VBID Flexibilities that imposed such participation requirements. For example, the number of POs with participation requirements declined from six in 2020 and 2021 to three in 2022, while the

number of POs offering VBID Flexibilities interventions without participation requirements increased from four in 2020, to seven in 2021, and to 21 in 2022 (Figure 2.6). (Two POs offered interventions both with and without participation requirements in 2022 but implemented them in different plans.) While there was an increase in the absolute number of plans with any participation requirements between 2020 and 2022, the relative share of plans with participation requirements declined over time. For example, in 2020, roughly twice as many plans had participation requirements as did not (63 with participation requirements versus 31 without). By 2022, this relationship had reversed, with 395 plans having no participation requirements, compared with 171 with participation requirements.

**Figure 2.6. Number of POs and Plans with VBID Flexibilities Interventions, by Participation**



SOURCE: RAND analysis of participating plan intervention data.  
 NOTE: The plans have been crosswalked to their 2022 ID. Appendix H provides details on the crosswalking methods. Plans may have more than one intervention; therefore, the numbers in the graph do not add to the total number of participating plans in each year. POs that offered interventions with and without participation requirements implemented them in different plans.

### Rewards and Incentives

Eight POs and 524 plans implemented RI interventions in 2022 (Figure 2.1). Nearly half of plans offering RI in 2022 served beneficiaries in Puerto Rico. By definition, all RI interventions have participation requirements. These interventions focused exclusively on improving chronic condition management and encouraging completion of such wellness activities as vaccinations or health screenings. While the number of POs offering RI interventions decreased from ten in 2020 to eight in 2022, the number of plans offering them increased from 78 in 2020, to 246 in 2021, and to 524 in 2022. The more than twofold increase in the number of plans offering RI between 2021 and 2022 was driven by PO P, which offered

two separate Part D RI programs—a medication review for beneficiaries with chronic obstructive pulmonary disease (COPD) and a Medication Therapy Management (MTM) program for eligible beneficiaries who did not complete the MTM program in the previous year. No POs or plans implemented RI programs that targeted low-income beneficiaries. In 2022, POs chose to focus on the same chronic conditions as in previous years (for example, congestive heart failure, COPD, and diabetes).

Beneficiaries were typically asked to complete screenings or receive certain vaccines annually or participate in CM/DM or medication management activities on a quarterly basis. Some plans determined the frequency based on beneficiary needs. Rewards earned per activity varied widely, from \$5 to \$75.

POs issued rewards through restricted-use cards. According to PO U representatives:

For the VBID reward, it is restricted. So, it's approved locations and it's approved items. You couldn't go to the Food Lion. You have to go to The Fresh Market. You couldn't buy paper towels, even if you were at The Fresh Market. So those types of restrictions, that's how we approached the VBID reward.

### *Cash Rebates*

In 2022, six POs<sup>5</sup> offered Cash Rebates in 48 plans (an increase from two POs and four plans in 2021) (Figure 2.1). In 2022, participating plans provided between \$15 and \$210 to their enrollees each month. POs had different reasons for offering this intervention. One PO offered Cash Rebates in a plan with younger and healthier beneficiaries who “would rather use some of these dollars to buy purchases [sic] outside of what [is covered under] the OTC model” (PO AD), referring to the restrictions imposed by the types of purchases that beneficiaries can make using the OTC card. Others wanted to offer additional financial resources to their low-income enrollees. POs felt that this flexibility for beneficiaries to spend the money on goods or services they needed the most was well-received by their enrollees. A PO AH representative explained:

Maybe this month I needed to spend it on utilities, but next month it's for groceries, or whatever else. I think with the idea that we still continue to do the menu-type items, it will allow the member to target or customize in on their own specific needs.

Cash Rebates were usually delivered via a debit card that could be used for cash withdrawals or purchases. Beneficiaries in some plans were also able to use this debit card as their health insurance card. While beneficiaries had to spend their Cash Rebates dollars within a certain number of days after the end of the plan year or after the beneficiary disenrolled from

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<sup>5</sup> For the quantitative portions of this report, we treat two POs that merged as one PO. As a result, the count of POs that offered Cash Rebates in 2022 is six (rather than seven, as reported in Appendix F, which describes PO interventions).

the plan, POs had different rules for OTC and food cards, with some requiring beneficiaries to spend the money every month.

## VBID General Implementation Experiences

Consistent with findings in our prior evaluation report (Khodyakov et al., 2022), PO representatives continued to report that VBID General implementation was not too burdensome and did not pose major challenges. Of the representatives of the 20 POs that completed our interview in 2022, 15 reported that implementation was either a small lift (POs B, G, J, L, N, P, Q, U, AD, AO, and AP) or relatively easy (POs E, W, Y, and AC). These include POs that have continued model participation without changing their interventions, as well as those that modified their VBID General offerings or joined the model in 2022. To use the words of a PO P representative, which has been continuously adjusting its VBID General interventions:

I will note that 2022, this is our third year of implementing a very similar program . . . . We've kind of continuously improved it and tweaked it year over year a little bit, but by and large, a lot of it has stayed pretty similar. So, I would say from an implementation perspective, the first year of that program was a lot of getting new processes set up, which is a heavier lift. . . . I would say overall for 2022, we kind of paved the way during the first year and subsequent years have been much easier.

The new model participants that felt that the implementation was not burdensome either issued Cash Rebates to all beneficiaries in their VBID plans (POs AD and AP) or offered Part D interventions that targeted beneficiaries based on SES (POs AC, AO, and AP). SES-based targeting requires less effort on the part of the PO than targeting beneficiaries with chronic conditions, because SES status is administratively determined based on receipt of the Part D LIS (or dual eligibility for Medicaid and Medicare in Puerto Rico).

Although most POs reported smooth implementation, five POs stated that the implementation was a major lift (POs N, AA, AE, AH, and AK). Only one of these five POs is continuing its participation from 2021. This PO's representatives felt that the process of determining who was eligible for its RI program turned out to be more difficult than expected because of miscommunication with programmers. The remaining POs were either new or rejoining model participants that have been learning about model requirements.

Moreover, in comparison to 2021, POs reported fewer implementation challenges and felt that some of the previous challenges had lessened. To illustrate, the top three previous implementation challenges were model-specific data reporting, working with vendors and subcontractors, and communication with providers (Khodyakov et al., 2022). While these challenges were rated in 2021 as moderate or slight-to-moderate challenges as in the case of provider communication, the 2022 questionnaire results show that POs generally considered them only as slight challenges (Table 2.1). In 2022, no challenge received a median rating of higher than "slight," and the modal value of the majority of challenges was "not at all." Unless

otherwise noted, POs that offered VBID General interventions for the first time in 2022 and those that have been doing so for more than one year rated VBID General implementation challenges similarly.

**Table 2.1. PO Questionnaire Ratings of VBID General Implementation Challenges**

<b>Implementation Challenges</b>	<b>Not at All</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Considerably</b>	<b>A Great Deal</b>	<b>Not Applicable</b>	<b>Median</b>
Communicating VBID benefits information to beneficiaries (N = 24)	8	12	3	1	0	0	Slightly
Implementing annual wellness health care planning services to all beneficiaries in a PBP (N = 25)	10	11	3	1	0	0	Slightly
Working with vendors or subcontractors that help implement your VBID intervention(s) (N = 24)	6	10	6	0	1	1	Slightly
Tracking beneficiary VBID eligibility over time (N = 25)	12	9	3	1	0	0	Slightly
Reporting data as part of model participation activities (N = 25)	8	7	6	1	3	0	Slightly
Communicating VBID benefits information to providers (N = 24)	11	7	4	1	1	0	Slightly
Administering multiple sets of benefits within one PBP (N = 25)	9	4	4	0	1	7	Not at all–Slightly
CMS reviews of marketing materials (N = 24)	12	8	2	1	0	1	Not at all–Slightly
Identifying VBID-eligible beneficiaries (N = 25)	13	10	2	0	0	0	Not at all

SOURCE: RAND analysis of 2022 MA VBID PO questionnaire data.

The 2022 questionnaire results show that model-specific data reporting and working with vendors continue to be the biggest challenges, with ten POs rating the former and seven POs rating the latter as at least “moderate” challenges. It is worth noting that while two of the three POs that felt that data reporting was a big challenge were new model test participants, five of the six POs reporting that it was a moderate challenge joined the model before 2022, and some of them (for example, POs B and Y) have not changed their VBID General interventions in 2022. New VBID General participants faced challenges accessing the data submission portal (POs AC and AK), experienced some “hiccup[s] with first quarterly data submission” (PO AP), or had to receive “additional support from the help desk . . . to get everything uploaded” (PO AC). POs AH and AO were particularly surprised by “the number of teams and the complexities involved with [reporting] . . . bringing everybody in, and ensuring we had everybody understanding the requirements for those reports” (PO AH). Data reporting was also particularly challenging if the data had to come from vendors first. “We had to make sure all of the datapoints from [the] PBM [pharmacy benefit manager] were still maintained and

calculated properly . . . and they were based on CMS requirements for reporting,” said a PO AK representative.

Vendor-related challenges primarily included working with card vendors to communicate VBID eligibility information, to deliver incentives for completed RI programs, to issue Cash Rebates, and to implement cards with multiple purses, as well as working with PBMs to operationalize Part D interventions.

### Card-Delivered VBID General Benefits

POs used gift and debit cards to deliver many VBID General benefits. POs contracted with vendors to issue cards, manage the lists of eligible items, establish and manage networks of stores that accept their cards, prepare reports describing benefit utilization, and ensure compliance with Medicare rules.

- **VBID-enabled supplemental benefits:** To deliver healthy food, gas, utilities, and OTC benefits, POs issued debit-like cards that their enrollees could use to buy eligible items. Healthy food items, for instance, were often restricted to the items eligible for the Supplemental Nutrition Assistance Program (SNAP). However, some POs further limited the type of food items that could be purchased by excluding unhealthy foods, such as donuts or soda. Some POs were able to offer one card with several “purses” that could be used to pay for OTC and VBID-enabled supplemental benefits, such as healthy foods or utilities, though the funds from these separate purses were not always fungible. While some POs allowed unspent funds to roll over from month to month or quarter to quarter to allow beneficiaries more flexibility, others chose the “use it or lose it” approach, especially for healthy food benefits.
- **RI:** RI program rewards were typically limited to gift cards for specific retailers (for example, Walmart or Amazon), with some limits on items that could be purchased (for example, no firearm, tobacco, or alcohol purchases).
- **Cash Rebates:** POs issued debit cards that beneficiaries could use for cash withdrawals or purchases. Beneficiaries in some plans were also able to use this debit card as their health insurance card. In general, beneficiaries were required to spend their Cash Rebates dollars within a certain number of days after the end of the plan year or after the beneficiary disenrolled from the plan.

Several POs, including POs AD and AP, reported issues related to delays in mailing reward cards and card activation issues. According to PO AP representatives, there was “a slight delay [with mailing out cards], which, I guess, was commonplace against [sic] all card suppliers, primarily due to supply chain issues as a result of the pandemic.” PO AD representatives noted that card activation “was a little bit tricky in the first quarter. We had some issues with our members actually activating their cards, but that pretty much sorted itself out once we hit [the] second quarter.” To streamline beneficiary experiences, several POs issued cards with multiple purses (for example, one card that combined OTC, reward, and healthy food cards) that allow purchases based on eligibility requirements. According to PO N representatives, transition to the multi-purse card required the vendor to address many questions from their beneficiaries about the nuances of using this new card.

Four POs (AA, AC, AE, and AK), all of which joined or rejoined VBID in 2022, reported a range of challenges working with their PBMs to operationalize and implement their Part D VBID General interventions that required substantial engagement with PBMs. A PO L representative said:

[We need to communicate eligibility] to make sure that they understand these are the members who are getting VBID, these are the members who are getting the regular benefit, how to tell them apart to make sure that everybody has it straight. Just because the more variation we add, the more complexity it adds to our interactions with that vendor to make sure everybody gets the right benefit.

This was a somewhat unexpected finding because our interviews with POs in previous years showed that, from the POs' perspectives, Part D interventions were easier to implement than Part C interventions. New model participants felt that the main implementation burden of their VBID General interventions fell on PBMs, some of which did not have extensive previous experience with VBID implementation for other clients. As a PO AC representative put it, the PBM is

responsible for programming the benefit. . . . PBMs are getting up to speed in accounting and reporting. You need to make sure the calculations add up in the background. We had to engage with the PBM often to understand the design. They had to pull in an expert. They only had a handful of clients that implemented VBID [this year] as well. They had to ensure they had the right understanding, the calculations were done properly, and the reporting to us was in place.

Representatives of PO AA stated that they experienced some implementation challenges related to charging beneficiaries within the same plan different copay amounts for the same drugs, depending on their VBID eligibility:

[T]here was an issue at the start of the year, in terms of actual [claims] adjudication. But I think because [our PBM is] doing it for a number of different clients, they were able to correct that adjudication after one or two months, and I think things look to be flowing through the [Part D events] now appropriately.

## Summary

The number of POs and plans participating in VBID General roughly doubled in 2022, with substantial increases across all VBID General subcomponents (VBID Flexibilities, RI, and Cash Rebates). Compared with nonparticipants, 2022 participating POs were more likely to be located in areas with higher MA penetration and lower median county income levels. Participating plans were more likely to be D-SNPs, have a higher proportion of dual- and LIS-eligible beneficiaries, and have higher average OOP costs. These plans also had slightly younger enrollees but a smaller proportion of males and non-Hispanic White beneficiaries. Finally, participating plans were more likely to participate in the PDSS Model test and implement UF, SSBCI, and/or new PHRSB.

VBID Flexibilities was the most commonly implemented VBID General subcomponent, and reduced cost sharing was the most commonly implemented VBID Flexibility between 2020 and 2022. Reduced cost sharing for Part D drugs drove the increase in the number of POs and plans that implemented reduced cost-sharing interventions in 2022. Also, during this time,

substantially more plans implemented non-PHRSB than PHRSB, and the number of plans offering healthy food benefits more than doubled.

Another noteworthy trend is the influx of D-SNPs into the model test, consistent with an overall increase in the number of D-SNPs in the market and the steady growth in the number of beneficiaries enrolled in these plans (Freed et al., 2022; Johnson, Hallum, and Gipe, 2022). Participating D-SNPs generally targeted beneficiaries based on SES and offered reduced cost sharing for Part D drugs, healthy food benefits, and other VBID-enabled supplemental benefits.

As in 2021, most PO representatives reported that VBID General implementation was not too burdensome and did not pose major challenges in 2022. Of the five POs reporting that implementation was a major lift, four were new or rejoining model participants. Model-specific data reporting and working with vendors remained the biggest VBID General implementation challenges. New model participants were particularly surprised by the challenges related to the data reporting requirements.

## Chapter 3. Plan Enrollment

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### Key Findings

- When we analyzed all VBID General interventions together, we found no association between VBID General implementation and plan enrollment.
  - In subgroup analyses, we found a positive association between VBID participation and enrollment in plans that implemented VBID Flexibilities in 2021, driven by plans that targeted their interventions based on SES:
    - an 18.8% increase in enrollment in VBID Flexibilities plans in 2021 ( $p < 0.01$ , 95% confidence interval [CI]: 5.8% to 33.4%)
    - a 35.0% increase in enrollment in VBID Flexibilities plans with SES targeting in 2021 ( $p = 0.02$ , 95% CI: 4.7% to 74.2%)
  - POs also reported that VBID General implementation had a positive impact on enrollment, but it was difficult to disentangle changes that were due to VBID General from changes that were attributable to other factors.
  - Our beneficiary interviews showed that most beneficiaries who switched into a VBID General plan from another MA plan or from FFS were attracted by dental and healthy food benefits. Beneficiaries tended to learn about VBID from plan representatives or family and friends.
  - Both beneficiaries and PO representatives reported that VBID-enabled supplemental benefits, such as healthy food and OTC cards, helped with low-income beneficiaries' everyday expenses and factored into enrollment decisions.
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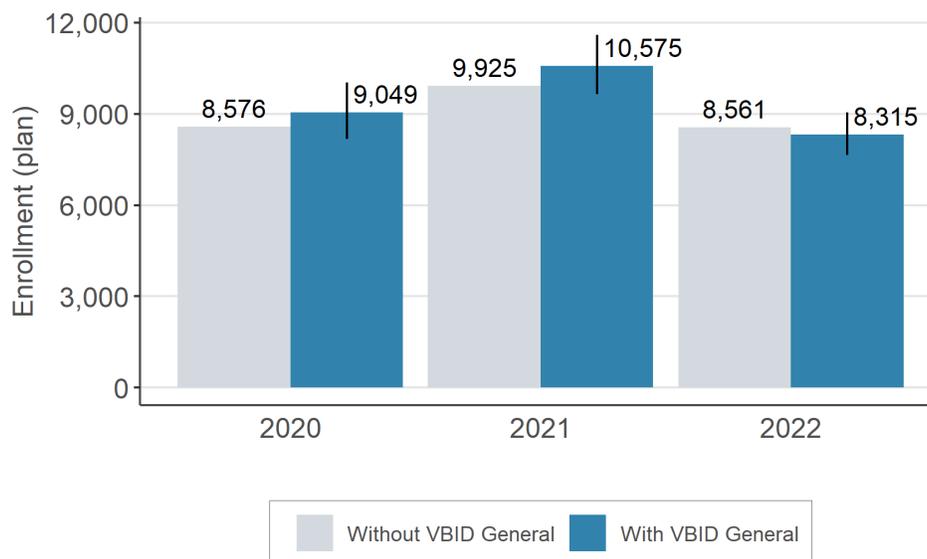
Because VBID General offers additional benefits to some or all plan enrollees, it is possible that implementation could affect enrollment levels. In our previous report (Khodyakov et al., 2022), we found that a plan's participation in VBID General was associated with a marginally significant increase in enrollment in 2021, a finding that corresponded with POs' expectations that VBID might increase enrollment over time. However, we also found that VBID General implementation was associated with small but statistically significant increases in premiums, which could deter enrollment for some beneficiaries. In this chapter, we revisit the relationship between VBID General implementation and plan enrollment using additional years of data. Our outcome of interest was **total plan enrollment**, measured on July 1 of each year. We conducted our analysis at the plan level and used the natural logarithm of total enrollment as our dependent variable. We can estimate percent changes in outcomes by exponentiating the regression coefficients and subtracting one. Appendices C and I provide more detail on the methods we used for this analysis.

### Plan Enrollment

The results presented in Figure 3.1 show the relationship between VBID General implementation and plan enrollment, as estimated in our DD models. The gray bars show estimated enrollment in VBID General plans had they not implemented the model, and the blue bars show actual enrollment in participating plans. The black lines represent the 95% CIs surrounding the estimated change in enrollment associated with VBID General such that if the

CI does not reach to the gray bar for the corresponding year, the estimated effect is significant at the 5% level. We found no statistically significant association between VBID implementation and health plan enrollment in any year. The 7.1% change that we estimated in 2021 ( $p = 0.15$ , 95% CI:  $-2.4\%$  to  $17.7\%$ ) was similar in magnitude to that reported in our prior evaluation but was no longer statistically significant, even at a marginal level ( $p < 0.10$ ). Although we used the same data, the slight changes in the results reported previously (Khodyakov et al., 2022) are due to an update we made to our approach to tracking plans that consolidated over time and to refinements in our entropy balancing approach, such as changes in the covariates included. Changes in methods that could contribute to these differences in estimates are discussed in Appendix C, and a full list of variables included in the balancing algorithm is provided in Appendix D.

**Figure 3.1. Estimated Association Between VBID General Interventions and Plan-Level Enrollment**



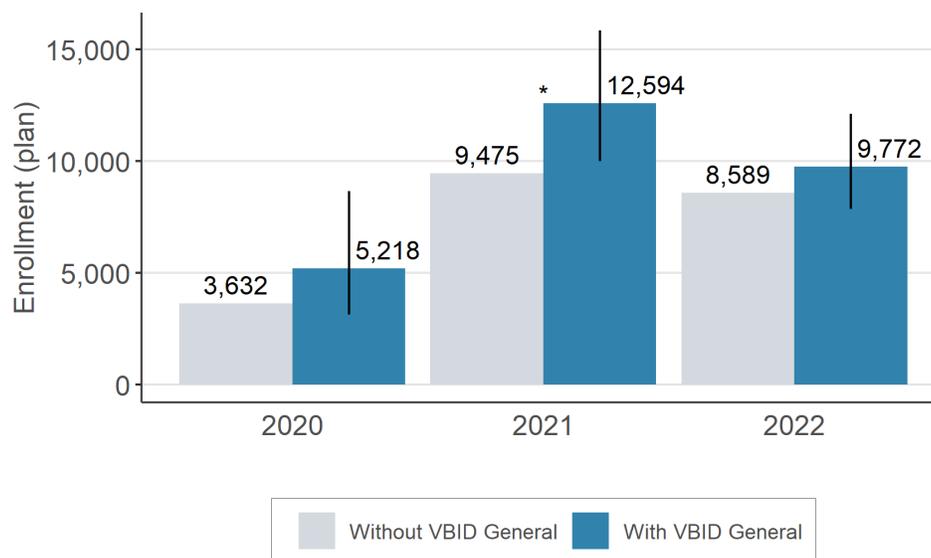
SOURCE: RAND analysis of MAPD enrollment data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in VBID General with a weighted sample of comparison plans. The number of participating plans included in the analyses was 777, and the total effective sample size (including participating plans and weighted comparison plans) was 3,152. The black line(s) shown represent the 95% CI for the estimated effect of VBID General on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level.

The model allows POs that participate in VBID General to offer a range of interventions. In Appendix E, we analyzed whether results differed across five subtypes of interventions: VBID Flexibilities, VBID Flexibilities targeted based on SES, Part D cost-sharing reductions, VBID Flexibilities with participation requirements, and RI programs. We found a positive and statistically significant association between VBID General participation and enrollment in VBID Flexibilities plans in 2021, driven by VBID Flexibilities plans that targeted their interventions based on SES. Specifically, our estimates suggested an 18.8% increase in

enrollment in VBID Flexibilities plans in 2021 ( $p < 0.01$ , 95% CI: 5.8% to 33.4%), and a 35.0% increase in enrollment in VBID Flexibilities plans with SES targeting ( $p = 0.02$ , 95% CI: 4.7% to 74.2%). Associations between enrollment and other VBID Flexibilities subcomponents were not statistically significant in any year, nor were associations between enrollment and participation in RI. Figure 3.2 shows the associations for VBID Flexibilities plans that targeted their interventions based on SES. We note that it was challenging to achieve balance for the subgroup of plans with SES-based interventions, requiring us to use a parsimonious selection of balancing variables for this analysis to preserve adequate sample size. We discuss this further in Appendix E.

**Figure 3.2. Estimated Association Between VBID General Interventions and Plan-Level Enrollment, VBID Flexibilities Targeted Based on SES**



SOURCE: RAND analysis of MAPD enrollment data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in VBID General with a weighted sample of comparison plans. The number of participating plans included in the analyses was 276, and the total effective sample size (including participating plans and weighted comparison plans) was 728. The black line(s) shown represent the 95% CI for the estimated effect of VBID General on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level.

### *PO Perspectives*

Our analysis of PO survey and interview data collected in 2022 found that PO representatives had a generally positive view on the impact of VBID General implementation on beneficiary enrollment and retention, though it may be hard for them to attribute changes in enrollment specifically to their VBID General interventions. Of the 25 POs that responded to a survey question about how their VBID General affected (or is likely to affect) beneficiary enrollment and retention in 2022, most ( $N = 16$ ) reported an increase in beneficiary enrollment

and retention; nine reported no impact. Although no POs reported a decrease in enrollment or retention attributable to VBID General, representatives of PO U noted that while there was an increase in enrollment, there was also an increase in disenrollment, “like a turnover kind of effect.”

Representatives of some POs reporting an increase in enrollment (POs E, Q, AK, and AP) noted that it is hard to attribute increased plan enrollment to VBID alone because they entered D-SNPs into the model test, which is a growing line of business. A representative from PO E reported:

Our D-SNP continues to grow. It’s difficult to tell if this was a direct correlation to our VBID intervention because it is a growing block of business for us, even prior to incorporating our zero-dollar cost share [benefit as part of VBID]. But it’s certainly something that we’ll track and do reporting on at the close of this year.

Others reported a decrease in enrollment that they did not attribute to their VBID General participation. For example, PO Q representatives reported creating a new D-SNP that did not participate in VBID that attracted some low-SES beneficiaries who were enrolled in their VBID-participating plans. Moreover, representatives of POs AD and R, both of which offered Cash Rebates as part of their VBID General interventions, reported that their competitors’ offering of Cash Rebates as part of the model negatively affected their own plan enrollment. To illustrate, PO R representatives said that, although their VBID plans saw a large increase in enrollment in the first year of offering VBID General, enrollment went down in 2022 because their competitors were “very aggressive in the amounts [of Cash Rebates] they offered.”

During interviews, several PO representatives described VBID-enabled supplemental benefits as one of the main drivers of increased plan enrollment and retention. A PO N representative called out its OTC/food card benefit as being responsible for plan growth:

I will tell you—it [the OTC card] is a much-loved benefit. It’s our number one source of calls to customer service. It’s the number one thing we hear from agents who are selling the plan, that that’s the thing that makes members go, “Oh my gosh, this is phenomenal.” It is a much-loved benefit. Well, these people live on generally \$700 to \$900 a month, so it’s a lot of money for them . . . We’ve had larger growth this year than we’ve ever had. We had our biggest annual enrollment for 2022. We’ve had more growth throughout this year than we have had in the past, and we have not changed our agent pool. So, we have the same agents and we’re getting many, many more sales.

A PO P representative shared a similar sentiment about the impact that their healthy food card benefit had on beneficiary enrollment and satisfaction with the plan:

So, from a healthy foods card perspective, we do absolutely see increased enrollment, as well as increased engagement with the health plan, and that’s largely due to satisfaction. In fact, we have even seen in some of our call listening work, that even from members who call in with a problem, call in with an issue, they still tend to be more satisfied with the plan overall because of that healthy foods intervention. And that tells us it’s having that very real,

meaningful impact at a foundational level, and addressing financial strain and food insecurity. And that plays out too in our utilization.

### *Beneficiary Perspectives*

In addition to asking POs about factors affecting enrollment in their VBID General plans, we asked beneficiaries enrolled in these plans in 2022 to identify the main reasons for choosing their current MA plan (Table 3.1). Our beneficiary sample for this question included 62 low-income beneficiaries, 33 of whom switched into a VBID General plan from an MA plan offered by a different PO and 29 beneficiaries who switched from FFS Medicare. All of these beneficiaries were enrolled in VBID General plans that offered at least one additional supplemental benefit and/or Cash Rebates.

**Table 3.1. Beneficiary Reasons for Choosing a VBID-Participating Plan**

<b>Reason</b>	<b>Overall (N = 62)</b>	<b>Switching from MA Plan (N = 33)</b>	<b>Switching from FFS Plan (N = 29)</b>
<b>Benefits offered</b>	<b>35 (56.5%)</b>	<b>22 (66.7%)</b>	<b>13 (44.8%)</b>
Dental benefits	16 (25.8%)	14 (42.4%)	2 (6.9%)
Healthy food benefits	15 (24.2%)	8 (24.2%)	7 (24.1%)
Coverage of OTC products	12 (19.4%)	9 (27.3%)	3 (10.3%)
Coverage of prescription medications	11 (17.7%)	7 (21.2%)	4 (13.8%)
Vision benefits	8 (12.9%)	8 (24.2%)	0
Debit or rebate cards	5 (8.1%)	3 (9.1%)	2 (6.9%)
Nonemergency medical transportation	5 (8.1%)	4 (12.1%)	1 (3.4%)
Hearing-related benefits	3 (4.8%)	3 (9.1%)	0
Assistance with daily expenses like utilities	1 (1.6%)	1 (3.0%)	0
Assistance with home equipment	1 (1.6%)	1 (3.0%)	0
<b>Premiums and copays</b>	<b>14 (22.6%)</b>	<b>7 (21.2%)</b>	<b>7 (24.1%)</b>
No or low copays	10 (16.1%)	6 (18.2%)	4 (13.8%)
No or low premiums	4 (6.5%)	2 (6.1%)	2 (6.9%)
Minimize OOP costs	1 (1.6%)	0	1 (3.4%)
<b>Continuity of care with existing providers</b>	<b>6 (9.7%)</b>	<b>3 (9.1%)</b>	<b>3 (10.3%)</b>

SOURCE: RAND analysis of 2022 VBID beneficiary interview data.

The majority of beneficiaries (56.5%) were attracted by specific benefits offered by the plan either as part of the VBID Model or as part of a standard benefit design. A higher proportion of those who switched from an MA plan other than FFS cited benefits offered as the main reason why they chose their current plan (66.7% versus 44.8%, respectively). Looking at specific benefits, dental benefits were the most commonly mentioned (25.8%), especially by those who switched from another MA plan (42.4% versus 6.9% by those switching from FFS),

followed closely by a healthy food benefit (24.2%). Although healthy food was the VBID General benefit most commonly mentioned as the main reason for choosing a VBID plan by the beneficiaries we interviewed, other VBID General benefits that the beneficiaries named included debit or rebate cards and nonemergency medical transportation. However, less than 10% of our interviewees chose them as a reason for selecting their current plan. Among the financial reasons, which were mentioned by 22.6% of our interviewees, \$0 or low copays—reported by 16.1% of the interviewed beneficiaries as a key part of their decision—are worth noting. While many MA plans have low premiums, only 6.5% of the interviewed beneficiaries named them as the reason for choosing their current plan. Finally, less than 10% of our interviewees stated that they chose their plan to ensure continuity of care with existing providers.

Nonetheless, beneficiaries we interviewed rarely gave just one reason for choosing a plan. A beneficiary who switched from FFS Medicare into a VBID-participating PO P plan described their reasons for selecting this plan thusly:

[PO P] offered me a car service to go back and forth to doctors, they give me an OTC card where I can get over-the-counter products such as [Aspirin], calcium pills, things like that. They also give me a food card with \$75 where I can purchase certain food from certain supermarkets. Not everybody has [this PO’s benefit] of OTC. And it was very interesting to me, very, very interesting . . . because I’ve never had like the car service thing—they picked me up, take me to my doctor. . . . The car delivers my medication to my home instead of me going all the way uptown to take my medication. . . . The food card, which is very, very helpful, since I don’t have any income [besides] Social Security, so whatever else can help out is greatly appreciated.

Table 3.2 shows that beneficiaries most commonly learned about their current plans from plan representatives (33.9%), media (19.4%), family and friends (17.7%), and information mailed to them by the plan (14.5%).

**Table 3.2. Sources of Information About MA Plans Used by VBID Beneficiaries**

<b>Sources of Information</b>	<b>Overall (N = 62)</b>	<b>Switching from MA Plan (N = 33)</b>	<b>Switching from FFS Plan (N = 29)</b>
Plan representatives	21 (33.9%)	12 (36.4%)	9 (31.0%)
Digital media (for example, TV, internet)	12 (19.4%)	9 (27.3%)	3 (10.3%)
Family and/or friends	11 (17.7%)	3 (9.1%)	8 (27.6%)
Mailed letters and brochures	9 (14.5%)	4 (12.1%)	5 (17.2%)
Insurance brokers	7 (11.3%)	4 (12.1%)	3 (10.3%)
Other social services (for example, Social Security, Medicaid)	5 (8.1%)	1 (3.0%)	4 (13.8%)
Senior centers	3 (4.8%)	2 (6.1%)	1 (3.4%)

SOURCE: RAND analysis of 2022 VBID beneficiary interview data.

While those who switched from other MA plans and FFS listed the same information sources, a higher proportion of MA switchers mentioned digital media (27.3% versus 10.3%), whereas a higher proportion of FFS switchers mentioned family and friends (27.6% versus 9.1%). It appears that “trusted messengers”—individuals with close and personal relationships with beneficiaries—also played an important role in choices to enroll in VBID-participating plans, with 17.7% of the interviewed beneficiaries choosing family and friends as a key information source.

## Summary

Although many POs reported that participation in VBID General increased enrollment, some acknowledged that it is difficult to disentangle the effects of VBID General participation from other factors. Our DD regression analyses are designed to do just that, by comparing VBID participating plans with a weighted comparison group to assess whether enrollment increased differentially after VBID was implemented. In that analysis, we found no evidence that VBID General increased enrollment in plans participating in the model test, although we found large increases in enrollment among plans that implemented VBID Flexibilities that focused on low-income beneficiaries in 2021. Most POs reporting enrollment increases did in fact offer VBID General interventions to low-income beneficiaries, but others did not. PO perspectives on enrollment may diverge from our quantitative results for many reasons. For example, their perspectives could reflect anecdotal experiences from a small subset of plans. Respondents could also be attributing increases in enrollment to VBID General participation that actually stem from other factors, such as an increasing tendency for beneficiaries to choose MA over FFS Medicare (Freed et al., 2022). Our quantitative analysis also has limitations, such as requiring an assumption that trends in enrollment growth would have been similar in VBID General and entropy-weighted comparison plans in the absence of the model test (the parallel trends assumption).

Both beneficiaries and POs reported that supplemental benefits that could be used to reduce the cost of everyday expenses, such as healthy food and OTC cards or Cash Rebates, were a key driver in increasing enrollment. These types of benefits may have been a particularly appealing feature in plans that targeted their benefits to low-income beneficiaries, where enrollment growth was the largest. Both beneficiaries and POs cited income-related needs as a factor that underscored the value of these particular benefits.

## Chapter 4. Beneficiary Experiences with and Use of Benefits

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### Key Findings

- Almost all interviewed beneficiaries who were eligible to receive card-delivered VBID benefits, including healthy food, Cash Rebates, and OTC benefits, reported using them.
  - PO representatives agreed that these benefits were the most appreciated benefits by their enrollees, especially those with lower incomes. However, they noted that the uptake of Cash Rebates was lower than expected.
  - Only about one-third of interviewed beneficiaries eligible to receive benefits that provided equipment to improve home safety and nonemergency medical transportation reported using them. Not knowing about the existence of these benefits was the main reason cited for not using them.
  - While beneficiaries generally felt that the card-delivered benefits helped supplement their low incomes, some felt that they did not go far enough to address their health-related social needs.
  - PO perspectives on the uptake of reduced cost sharing, VBID-enabled supplemental benefits, and care management (CM) programs varied. Participation requirements, beneficiary understanding of how the benefit fits with their needs, and benefit delivery mode (that is, in person versus virtual) appeared to affect the uptake.
  - POs generally viewed uptake of their RI interventions to be increasing.
  - Of 3.5 million beneficiaries targeted for VBID Flexibilities interventions, only 6.5% faced participation requirements; however, among those with participation requirements, only 8.3% became eligible to receive these benefits.
  - Though the number of targeted beneficiaries in RI plans is small relative to the number in VBID Flexibilities plans (274,000 versus 3.5 million), relatively few targeted beneficiaries in RI plans (10.4%) become eligible to receive rewards.
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This chapter describes beneficiaries' awareness of, experiences with, and use of VBID General benefits offered to them. We conducted semi-structured interviews with 117 beneficiaries from 11 POs (G, L, N, P, Q, R, S, AD, AG, AH, and AP). These interviews focused specifically on the following six supplemental benefits designed to address health-related social needs of low-income beneficiaries: **healthy food benefits, OTC benefits, equipment to improve home safety, Cash Rebates, nonemergency medical transportation, and services that make homes more comfortable or connected** (for example, portable air conditioners, home internet). We chose to focus interviews on these benefits because of a substantial increase in the number of VBID plans offering them and targeting them to low-income beneficiaries in 2022. Appendix B provides additional details on the methods we used to collect beneficiary perspectives on the VBID General benefits.

Interviews with PO representatives also touched on perceptions of VBID General benefit use among enrollees. In particular, representatives' comments centered on card-delivered benefits (healthy food and OTC benefits), reduced cost sharing, supplemental benefits (transportation, in-home assistance for dementia, falls risk assessment), RI, Cash Rebates, and CM.

## Beneficiary Experiences with VBID General Benefits

Table 4.1 shows the number of beneficiaries in our sample whose plans offered each benefit and who reported being aware of and using them, as well as the utilization rate among those interviewed. All or almost all beneficiaries eligible to receive the benefits were aware of Cash Rebates, healthy food, OTC, and transportation benefits; less than half of eligible beneficiaries knew about equipment to improve safety within the home; and nobody knew about services to make homes more comfortable and connected. While healthy food, Cash Rebates, and OTC benefits were used by almost all beneficiaries whose plans provided them (about 90% utilization rate), only about one-third used equipment to improve home safety (36%) and nonemergency medical transportation (30%).

**Table 4.1. Beneficiary-Reported Awareness and Utilization of VBID General Benefits (N = 117)**

<b>VBID General Benefit</b>	<b>Offered (N)</b>	<b>Aware (N)</b>	<b>Used (N)</b>	<b>Utilization Rate</b>
Healthy food benefit	77	73	69	90%
OTC benefit	23	21	20	87%
Equipment to improve safety within the home	23	13	6	26%
Cash Rebates	20	20	18	90%
Nonemergency medical transportation	10	9	3	30%
Services to make homes more comfortable or connected	2	0	0	0.0%

SOURCE: RAND analysis of 2022 VBID Model test application materials and beneficiary interview data. Beneficiaries from 11 POs were represented in our sample.

### *Healthy Food Benefit*

The healthy food benefit was one of two benefits with a 90% utilization, the highest of any reported by the beneficiaries we interviewed. Of the 77 beneficiaries across six POs (G, L, N, P, S, and AG) eligible to receive the healthy food benefit, 73 (95%) reported being aware of it, and 69 (90%) reported using it. Beneficiaries reported receiving healthy food benefits worth between \$25 and \$175 every month via cards or in-kind benefits. Two beneficiaries also received post-discharge meals. One PO P beneficiary stated:

I am low-income. My disability [income] is now my retirement. To have the extra monies coming in that I can [use to] buy foods that are appropriate for me has been a godsend. . . . [I] have been hospitalized two times, and when I came out of the hospital, I was sent meals that went for about two weeks each time. That made it easier for me to not have to worry about trying to cook a meal because when I came home, I wasn't in the best shape. So, I just love both of them.

Those who received funds on the higher end of the benefit range reported being able to use their monthly allocation to buy either food or OTC items. Walmart was the most frequently mentioned store at which beneficiaries used their food cards. Most reported using the benefit in full on a monthly basis; some ( $N = 13$ , 19%) reported combining it with their SNAP benefits.

Although beneficiaries liked this VBID-enabled supplemental benefit, they also saw two shortcomings with it. About one-quarter reported needing to spend the allocation each month or quarter to avoid losing the balance ( $N = 17$ ), because POs generally have a date by which funds need to be spent. As one PO P beneficiary explained:

Well, what I don't like about it is that if I don't use all my benefits, all the money on the card goes away, it's not cumulative. . . . I'll lose it if I don't use it by the end of the month.

Slightly less than 10% ( $N = 6$ ) complained about the limited number of stores that accept the card.

Eight beneficiaries (12%) who were offered but did not use the healthy food benefit reported not being aware of it. After learning about this benefit during the interview, four stated that they wanted to learn more about it, two reported needing more information on how to use the benefit, and one said that the stores accepting the benefit were located too far away to be useful.

### *Cash Rebates*

Cash Rebates was the other benefit with a 90% utilization rate. Of the 20 beneficiaries from four POs (R, AD, AH, and AP) offering Cash Rebates, all reported being aware of this benefit, and 18 (90%) reported using it. Beneficiaries reported receiving between \$20 and \$65 a month; some said that the unspent funds did not roll over into the next month. Although beneficiaries could spend Cash Rebates on anything they wanted, our interviewees reported primarily using these funds to buy food ( $N = 11$ , 61%), OTC-eligible products ( $N = 9$ , 50%), personal hygiene products not eligible for OTC benefit (for example, toothpaste) ( $N = 3$ , 17%), household supplies ( $N = 3$ , 17%), and copays ( $N = 1$ , 5.6%). Walmart was the most frequently mentioned store where these funds were used. A PO AH beneficiary appreciated getting cash, saying, "Whenever I get a chance to use it . . . when I'm short on money or low on money, yeah, like that . . . I love it. I mean it's nothing to dislike."

The two beneficiaries we interviewed who were not using this benefit reported either not understanding how they could benefit from these rebates or wanted to learn more about this benefit before starting to use it.

### *OTC Benefit*

The OTC benefit had the second highest utilization rate based on our beneficiary interviews. Twenty-one of 23 beneficiaries (91%) from three POs (P, Q, and S) that offered it reported being aware of the OTC benefit, and 20 (87%) reported using it. Beneficiaries

reported receiving between \$25 and \$375 loaded onto their OTC cards each quarter, which they used in person at stores and pharmacies, on OTC websites, and with mail-order OTC catalogues. Among those using the benefit in person, CVS was the most frequently mentioned store ( $N = 7$ , 35%). One PO Q beneficiary stated:

I like using CVS, because I can use my coupons, I can use my Extra Bucks on top of my OTC, and then . . . if I got the vitamins and I can get Extra Bucks and then, I can use it for something else.

Although beneficiaries generally reported finding OTC funds helpful for purchasing daily necessities like vitamins, some ( $N = 4$ , 20%) expressed confusion around the benefit terms and eligible goods. One PO Q beneficiary explained:

Well, it's really hard to tell which items you can and can't get. You have to go up to the counter, [and they tell you if you can] . . . put it on the card. [I went once and] the lady said: "Oh, that's not eligible." I said: "Well, swell." By that point you're up at the counter, it looks like you're looking for a handout. You ain't getting one. So, it's kind of a waste, I mean they gave me this big little book, this booklet of all the things that were covered, but even that was kind of cloudy.

Beneficiaries not using the OTC benefit reported not being aware of it ( $N = 3$ , 13%) or not needing OTC products ( $N = 1$ , 4.3%). Two (8.7%) reported wanting to learn more about this benefit.

### *Other VBID General Supplemental Benefits*

The benefits with the lowest utilization rates as reported by our interviewees were equipment to improve safety within the home (26%) and nonemergency medical transportation (30%).

Six beneficiaries, all from PO G, reported ordering equipment to improve the safety of their homes, including shower seats, grab bars, motion lights, shower chairs, and canes. Two of these beneficiaries specifically mentioned that their plan would pay up to \$150 annually for the home safety benefit. Among the 17 beneficiaries who did not request equipment to improve safety within their homes, almost half ( $N = 8$ ) were aware of the benefit but reported not understanding how this benefit works, not needing it, or already having necessary equipment. Five beneficiaries (29%) were not aware of this benefit and reported not needing it; four beneficiaries (24%) were not aware of it but expressed interest in learning more about it.

The least frequently used benefit was nonemergency medical transportation: Only three beneficiaries from PO L reported using this benefit to visit their health care provider. Six out of the seven beneficiaries who have not used the transportation benefit reported being aware of it but not needing it; two of these beneficiaries mentioned the need to schedule rides at least a few days in advance and reported concerns about being stranded if they were to use the benefit. One beneficiary was unaware of this benefit but expressed concern around the long wait times for pick-ups.

## Beneficiary Perspectives on Impact of Benefits

Beneficiaries had different perspectives on the impact that these VBID General benefits had on their lives. More than half of beneficiaries ( $N = 66$ ) we interviewed were pleased with having these benefits and said that the healthy food benefit, Cash Rebates, and OTC benefits helped supplement their low incomes. On the financial impact of VBID General benefits, one PO G beneficiary said:

[The Cash Rebates is] by far one of the better parts of [the plan's benefits]. The over-the-counter, that's kind of another part that's actually really helpful, because it [helps with] the cost of some of the stuff. . . . I don't have to worry about getting things or [saving money] . . . for medical [items], for emergency kits, and stuff like that that I need. So that works out pretty good.

Beneficiaries generally appreciated being able to purchase healthier and more nutritious food as a result of having these benefits. One PO L beneficiary said that these benefits “provide help [to] me and my family to get by, to make ends meet, to live, to survive [in a] healthy way.” A PO G beneficiary stated that some of the VBID General benefits made a big difference for fall prevention:

The night lights are [on a] motion [detector] so when you come in, they go out, so it's cost effective. . . . In the bathroom, the handles, the suction cup handle for [the tub] and then the showerhead, that's something that you don't normally think of . . . but it does make a difference.

In contrast, slightly less than 10% of beneficiaries ( $N = 11$ ) viewed these benefits as less useful, saying that they did not provide enough help (for example, they did not offer enough money). Finally, 19 beneficiaries (16%) reported that these benefits were only somewhat helpful because healthy food funds were not large enough to offset the cost of inflation, some products they needed were not eligible for the OTC benefit, or they could not use the OTC card to purchase several items of the same type (for example, purchasing multiple packages of adult diapers). The remaining beneficiaries in our sample could not comment on the impact of the VBID General benefits because they did not use them.

### *Strategies for Improving the Impact of VBID General Benefits*

To increase the impact of VBID General benefits, some beneficiaries suggested that plans should proactively reach out to beneficiaries to inform them about these benefits and to explain how these benefits can be used. In addition, the beneficiaries suggested a number of specific ways to expand the top three benefits. To illustrate, they felt that the healthy food benefit could be improved by increasing the monthly allowance, allowing beneficiaries to spend it on nonfood items at grocery stores, increasing the number of grocery stores that accept the food card, expanding the list of eligible food items, and allowing unused funds to roll over to the next disbursement period. Suggested improvements to the OTC benefit included expanding the list of eligible items, improving the mail ordering process, increasing the amount of OTC funds

provided, and increasing the number of stores that accept the OTC card. The two ways to improve the Cash Rebates included increasing the benefit amount and clarifying how the funds could be spent.

## PO Perspectives on Benefit Use

Representatives from 16 POs shared their perspectives on VBID General benefits and commented on their use. Out of all VBID Flexibility benefits, card-delivered benefits (for example, OTC, healthy food card) seemed to be most appreciated by beneficiaries, based on both feedback received by POs and POs' analyses of benefit utilization data. This result is consistent with the results of our interviews with beneficiaries described in the previous section. As noted in Chapter 2, some POs offered multi-purse cards; therefore, PO representatives sometimes discussed all of their card-delivered benefits together during the interviews.

### *Card-Delivered Benefits*

The four POs (G, L, N, and P) with the most positive perspectives on benefit uptake all offered benefits that targeted low-income beneficiaries. A representative from PO P attributed high utilization of its healthy food benefit to high levels of food insecurity in this population:

Starting with healthy foods card, we continue to see very high activation and utilization rates in that intervention and continue to see increasing activation and utilization rates over time. We fully expect that activation and utilization in the future will exceed 90% for both because of the high degree of need within the populations in question.

A representative from PO G, which allowed beneficiaries to spend their monthly healthy food allowance to pay for utilities in some markets, felt that their members greatly appreciated this VBID General benefit:

Oh, they love it. . . . I've gotten feedback directly telling me about where the member has literally told the care manager: "I haven't been able to pay my electricity for three months and this really helped me." They're calling us back and saying: "Thank you." So, the uptake is great. We're very proud of this program.

To increase the uptake of the food card benefit, some POs had to make adjustments. A PO L representative described some key lessons learned and course corrections that they believe led to an increase in member uptake of healthy food allowances among their low-income beneficiaries:

We've definitely started to see increases and . . . the amounts we're giving are more meaningful. Like, our lesson learned from 2021 was just if the amounts aren't meaningful enough that it's truly a change in the member shopping behavior, they're not generally going to do it. I mean, if it's \$25 and they're saying: "I've got to go to a different store, I've got to take a bus to get there,

and it's not down the street from me," it just becomes more of a challenge. Maybe it's too much of a hassle. So, this year, because we've increased the dollar amounts, we've increased the access. There are more store locations. We've also increased the ability from a shipping standpoint, so now members have more options for shipping. So yeah, we've definitely seen an increase in utilization this year.

Some POs had the ability to track the types of items their members purchased and the stores they used. Representatives from two POs (AG and S) indicated that more dollars were spent on OTC items than food. A representative from PO AG estimated that "less than 5% of overall spend is on food, and 10% of our transactions are on food items," implying the majority of both the dollar amount as well as number of transactions were OTC items. Conversely, representatives from PO L said that more of these dollars were spent on food than OTC items. A representative from PO N reported that Walmart was the top vendor for their OTC card, which is consistent with what beneficiaries told us during the interviews.

### *Reduced Cost Sharing*

When asked about reduced cost-sharing interventions, PO representatives had differing perspectives. On the one hand, representatives from three POs described an increase in uptake compared with the previous year (POs B, G, and Y). All of these POs have a participation requirement. PO B representatives reported that this increase could be partially attributed to a relaxation of a requirement to have quarterly contact with care managers to receive the benefits. PO G representatives described low opt-out rates for reduced cost sharing:

The way that we structured the program is that in order to have access to the enhanced benefits, including the reduced cost share, the members need to be engaged in the program. So, I think that has something to do with the low opt out rate.

Furthermore, PO Y indicated an increase in participation (40% to 50% more than in 2021) to receive reduced cost sharing for Part D drugs.

In contrast, representatives of three other POs (J, P, and AO) described uptake of their reduced cost-sharing interventions as meeting but not exceeding their expectations. PO P representatives described participation in its CM program, which is required to receive reduced cost sharing for Part D drugs, as being "exactly in line with what we would expect" and further stated that "the numbers look small, but that is by design, given that we're targeting that smaller subset of enrollees who have the diagnosis [of COPD] that do not appear to be filling or using their inhalers."

### *Other VBID-Enabled Supplemental Benefits*

Representatives of two POs (G and R) commented on the **transportation** benefits they provided as part of the VBID Model. PO G representatives felt that the utilization of their VBID and non-VBID transportation benefits was similar. Representatives from PO R, which

offered VBID General benefits of transportation to medical and nonmedical destinations, reported that members only used this benefit to go to medical appointments, saying that the enhanced transportation benefit had not been as highly utilized as they anticipated. This finding is consistent with beneficiary interview results that showed that some beneficiaries were not aware of the transportation benefits, did not think they needed them, or did not fully understand how to use them.

The only PO (W) to describe its experiences with a new technology intervention reported positive uptake of continuous glucose monitoring devices among its beneficiaries with diabetes.

In terms of other VBID-enabled supplemental benefits, representatives from two POs (U and AE) reported lower-than-expected uptake. A representative from PO AE speculated that **in-home assistance** for beneficiaries with dementia was not well utilized because they might not know how best to use the benefit:

Members are still not really sure what that means and then . . . the caregiving team still isn't really sure on how to utilize that to its fullest extent, even with us explaining it, just because it's such a very personal thing.

A representative from PO U speculated that low uptake of its **falls risk assessment** may be due to members not believing that they are at risk for falling, even if they had a previously documented claim for a fall:

We can't really figure out what it is, but we do still have a pretty high rate of decline for the service. I can only speculate that part of that is that members don't want to accept that they are a fall risk. And I say that based on some of the comments because [when asked]: "Why aren't you interested in participating?" to try to get that information from them, a lot of times, they get the response: "I don't think it will be beneficial" or "I don't have a problem with falling." But a lot of times these are people who have a claim for a fall in their history, so they are people who are falling. I think a lot of it is just really . . . I think it's just that embarrassment, maybe, or the "I'd rather not even know" kind of mentality that tends to make them decline.

### *Rewards and Incentives*

Representatives from four POs (N, U, Y, and AO) reported that uptake in RI interventions was either increasing ( $N = 3$ ) or on track ( $N = 1$ ), relative to expectations. PO N representatives reported that they were projecting to quadruple the number of reward activities completed in 2022, compared with 2021, and attributed this to the number of rewards and incentives they added for various wellness activities in 2022. However, PO N representatives also described high initial uptake of another RI intervention they offer that provides rewards for quarterly medication adherence check-ins but reported that members were not staying engaged throughout the year:

From 2020 to 2021, we saw an increase in engagement, but we're still seeing that pattern where members are less engaged when it comes to getting their

second, third, and especially their fourth consult. And in 2021, the fourth quarter was especially hard for us. Our MTM vendors, and I've heard that it's across the nation, that . . . it was really difficult to reach members on the phone. . . . So that had a huge factor in the number of members disengaging in the fourth quarter.

PO U noticed an increase in uptake of its RI program activities from 2021 to 2022 and believed that this growth could be attributed to increased promotion of the benefit and more active outreach to eligible beneficiaries:

I just looked at [the data for] Q2 [quarter 2]; it looked like we were somewhere around 37% completion rate last year. This year, it's looking at 45%. It's hard to look at the absolute numbers since we did expand, so naturally we have higher participation in terms of absolute numbers, but the completion rate is higher. I would expect that [the increase in participation rates] is a result of our increased promotion of [participation in RI programs], as well as what our pharmacy team does to outreach to the member.

### *Cash Rebates*

Representatives from four POs (R, W, AD, AP) described the uptake of Cash Rebates. Three of the four POs reported lower-than-expected uptake. PO AD representatives indicated that they “expected to see a little bit more engagement” with the Cash Rebates program but said that members may be waiting to spend their rebate dollars at the end of the year. A representative from PO AP said that many beneficiaries were not using the rebate cards and described a potential issue raised about the rebates affecting Medicaid eligibility:

Because we're offering exclusively on a D-SNP product, there were concerns about this affecting their Medicaid eligibility, primarily. That could be the reason why they're not utilizing it. We did have some opt-outs for this benefit, and those were their primary reasons for opting out, so that is our assumption.

PO R reported increased rebate uptake. A representative said that rebate cards “doubled and tripled the memberships in the PBPs that had the benefit,” and a vendor for the PO reported that the top use for members was withdrawing cash, followed by using money on groceries.

### *Care Management*

Representatives from three POs (B, G, AE) described the uptake of CM/DM as a participation requirement for receiving reduced cost sharing or supplemental benefits. PO B and G representatives reported high levels of participation in CM. A PO G representative said that “engagement is quite high in this program versus our regular [non-VBID] care management” and suggested that members are willing to engage in CM to receive additional benefits, such as reduced copayments, meal benefits, or transportation benefits:

Yeah, I think the supplemental benefits are huge for these members, and especially its copays and the—I think the additional support...really helps those members [who] stay in [CM] year after year.

Representatives of PO AE described uptake of its CM intervention as relatively low due to the virtual delivery of CM due to COVID-19, and they posited that their members would prefer in-person engagement:

When you're talking about the [virtual] wellness classes . . . our patient populations prefer to have those classes in person. And so, with the COVID case count surges, that's dampened that engagement and enthusiasm. And just transparently, that's just due to the nature of the patient population. They want to come to the classes. We've had people who've expressed interest in them, but they want to come in person.

## Participation Requirements

In addition to targeting benefits based on chronic conditions or SES, POs participating in VBID Flexibilities may ask beneficiaries to complete requirements to become eligible for VBID benefits. For example, a PO could waive cost sharing for primary care visits for beneficiaries with congestive heart failure if they meet quarterly with a care manager. By definition, all RI programs have a participation requirement, because beneficiaries can only receive rewards after completing desired activities, such as receiving a preventive screening.

Table 4.2 shows the number of VBID Flexibilities and RI plans that include participation requirements and the number of beneficiaries who are eligible to receive VBID benefits in plans with and without these requirements. We include a separate row for VBID Flexibilities interventions focused on new technologies (such as glucose monitors), which require beneficiaries to accept the device. A key takeaway from the table is that the vast majority of targeted beneficiaries in VBID Flexibilities plans, 93.5%, do not face participation requirements. While RI plans by definition have participation requirements, many fewer targeted beneficiaries are in RI plans than are in VBID Flexibilities plans (274,606 versus 3.5 million).

**Table 4.2. Number of Targeted and Benefit-Eligible Beneficiaries in VBID Flexibilities and RI Plans, With and Without Participation Requirements, 2022**

	POs	Plans	Total Beneficiaries (Includes Ineligible)	Targeted Beneficiaries	Eligible to Receive Benefits	Benefit Eligibility Rate
VBID Flexibilities	26	566	7,519,194	3,535,433	3,305,394	93.5%
No participation requirements	23	387	7,254,450	3,286,357	3,285,980	100.0%
Participation requirements	5	171	1,746,189	233,615	19,410	8.3%
New technology	1	8	193,055	15,474	10	0.10%
RI	8	511	5,573,467	274,606	28,499	10.4%

NOTE: Data are from CMS' Reusable Framework. Two POs offered VBID Flexibilities interventions both with and without participation requirements, and one PO offered a new technology intervention and another offered a VBID Flexibilities intervention without participation requirements; these observations are included in both table rows. Beneficiary counts represent all beneficiaries who enrolled in a VBID Flexibilities or RI plan at any point during the year. Some beneficiaries moved from a plan with one intervention to a plan with another intervention over the course of the year. In the VBID Flexibilities row, we deduplicated beneficiary observations by counting beneficiaries as targeted if they were targeted at any point by a plan's VBID Flexibilities intervention and as eligible if they were eligible to receive benefits in at least one VBID Flexibilities intervention. Thirteen plans offered RI but did not have any targeted beneficiaries and were excluded from the analysis.

Among the 3.3 million targeted beneficiaries in VBID Flexibilities plans without participation requirements, nearly 100% were eligible to receive VBID benefits. The slight difference in the number targeted and the number eligible is the result of a few hundred targeted beneficiaries who opted out of the model entirely. However, among the 233,615 targeted beneficiaries in VBID Flexibilities plans with participation requirements, only 8.3% met those requirements. Similarly, among the 274,606 targeted beneficiaries in plans with RI interventions, only 10.4% completed activities that would enable them to receive rewards. Beneficiary engagement was especially low (less than 1%) in the eight plans that offered new technology interventions, with only ten beneficiaries opting to accept the technology.

While, overall, the benefit eligibility rate in plans with participation requirements is quite low, the findings in Table 4.2 mask considerable variation across POs. Table 4.3 shows PO level statistics on benefit eligibility in VBID Flexibilities plans with participation requirements. Benefit eligibility rates among targeted beneficiaries range from 3.2% in PO P to 98.0% in PO Y. These differences may be explained by the fact that participation requirements vary widely across POs, with some requiring minimal contact with care managers and others requiring more substantial interaction. The low overall eligibility rate (8.3%) is driven by PO P, which was very large and had especially low engagement.

**Table 4.3. Number of Targeted and Benefit-Eligible Beneficiaries in VBID Flexibilities Plans, with Participation Requirements, 2022**

<b>PO</b>	<b>Total Plans</b>	<b>Total Beneficiaries (Includes Ineligible)</b>	<b>Total Targeted Beneficiaries</b>	<b>Total Eligible to Receive Benefits</b>	<b>Benefit Eligibility Rate</b>
G	8	101,869	9,607	2,685	27.9%
O	8	47,260	5,531	3,400	61.5%
P	152	1,511,525	208,159	6,760	3.2%
Q	1	50,031	4,725	1,085	23.0%
Y	2	35,504	5,593	5,480	98.0%
Total	171	1,746,189	233,615	19,410	8.3%

NOTE: Data are from CMS' Reusable Framework. Beneficiary counts represent all beneficiaries who enrolled in a VBID Flexibilities plan with participation requirements at any point during the year.

Similarly, there was variation in engagement across POs offering RI interventions (Table 4.4), with the benefit eligibility rate ranging from 2.9% in PO AE to 99.6% in PO Y. The low engagement in PO AE may reflect that beneficiaries were offered a relatively small incentive (\$25 total) for completing up to eight CM sessions. In contrast, PO Y offered \$10 for completing each of three diabetic screenings for a total of up to \$30, more than double the incentive per interaction, compared with PO AE. Again, the low benefit eligibility rate is driven by PO P, which contributed the majority of beneficiaries and had a 3.6% benefit eligibility rate.

**Table 4.4. Number of Targeted and Benefit-Eligible Beneficiaries in RI Plans, 2022**

<b>PO</b>	<b>Total Plans</b>	<b>Total Beneficiaries (Includes Ineligible)</b>	<b>Total Targeted Beneficiaries</b>	<b>Total Eligible to Receive Benefits</b>	<b>Benefit Eligibility Rate</b>
N	1	22,433	15,575	7,163	46.0%
O	8	47,260	2,909	806	27.7%
P	465	5,194,823	219,029	7,859	3.6%
U	10	36,895	4,852	3,225	66.5%
Y	2	35,504	5,578	5,555	99.6%
AE	16	30,265	6,932	203	2.9%
AH	8	193,055	15,513	758	4.9%
AO	1	13,232	4,218	2,930	69.5%
Total	511	5,573,467	274,606	28,499	10.4%

NOTE: Data are from CMS' Reusable Framework. Beneficiary counts represent all beneficiaries who enrolled in a VBID Flexibilities plan with participation requirements at any point during the year. Thirteen plans offered RI but did not have any targeted beneficiaries and were excluded from the analysis.

## Summary

Results of our interviews with POs and beneficiaries show that card-delivered benefits, such as healthy food and OTC benefits, were the most frequently used and appreciated VBID General benefits, especially by beneficiaries with lower incomes. Most interviewed beneficiaries who used these benefits appreciated the ability to buy OTC items and healthy food, often in conjunction with their SNAP benefits. Likewise, PO representatives received positive feedback about these card-delivered benefits and saw high utilization of them.

Nearly all the beneficiaries we interviewed reported using the Cash Rebates benefit and reportedly appreciated the flexibility to use Cash Rebates on anything they wanted, but they did not like that the unspent funds did not always roll over into the next disbursement period. In contrast, most POs offering Cash Rebates reported lower-than-expected utilization of this benefit. The one PO that reported high uptake of Cash Rebates stated that this VBID General subcomponent helped substantially increase plan enrollment.

Although beneficiaries generally felt that these two VBID General benefits helped supplement their low incomes, some noted that these benefits did not go far enough to address their health-related social needs. They suggested that plans should be more proactive in reaching out to their enrollees to explain how these benefits work and should consider increasing monthly allocations. Beneficiaries who did not use these VBID General benefits reported not knowing about them but being willing to learn more.

Fewer than 10% of targeted beneficiaries in VBID Flexibilities plans face participation requirements. While all plans that implemented RI interventions have participation requirements, the number of targeted beneficiaries in these plans is substantially smaller than in VBID Flexibilities plans. Although PO representatives generally viewed their RI program participation as increasing over time, they differed in their perspectives on uptake of other benefits. The details of participation requirements for reduced cost sharing appear to affect uptake of that benefit, with benefit eligibility rates ranging from less than 3% in PO AE to 99.6% in PO Y. The need for, or the process for accessing, certain supplemental benefits, including transportation, in-home assistance, and falls risk assessment, may not be sufficiently clear to beneficiaries. Some POs, however, have invested in ways to improve awareness and use of benefits.

## Chapter 5. Quality of Care, Risk Scores, and Health Outcomes

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### Key Findings

- For the 2021 measurement year, VBID General participation was associated with a 0.31 point (8.0%) increase in Star Ratings, which are on a 1–5 scale ( $p < 0.01$ , 95% CI: 0.24 to 0.38).
  - VBID General was associated with small increases in the probability that targeted beneficiaries adhered to their medications in 2020:
    - 1.4 percentage point increase for diabetes medications ( $p < 0.01$ , 95% CI: 0.9 to 1.9)
    - 1.6 percentage point increase for statin medications ( $p < 0.01$ , 95% CI: 1.3 to 2.0)
    - 0.7 percentage point increase for hypertension medications ( $p < 0.01$ , 95% CI: 0.3 to 1.0)
  - Targeted beneficiaries experienced a 0.07 point (6.8%) increase in their risk scores in 2020 ( $p < 0.01$ , 95% CI: 0.07 to 0.08). Some POs speculated that risk scores might increase because VBID General created additional opportunities to identify and code diagnoses.
  - Consistent with most POs' expectations, VBID General was not associated with changes in beneficiary-level measures of health status in 2020.
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VBID General benefits, including lower cost sharing for high-value services, VBID-enabled supplemental benefits, or RI programs, may encourage beneficiaries to access high-quality services. In turn, increased utilization of these benefits and services may increase plan performance on quality measures. VBID General implementation may also lead to improvements in health status through a variety of mechanisms, such as increased contact with providers, receipt of recommended screenings, better management of chronic conditions, increased medication adherence, or access to such non-PHRSBs as home modifications and healthy food cards. As a result of these improvements in their care, beneficiaries may experience fewer exacerbations of their existing conditions and may not experience declines in their functional abilities.

This chapter describes the relationship between VBID General implementation, quality of care, and beneficiary-level measures of prevention, adherence, and health outcomes. For care quality, our outcome of interest was the overall **MA & PDP Star Rating**, which is measured at the contract level (across a group of plans offered by the same PO). Star Ratings reported in a given year reflect data collected one to two years prior, so we used Star Ratings reported for the 2023 plan year to assess the association between VBID General implementation and care quality in 2021. During the COVID-19 pandemic, CMS altered data collection for a range of Star Rating measures and the methodology for calculating the Ratings themselves. As a result, we were not able to assess overall Star Ratings for the 2020 measurement year.

For beneficiary-level measures of prevention, adherence, and health outcomes, we analyzed the following outcomes for 2020:

- **adherence to prescription drug and breast cancer screening recommendations** using beneficiary-level data from the Star Ratings<sup>6</sup>
- **Hierarchical Condition Category (HCC) risk scores**, which measure the predicted use and cost of services for a given beneficiary based on their diagnoses
- **Physical Component Summary (PCS) and Mental Component Summary (MCS)**, which are validated measures of physical and mental health based on a range of self-reported responses. Higher scores are better for both measures, representing very few physical limitations or high emotional well-being.
- **ADLs and instrumental activities of daily living (IADLs)**, which are summed together for a composite ADL or IADL score. Higher scores indicate more limitations in ADLs or IADLs.

More details on the measures and years of data used for specific outcomes can be found in Appendix J.

## Contract-Level Quality of Care

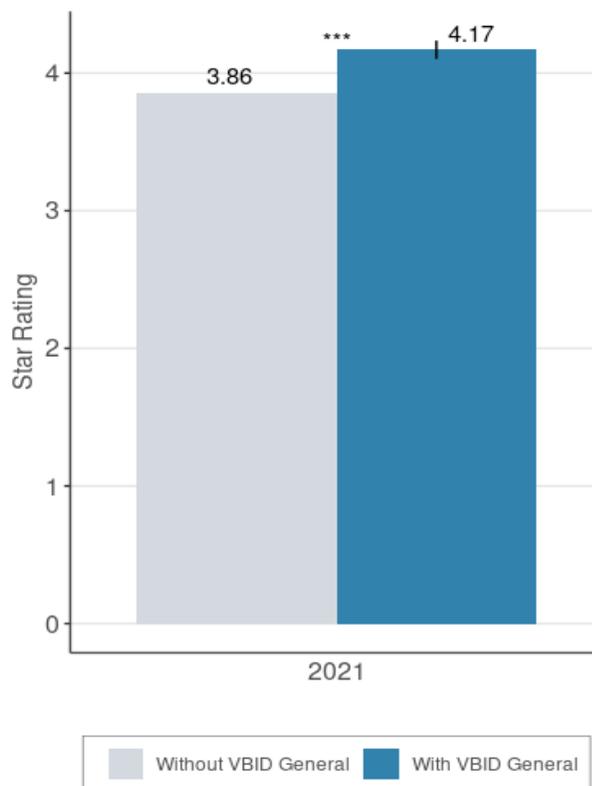
Quality of care for enrollees is captured in the overall MA & PDP Star Rating, which combines multiple quality measures at the contract level into a single rating, ranging from one Star (poor quality) to five Stars (high quality). Component measures include process measures (such as the receipt of recommended screenings), adherence to specific care regimens, beneficiary experience with the plan, rates of disenrollment from the plan, and customer complaints. We evaluated the relationship between VBID General implementation and contract-level Star Ratings by comparing contracts with at least one participating plan to contracts with no participating plans. Star Ratings are a particularly important quality measure because higher ratings result in larger MA rebate payments for plans bidding below benchmarks.

VBID General implementation was associated with a statistically significant 0.31 point increase in Star Ratings for measurement year 2021 ( $p < 0.01$ , 95% CI: 0.24 to 0.38) (Figure 5.1). This represents an 8.0% increase relative to the value that would have been expected without VBID General. Star Ratings affect plan payment both by increasing MA rebates and enabling quality bonus payments, with discrete increases in payment occurring for each 0.5 point increase in Star Ratings between 3 and 4.5. Payment changes across thresholds can be substantial—for example, moving from 3 to 3.5 Stars increases the amount of the MA rebate that the plan retains by 15 percentage points (Biniek, Cubanski, and Neuman, 2021; Grzeskowiak and Zenner, 2017). A 0.31 point increase may be enough to boost some contracts' Star Rating to a higher payment level.

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<sup>6</sup> We selected breast cancer screening as a beneficiary-level outcome because it is recommended on a biannual basis for all women ages 52 to 74. Other screenings, such as colorectal cancer screenings, are recommended on a less frequent basis (for example, five or ten years, depending on health history), making it difficult to assess changes over a short period of time.

**Figure 5.1. Estimated Association Between VBID General Interventions and Star Ratings, Measurement Year 2021**



SOURCE: RAND analysis of Star Ratings data from measurement years 2017, 2018, and 2021.  
 NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing contracts with at least one plan that participated in VBID General with a weighted sample of comparison contracts. The number of participating contracts included in the analyses was 199, and the total effective sample size (including participating and weighted comparison contracts) was 1,023. The black line(s) shown represent the 95% CI for the estimated effect of VBID General on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level.

The analysis reported in Figure 5.1 compared contracts that included at least one participating plan and contracts without participating plans. In Appendix J, we reran the analysis after restricting the intervention sample to contracts with a minimum threshold of beneficiaries in participating plans: 25%, 50%, and 75%. The estimates remained positive and statistically significant, but we found no evidence of a “dose-response” effect. However, we view this analysis as inconclusive because it is challenging to determine how a “dose” of VBID General should be defined. Our measure of dosage referred to the share of contract beneficiaries in participating plans, but not all of those beneficiaries were targeted or eligible for VBID.

In addition to analyzing the overall Star Rating, we also analyzed VBID General’s relationship to contract-level Star domains that contribute to the overall Star Rating. We included all Part C Star domains and the Part D drug domain focused on drug safety, which

encompasses measures of adherence to medications. The domain-specific effects for receiving preventive screenings, managing chronic conditions, and health plan customer service were positive and statistically significant; the domain member experience with the health plan was positive and marginally statistically significant. We found no evidence of an association between VBID General implementation and Star domains related to Part D drug safety or member complaints.

### *PO Perspectives*

Many POs designed VBID General interventions specifically to improve their Star Rating and care quality by focusing on beneficiary experience or management of chronic conditions. As a PO AO representative explained:

The goal of having more members be able to access their medication or having them complete some of the tests that we're trying to address within the RI or with the WHP program and having our care coordinators assist members with those needs, the assumption is that we would increase our Star Rating because of that.

Nonetheless, PO representatives had different perspectives on the impact of their VBID General interventions on their Star Rating in 2022, either overall or for specific measures (summarized in Table 5.1). While most participating POs completing our survey ( $N = 17$ ) thought that VBID General would have no impact, one-third ( $N = 8$ ) thought the model test increased their overall Star Rating. More POs ( $N = 11$ ) thought that individual measures rather than their overall Star Rating improved, and one PO reported decreases in individual Star measures in 2022. Because Star measures are calculated at the contract level and therefore include beneficiaries not eligible for VBID General, we also asked POs about the impact of their VBID General interventions on targeted beneficiaries in their participating plans in 2022. The number of POs reporting a positive impact on care experiences ( $N = 18$ ) and care quality ( $N = 15$ ) among targeted beneficiaries was higher than the number of POs reporting a positive impact on their overall Star Rating ( $N = 8$ ).

**Table 5.1. Survey Results for VBID General Impact on Star Ratings**

	Decrease	No Impact	Increase
Overall Star Rating ( <i>N</i> = 25)	0	17	8
Individual measures that contribute to the overall Star Rating ( <i>N</i> = 25)	1	13	11
Care experiences/satisfaction among targeted beneficiaries ( <i>N</i> = 24)	0	6	18
Care quality for targeted beneficiaries ( <i>N</i> = 24)	1	8	15

SOURCE: Author analysis of the following PO survey question: “How will (or has) Benefit Design Innovations (BDI)<sup>7</sup> component (for example, VBID Flexibilities, Rewards and Incentives programs, Cash Rebates) affect(ed) the following outcomes in 2022?”

Representatives of several POs noted that they did not expect major changes because the targeted populations were too small to influence the overall Star Rating (POs B, J, and L): “We are trying to be realistic in that expectation of how much will it fully impact those measures (PO J).” Moreover, some PO representatives reported not expecting positive impact on their Star Rating in 2022 because it was high even before the start of their VBID participation: “It was really about [whether] we [are able to] maintain performance in an ever-competitive market,” said a PO AK representative. Finally, representatives from PO AH thought that it would be difficult to attribute changes in Star Rating specifically to VBID rather than other ongoing initiatives and programs:

[W]e also have care management programs, diabetes management programs, provider incentives through risk deals. There are lots of things that are trying to influence and improve drug adherence. Any one of them by itself may or may not be the cause for why something shifted. There are certainly opportunities to compare different populations with different interventions and see if one has moved more than another. But even in those, there are going to be changes in those populations and other confounding variables that make it hard.

Representatives of POs AG and AN thought that WHP-related activities, such as the annual wellness visits or health risk assessments, may have positively influenced their Star Rating. For example, PO N implemented a \$50 incentive for beneficiaries to complete an annual wellness visit as part of its VBID General intervention, which the PO was hoping would increase performance on clinical process measures related to completion of health screenings.

PO P representatives thought that their VBID General interventions, especially the healthy food benefit, had a positive impact on the beneficiary experience domain:

We have even seen in some of our call listening work that even members who call in with a problem, call in with an issue, they still tend to be more satisfied with the plan overall because of that healthy foods intervention. And that tells us it’s having that very real, meaningful impact at a foundational level.

<sup>7</sup> During the data collection, we referred to VBID General as BDI.

One PO reported anticipating decreases in the beneficiary experience measures that factor into the Star Rating in 2022, which they attributed to the discontinuation of the Cash Rebates intervention starting from 2023. PO AP representatives reported taking steps to mitigate any negative consequences related to switching the Cash Rebates to a healthy food card for 2023: “So while they lose the flexibility to spend the cash card on really anything they want health-related, they do gain additional funds to spend on food.”

### *Beneficiary Perspectives*

As part of our beneficiary interviews, we asked participants to rate their current MA plan from 0 as the worst plan to 10 as the best plan. The average score provided by 115 beneficiaries who answered this question was 8.8 (range: 0 to 10). Two-thirds of beneficiaries we interviewed ( $N = 76$ ) were overwhelmingly satisfied with their plans, providing ratings of 9 or 10. They appreciated having necessary medications and health care services covered at little to no OOP cost, the availability of benefits that addressed their needs (for example, home visits, healthy food benefits), quality of interactions with physician and other health professionals, availability and responsiveness of plan representatives, and ease of using plan benefits. As a PO Q beneficiary who rated their current plan as 10 said: “[My plan] is very popular, very convenient, [it has] everything I need, and I don’t have to pay for it.” A PO P beneficiary stated, “Whenever I call, [PO P plan representatives just] seem so helpful, and they answered my questions. And if they can’t do it, they send me to somebody who can, and all of my health needs are covered.”

Among beneficiaries who provided a rating of 6 or below ( $N = 8$ ), the most commonly mentioned concerns included receiving fewer benefits than expected or in comparison to other plans ( $N = 4$ ), lack of adequate coverage of necessary medications ( $N = 3$ ), high copays ( $N = 2$ ), poor experience with existing benefits (for example, nonemergency medical transportation canceled on the beneficiary) ( $N = 2$ ), lack of clarity around plan benefits ( $N = 2$ ); and lack of or inadequate dental and mental health coverage ( $N = 2$ ). A PO N beneficiary said that the plan “denied me a lot of medications and services or refused to pay bills . . . and I’m as low income as you can get without having any income at all.”

### **Beneficiary-Level Outcomes**

As described above, we analyzed the relationship between VBID General implementation and several beneficiary-level process measures and health outcomes, including adherence to prescription drug and breast cancer screening recommendations; HCC risk scores; and PCS, MCS, ADL, and IADL measures. We compared targeted beneficiaries who were enrolled in the same plan before and after VBID General implementation with comparison beneficiaries enrolled in nonparticipating plans.

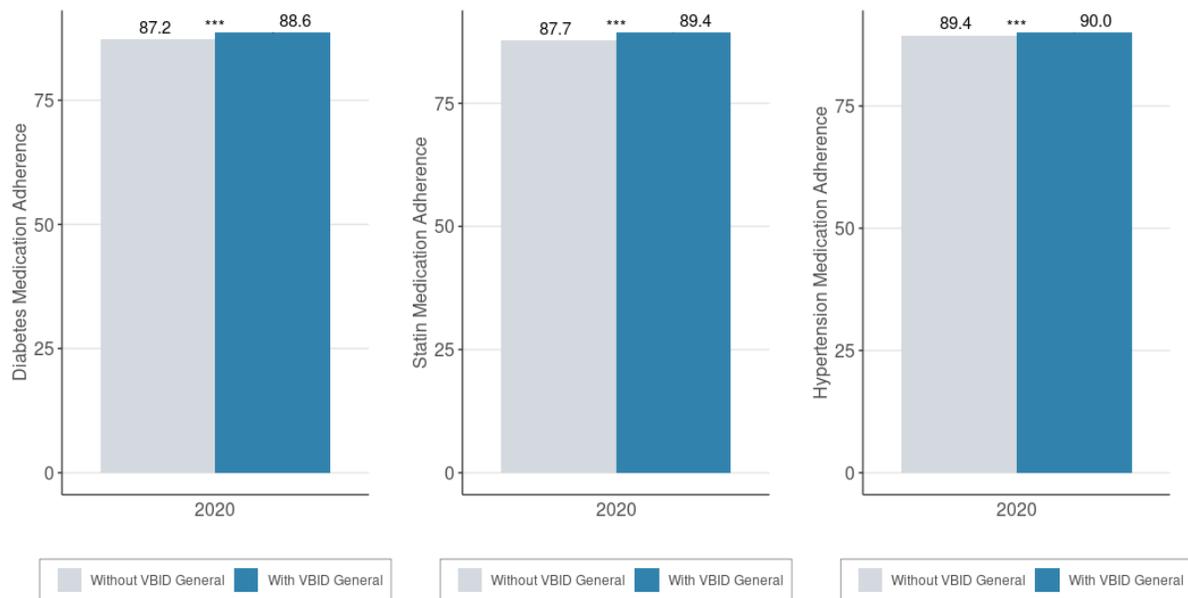
Data to assess beneficiary process and outcome measures are generally available only for a subset of targeted beneficiaries. For example, breast cancer screening information is available only for women ages 52 to 74, and drug adherence measures are available only for beneficiaries with indicated conditions. Furthermore, the PCS, MCS, ADL, and IADL measures are available only for beneficiaries who participated in CMS' Health Outcomes Survey (HOS).

### *Beneficiary-Level Adherence Measures*

We estimated the impact of VBID General interventions on prescription drug adherence. Representatives of several POs, including those from POs E, J, N, AA, and AP, noted that they designed their VBID General interventions specifically to improve performance on drug adherence measures. PO AP implemented an intervention to reduce cost sharing for Part D drugs for low-income beneficiaries, and its representative said, "I strongly believe that [the VBID General intervention] will have some sudden impact on the Star Ratings on the drug side."

Among targeted beneficiaries in VBID General plans, the model was associated with a small yet statistically significant increase in the likelihood of adherence to noninsulin diabetes, hypertension, and statin medication measures. Specifically, VBID General implementation was associated with a 1.4 percentage point increase in the probability of being adherent to noninsulin diabetes medications ( $p < 0.01$ , 95% CI: 0.9 to 1.9); a 1.6 percentage point increase in the likelihood of being adherent to statin medications ( $p < 0.01$ , 95% CI: 1.3 to 2.0), and a 0.7 percentage point increase in the likelihood of being adherent to hypertension medications ( $p < 0.01$ , 95% CI: 0.3 to 1.0) (Figure 5.2). To put these results in perspective, VBID General implementation was associated with an additional 687 enrollees becoming adherent to noninsulin diabetes medications, 824 enrollees becoming adherent to hypertension medications, and 2,286 enrollees becoming adherent to statin medications. The numbers are very low because only 257,675 beneficiaries were targeted for VBID General interventions in 2020. Because the model has grown rapidly over time, we may expect that more beneficiaries will be affected in the future, should these associations persist.

**Figure 5.2. Estimated Association Between VBID General Interventions and Probability of Beneficiary-Level Drug Adherence, 2020**



SOURCE: RAND analysis of Star Ratings adherence measures derived from the prescription drug event (PDE) data for the years 2017–2020. Numbers reported in this figure may not consistently sum to the estimates presented in the text due to rounding.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing VBID-targeted beneficiaries with a weighted sample of comparison beneficiaries. For the diabetes medication adherence outcome, the number of targeted beneficiaries included in the analyses was 30,860, and the total effective sample size (including targeted and weighted comparison beneficiaries) was 108,091. For the statin medication adherence outcome, the number of targeted beneficiaries included in the analyses was 88,267, and the total effective sample size was 256,391. For the hypertension medication adherence outcome, the number of targeted beneficiaries included in the analyses was 78,151, and the total effective sample size was 200,828. The black line(s) shown represent the 95% CI for the estimated effect of VBID General on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level. The CIs (88.6 to 88.7, 89.3 to 89.4, and 90.0 to 90.1, respectively) are so narrow that they are difficult to see.

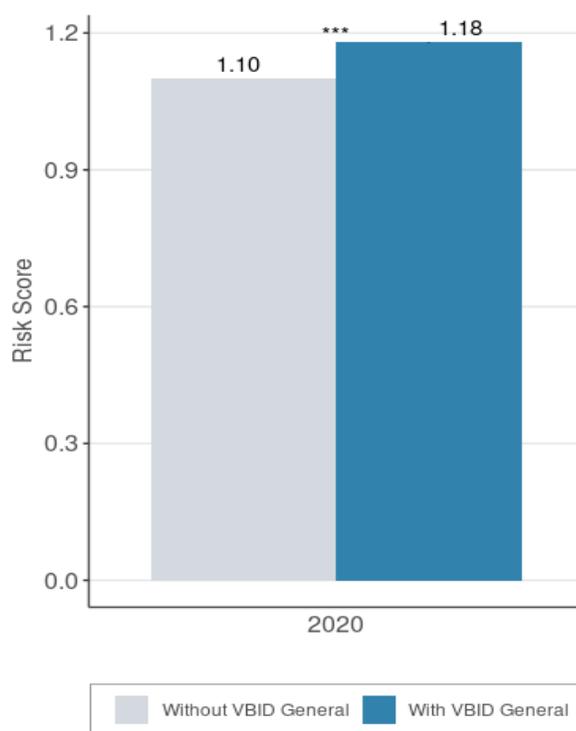
### PO Perspectives

Results of our 2022 interviews with PO representatives show that they had mixed perspectives on whether adherence had improved, which may be helpful in contextualizing the quantitative results presented above. PO J representatives explained that they “have seen the med[ication] adherence increase in these [targeted] members, which is wonderful.” In contrast, PO AA saw a decrease in adherence: “I think we did expect to see an increase because there is a fair amount of generic drugs [in those classes], but we’re sort of trying to understand why it’s dropping.” This PO implemented an intervention to reduce cost sharing only for generic Part D drugs for low-income beneficiaries where adherence may have already been high because the copayments for LIS-eligible beneficiaries for generic drugs are low or because LIS-eligible beneficiaries may use more brand-name drugs.

### *Beneficiary-Level Risk Scores*

We estimated that VBID General implementation was associated with an average 0.07 point (6.8%) increase in risk scores among targeted beneficiaries relative to comparators ( $p < 0.01$ ; 95% CI: 0.07 to 0.08; Figure 5.3). The HCC risk scores are designed such that a 1.0 risk score represents a beneficiary with average Medicare expenditures (CMS, undated); beneficiaries with a risk of higher-than-average expenditures receive scores above 1, and beneficiaries with below-average expenditures receive scores below 1 (the 90th percentile in 2020 for VBID beneficiaries was 2.3). Increases in beneficiary risk scores of this magnitude could plausibly lead to meaningful increases in the MA cost to CMS. The average standardized MA bid for VBID General plans in 2020 was \$801; holding the MA bid and other factors constant, an increase of 0.07 points in the risk score for targeted beneficiaries would imply an increase of \$56 in the per member per month (PMPM) MA cost to CMS for those beneficiaries.

**Figure 5.3. Estimated Association Between VBID General Interventions and Beneficiary Risk Score, 2020**



SOURCE: RAND analysis of risk scores derived from HCC data for the years 2017–2020.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing VBID-targeted beneficiaries with a weighted sample of comparison beneficiaries. The number of targeted beneficiaries included in the analyses was 165,673, and the total effective sample size was 806,234. The black line(s) shown represent the 95% CI for the estimated effect of VBID General on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level. The CI (1.178 to 1.179) is so narrow that it is not clearly visible on the graph. Numbers reported in this figure may not consistently sum to the estimates presented in the text due to rounding.

### PO Perspectives

The majority of POs responding to the survey (19 of 25) did not expect that their VBID General interventions would affect their risk scores in 2022, while four POs expected an increase and two expected a decrease. Those expecting increases in risk scores (POs N, U, and AC) attributed this change to the WHP component rather than their VBID General interventions. Indeed, most POs delivered WHP services through annual wellness visits, health risk assessments, or in-home visits, which offer additional opportunities to identify any missing diagnoses or ensure accuracy of existing diagnoses. According to a PO U representative, WHP-related activities make the risk scores more accurate:

It’s also doing the annual wellness visit when we collect all of the members’ existing conditions, so that improves risk scores. It makes the risk scores accurate. So especially for those new to Medicare and new to our health plan,

we may not always have their history, so we may not know the conditions that we need to recapture the codes for, for this current year.

### *Other Beneficiary-Level Health Status Outcomes*

We found no statistically significant association between eligibility for VBID General interventions and any of the health status outcomes derived from the HOS data (PCS, MCS, ADL, and IADL composite measures). Appendix J provides detailed results.

These quantitative results echo the results of our 2022 PO surveys and interviews. Most POs (15 of 25) completing our survey did not think that their VBID General intervention would have an impact on such clinical outcomes as beneficiary health status in 2022, with the remaining ten reporting that they expected improvements. Although surprising, these results could indicate that POs may not have been expecting to see an immediate impact on beneficiary health outcomes. Many POs designed interventions to prevent further deterioration rather than result in improvement, as PO N representatives explained: “It’s really trying to control those chronic conditions and improving their health status by keeping their chronic conditions under control and not sending them off on horrible adventures in the surgical unit.” Furthermore, some VBID General subcomponents—such as Cash Rebates—or interventions did not directly relate to beneficiary health. Therefore, POs’ responses to this survey question may reflect the nature of their VBID General interventions. Nonetheless, it is worth noting that PO U representatives said that the beneficiaries who participated in its VBID fall risk prevention program reported becoming more physically active, which could be viewed as a positive change in their health status: “Quite a significant number of the members reported that they have started engaging in active exercise programs after the assessment to strengthen their ability and their stability.”

### **Summary**

The majority of POs interviewed in 2022 expected that care quality and patient experiences would improve among beneficiaries targeted by their VBID General interventions. However, few POs expected that VBID General implementation would have a discernable impact on overall contract-level Star Rating. Because MA contracts can include a mix of plans (participating and nonparticipating in VBID General), a single plan’s influence on these measures may be relatively small. Nevertheless, we found that VBID General was associated with an 8.0% increase in the 2023 contract level Star Rating, which reflects 2021 measurement data. We also found small improvements in medication adherence among targeted beneficiaries relative to comparators.

We found that two-thirds of the 76 beneficiaries we interviewed were highly satisfied with their plans and that VBID General was associated with small improvements in beneficiary adherence to recommended drugs. However, despite improvements in beneficiary adherence measures, we also found an increase in HCC risk scores for 2020. Risk scores reflect

beneficiaries' health conditions that carry a high risk of medical spending, and CMS makes higher payments for beneficiaries with higher risk. The increase in risk scores could reflect that VBID General created increased opportunities for beneficiaries to interact with the health system, resulting in more diagnoses. One PO representative remarked that aspects of the model's WHP requirement, such as annual wellness visits and at-home risk assessments, helped them to identify and account for more diagnoses, particularly among beneficiaries who were new to the plan. If these additional diagnoses result in better treatment for conditions that would otherwise have been unnoticed, this dynamic could lead to improvements in beneficiary health over time. However, there is also concern that POs may code diagnoses for the purpose of increasing payment without improving beneficiaries' care (Geruso and Layton, 2020; Meyers and Trivedi, 2021).

One consideration is whether differential effects of the coronavirus pandemic could have led to differential changes in risk scores in the VBID General and comparison groups. While the CMS risk scoring methodology accounts for a variety of diagnoses, coronavirus disease is not among the diagnoses that directly affect the risk score (CMS, 2021b). It is possible that visits related to coronavirus could have resulted in providers diagnosing conditions included in the risk-scoring methodology, such as diabetes or COPD. Conversely, COVID-19 could have dampened utilization of non-COVID-19 services (and hence diagnoses) to a greater extent in the comparison group relative to the VBID General targeted group. However, the pandemic affected both VBID General and comparison beneficiaries, and we have limited reason to believe that effects would differ across groups. Furthermore, our methodology adjusted for the severity of the pandemic in beneficiaries' counties and for other characteristics—such as age and health status—that could affect beneficiaries' susceptibility to the virus.

We also found no evidence that VBID General affected other beneficiary-level health outcomes, including MCS, PCS, ADLs, and IADLs. The lack of differential effects on health further suggests that the impacts of the coronavirus did not vary in the intervention and comparison groups. However, we assessed health status based on the HOS, which is fielded only to a subset of beneficiaries. Therefore, we had limited power to detect statistically significant effects in this analysis, and the sample may not be representative of all VBID General-targeted individuals. Fewer than half of the POs that we interviewed anticipated that VBID General would affect health status in 2022. Although one of the ultimate goals of the model is to improve beneficiary health, such effects may take several years to materialize.

## Chapter 6. Use of High-Intensity Services

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### Key Findings

- Inpatient stays among beneficiaries in plans participating in VBID General increased by 11.9% in 2020 ( $p < 0.01$ ; 95% CI: 10.1% to 13.7%), relative to comparators. Although this finding was contrary to our expectations, it is possible that the VBID Model may have prompted an increase in beneficiary interactions with primary care providers (PCPs) and care managers, which may have identified latent need for services, including those requiring inpatient stays.
  - We conducted subgroup analyses to explore drivers of the increase in inpatient stays and observed increases in this outcome across several types of VBID interventions, including subtypes of VBID Flexibilities and RI.
  - We found no statistically significant association between implementation of VBID General and ED visits.
  - Although most POs did not expect VBID General to affect inpatient and ED use in 2022, some expressed cautious optimism that VBID General interventions would reduce inpatient and ED use over time.
- 

Most VBID General interventions aim to better manage chronic conditions or encourage healthy behaviors and, therefore, could reduce avoidable health care encounters stemming from poor disease control. Defining truly avoidable utilization is difficult, because some encounters may be inevitable even if beneficiaries and providers follow all relevant clinical guidelines. As a proxy for avoidable encounters, we considered the effect of VBID General on two types of high-intensity services: **hospital inpatient admissions** and **ED visits**.

Several POs in our study expected inpatient and ED visits to decline with the implementation of VBID. For example, a representative from PO E stated:

[I]n addition to expecting to see some improvements in just prescription fill adherence, we were also expecting and hoping that as members were filling those prescriptions in a more timely and appropriate manner, that we'd see some other impacts with condition management, potential downstream reductions in ER and inpatient utilization.

Moreover, representatives of other POs, such as POs N and S, told us that they considered reduced inpatient and ED use as indicators of the model's success.

Prior studies have also hypothesized that these services, which represent costly encounters that are not part of routine care or preventive treatment, might decline with improved CM (Stephenson et al., 2019; AlHabeeb, 2022; Iovan et al., 2020), though results have been mixed. Evaluations of VBID interventions offered by non-Medicare payers also frequently use inpatient and ED visits as outcomes, although, again, findings have been mixed (Agarwal, Gupta, and Fendrick, 2018; Maciejewski et al., 2014; Narain et al., 2022).

We ran DD models using Poisson regressions that estimated the percentage change in hospital inpatient stays and ED visits associated with the implementation of VBID General in 2020. We ran these regressions using beneficiary-level data, comparing a longitudinal cohort

of VBID General–targeted beneficiaries enrolled in the same plan, both before and after VBID General implementation, with entropy-balanced comparators in nonparticipating plans.

## Addressing Encounter Data Quality

We relied on the MA encounter data to measure utilization at the beneficiary level. However, the U.S. Government Accountability Office and other researchers have raised concerns about the quality and completeness of these data (Jung et al., 2022; U.S. Government Accountability Office, 2017). We explored the reliability of the encounter data for ED and inpatient visits by aggregating to the plan level and comparing them with plan-level measures of utilization submitted to CMS as part of the bidding process (Appendix K). While our analysis confirmed prior findings of relatively large differences between encounter data utilization estimates and estimates from alternative sources, we found that changes in encounter data utilization rates for both inpatient and ED services were highly predictive of changes in utilization rates found in the bid data. The strong relationship between the two data sources suggests that the encounter data may be used in a regression framework to predict changes in utilization, even if the absolute levels of utilization are mismeasured in the encounter data.

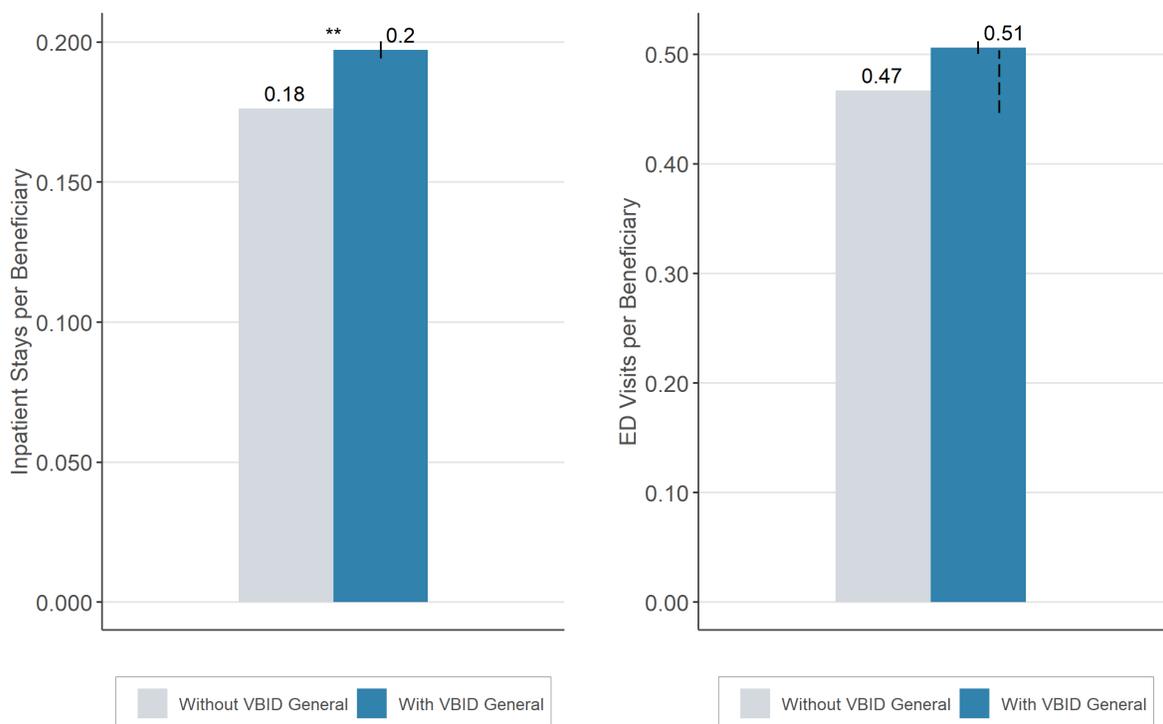
However, for ED visits, we also found that VBID General implementation was associated with an increase in reported encounters relative to the bid data. (We found no relationship between VBID General implementation and inpatient data reporting.) It is unlikely that a true change in utilization would result in a change in the encounter data without a corresponding change in the bid data because plan actuaries are required to certify the accuracy of the bid. We therefore interpret the change in the ED encounter data as a spurious change in reporting that is correlated with VBID General implementation. To address this spurious change, we made an adjustment to our ED regression based on a methodology described in Rambachan and Roth (2022) to account for the possibility of a reporting shift that occurred in tandem with VBID General implementation. The adjustment treats the change in encounter data reporting as a known violation of the parallel trends assumption and estimates the robustness of our findings to a deviation in parallel trends of an equivalent magnitude. Based on these results, we adjusted our CIs for the ED outcomes to reflect this increased uncertainty. We made no such adjustment for inpatient admissions because the relationship between the encounter data and the bid data did not change for this outcome.

## Use of Inpatient and ED Services

Figure 6.1 shows the results of our analysis. We found that VBID General implementation was associated with a statistically significant 11.9% increase in inpatient stays in 2020 ( $p < 0.01$ , 95% CI: 10.1% to 13.7%). The change in ED visits appeared to be statistically significant in the unadjusted analysis, resulting in a narrow CI, represented by the solid black line.

However, the CI is much wider and the result is not statistically significant after adjusting for the violation in parallel trends introduced by the reporting issues described above (dashed-line CI).

**Figure 6.1. Estimated Association Between VBID General Interventions and Use of High-Intensity Services, 2020**



SOURCE: RAND analysis of encounter data for the years 2017–2020.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels. Significance levels for the ED outcome were adjusted to account for a potential parallel trends violation (Rambachan and Roth, 2022); the dashed confidence line reflects this adjustment. The black line(s) shown represent the 95% CI for the estimated effect of VBID General on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level. The number of participating plans included in the analyses was 145, and the total effective sample size (including participating plans and weighted comparison plans) was 811,400.

Because utilization in 2020 was heavily influenced by the coronavirus pandemic, it is possible that some of the increase in inpatient stays could have been driven by differential effects of COVID-19 in intervention and comparison plans. Although our models adjusted for COVID-19 case rates, in sensitivity analyses, we took the additional step of excluding hospital inpatient admissions that included a COVID-19 diagnosis (U07.1 or B97.29) occurring on any claim. However, the association between VBID General and inpatient utilization remained similar (12.9% increase,  $p < 0.01$ , 95% CI: 11.0 to 14.9%).

The association with increased in inpatient stays contradicts the expectation that VBID General could lead to reduced use of high-intensity services. In Appendix E, we show

subgroup analyses to determine whether this unexpected finding was driven by a particular subtype of VBID General intervention. However, we found a positive and statistically significant association across multiple interventions, including VBID Flexibilities overall (12.4% increase,  $p < 0.001$ , 95% CI: 10.5 to 14.3%), VBID Flexibilities interventions that targeted beneficiaries based on SES (18.2% increase,  $p < 0.001$ , 95% CI: 14.4 to 22.2%), VBID Flexibilities interventions that included Part D cost-sharing reductions (11.1% increase,  $p < 0.001$ , 95% CI: 8.6 to 13.4%), and interventions that included participation requirements (10.3% increase,  $p < 0.001$ , 95% CI: 8.2 to 12.4%). The association between VBID General and inpatient stays was smaller, but still statistically significant, for RI plans (5.5% increase,  $p = 0.02$ , 95% CI: 0.8 to 10.3%).

Our subgroup analyses also suggested that ED visits increased among plans with Part D cost-sharing reductions and plans with participation requirements, even after applying the Rambachan and Roth (2022) correction to the CIs. However, we are cautious in interpreting this evidence because we did not analyze whether the reporting errors described above differed across plans depending on intervention subgroup.

### *PO Perspectives*

Of the 25 POs that responded to our survey questions about the impact of VBID General interventions on the use of high-intensity services in 2022, most ( $N = 17$ ) reported expecting no impact, seven expected to see a decrease, and one reported expecting an increase in ED visits. Similarly, the majority of POs reported expecting no impact on inpatient hospital stays ( $N = 16$ ), eight projected a decrease, and one reported a likely increase in inpatient hospital stays in 2022.

Nonetheless, in interviews, many PO representatives—even those who reported decreases in these outcomes on the survey—cautioned that it was too early to tell whether VBID had an effect on ED or inpatient utilization. This was either because results from internal evaluations were not yet available or because the sample was too small to produce statistically significant findings. A PO J representative said:

We did see a decrease in emergency room visits and items such as that, less doctor visits, so there was—it's showing that it's moving in the right direction as what we were hoping to see in the outcome, which is definitely a plus. Again, this is a smaller population, so to generalize or to make a strong statement on it, I can't, but we did see an impact within this population.

A PO AA representative noted that while results were preliminary, they were already seeing a reduction in medical costs but wanted to explore further:

I would just say that, very preliminarily, we are seeing a pretty significant decrease in Part C claims. Way too early to attribute that necessarily to participation in the VBID program and improved adherence, but I think it's something that—the change in cost is something that we want to look into more and to see what that's about. But too early to say if they're related, but, as

of now, we are seeing a trend reduction from '21 to '22 Part C costs. . . . A lot of it is inpatient, but again, very early to—I don't want to attribute it.

## Summary

Theoretically, we expected VBID General to reduce inpatient stays and ED visits because of increased use of preventive care and chronic disease management. Many POs that participated in the model test in 2022 had similar expectations, and some reported preliminary evidence that ED visits and medical claims might be decreasing alongside model implementation. However, our quantitative analysis indicated that hospital inpatient visits increased among targeted beneficiaries in VBID General plans after their plan implemented the model test. This finding remained unchanged after removing inpatient admissions that included COVID-19 diagnoses. We found no statistically significant change in ED visits.

In contrast to our findings about inpatient hospital stays, the literature has typically found statistically significant but weak associations between VBID-like interventions, such as enhanced CM or lower drug cost sharing, and reduced hospitalizations (Joo and Liu, 2017; Guindon et al., 2022; Fusco et al., 2023). Because the set of interventions included in VBID General is very broad and some interventions are targeted to specific subsets of plan enrollees, it is difficult to make direct comparisons with the existing literature. However, in subgroup analyses, we found statistically significant increases in inpatient utilization across several VBID General intervention types.

One possible explanation for the unexpected relationship between VBID General and inpatient service use is that the model resulted in increased interactions with providers, leading to more referrals for inpatient treatment. For example, CM/DM-focused interventions or those aimed at promoting primary care use may have uncovered health issues that otherwise would have gone unnoticed, resulting in more inpatient stays (Eibner et al., 2020). If this is the case, we might expect the positive relationship between VBID General implementation and inpatient use to diminish over time, as unmet need for services is addressed. Another possibility is that RI programs and VBID-enabled supplemental benefits that covered everyday expenses freed up beneficiaries' incomes, allowing them to spend more on medical care—for example, by scheduling appointments with their specialists, who might have identified a need for hospitalization.

## Chapter 7. Plan-Level Financial Outcomes

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### Key Findings

- We found no statistically significant relationship between the VBID Model and MAPD bids, which aligned with POs' expectations.
  - Despite the lack of effect on bids, VBID General interventions were associated with a \$44.90 PMPM (3.4%) increase in costs to CMS in 2021 ( $p < 0.01$ , 95% CI: \$25.81 to \$63.99).
  - Supplemental analyses suggest that costs to CMS increased despite stable bids because VBID General interventions were associated with larger MA rebates and higher projected MA risk scores.
- 

Because a primary objective of the VBID Model is to reduce the cost of care, we examined changes in plan-level financial outcomes associated with VBID General implementation, including **plan bids** and **costs to CMS**. We analyzed plan bids submitted to CMS for MA and Part D coverage because they reflect the projected costs of providing statutorily required benefits. The majority of the bid in both MA and Part D is determined by projected medical or prescription drug spending, although administrative costs and other plan expenses are also included. The theoretical impact of VBID General on bids is ambiguous. Interventions typically aim to increase utilization of recommended care or promote healthy behaviors, with the goal of reducing the use of high-intensity services over time. But it is unclear whether greater investments in health promotion and disease management will outweigh savings from averted downstream costs. Administrative costs associated with implementing VBID General could also result in higher bids.

We also analyzed costs to CMS for providing MA and Part D coverage using data submitted to CMS by plans through the annual bidding process. The MA cost to CMS reflects two components: (1) a monthly capitation payment based on the bid and beneficiary MA risk scores and (2) the MA rebate (a quality-adjusted payment made to plans that bid below a benchmark based on the cost of traditional Medicare). The Part D cost to CMS is more complex, because plans are paid through several different mechanisms, both during the contract year and through a reconciliation process after the close of the year. Although data fully capturing the final cost to CMS were not available for this report, we were able to construct a measure of Part D costs to CMS that reflects three major components of these costs: a risk-adjusted capitation payment based in part on the bid (known as the direct subsidy), LIS payments to reduce premiums and cost sharing borne by beneficiaries enrolled in the LIS, and individual reinsurance that reimburses plans for 80% of gross drug costs in the catastrophic benefit phase.

Impacts of VBID General on costs to CMS are difficult to predict for both MA and Part D because of the complexity of the mechanisms through which benefit design could affect costs. Furthermore, the effects of VBID General implementation on costs to CMS may differ across

the diversity of interventions implemented under the model. To gain insight into the mechanisms that may have contributed to any estimated impacts of VBID General implementation on plan-level financial outcomes, we also analyzed a wide range of variables that reflect components of plan bids, premiums, and costs to CMS. Appendix L provides comprehensive detail on these results. We also examined impacts of specific VBID General interventions on MAPD bids; these subgroup findings are presented in Appendix E.

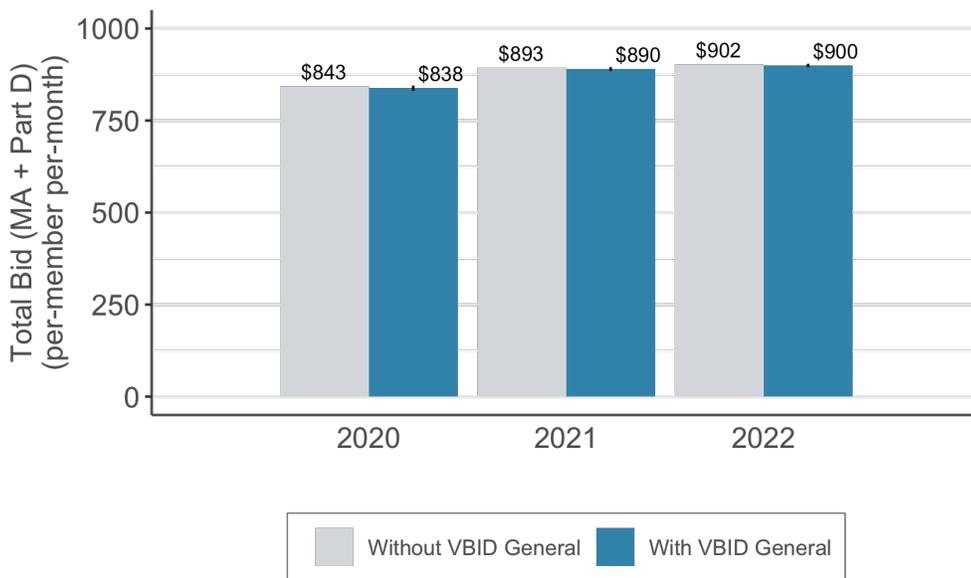
Finally, although our evaluation did not quantitatively examine the impact of VBID General implementation on POs' profits, our interviews with PO representatives captured their perspectives on **return on investment (ROI)**.

## Plan Bids

To obtain an MAPD bid reflecting plans' combined cost of providing both MA and Part D coverage, we summed the standardized MA and Part D bids using the data from the CMS Office of the Actuary (OACT). The average MA bid is roughly 20 times larger than the average Part D bid, so changes in the MA bid can be expected to drive changes in the total MAPD bid. We analyzed plan bids for the 2017–2022 contract years, with VBID General implementation beginning in 2020 or later.

We did not find a statistically significant association between VBID General implementation and MAPD bids in 2020, 2021, or 2022. Figure 7.1 shows the comparison of actual MAPD bids among participating plans versus the values that would have been expected in the absence of VBID General. The change associated with VBID General implementation was estimated to be a \$5.28 PMPM decrease in 2020 ( $p = 0.15$ , 95% CI:  $-\$12.42$  to  $\$1.86$ ), a \$3.03 PMPM decrease in 2021 ( $p = 0.26$ , 95% CI:  $-\$8.25$ ,  $\$2.19$ ) and a \$2.72 PMPM decrease in 2022 ( $p = 0.22$ , 95% CI:  $-\$7.09$ ,  $\$1.65$ ). In addition to not being statistically significant, these effect sizes are very small relative to the magnitude of the bid, which is upwards of \$800 PMPM. Specifically, the estimated changes represent decreases in the MAPD bid of 0.6% in 2020, 0.3% in 2021, and 0.3% in 2022. While these point estimates are slightly negative, they are not statistically significant and the 95% CIs rule out large changes in the MAPD bid in either direction.

**Figure 7.1. Estimated Association Between VBID General Interventions and MAPD Bids**



SOURCE: RAND analysis of CMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in VBID General with comparison plans. The number of participating plans included in the analyses was 773, and the total effective sample size (including participating plans and weighted comparison plans) was 2,243. The black line(s) shown represent the 95% CI for the estimated effect of VBID on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level.

We note that the 2020 and 2021 findings for MAPD bids reported here differ slightly from those reported in our earlier report (Khodyakov et al., 2022), where VBID General implementation was associated with a marginally significant decrease in MAPD bids of \$5.79 PMPM in 2020 ( $p = 0.09$ , 95% CI:  $-\$12.39$  to  $\$0.81$ ) and a statistically significant decrease in MAPD bids of \$5.37 PMPM in 2021 ( $p = 0.01$ , 95% CI:  $-\$9.30$  to  $-\$1.44$ ). We suspect that any differences in these estimates and CIs arose due to a slightly more conservative method of estimating standard errors and CIs or other minor differences in the statistical methods used. These differences include some changes in the set of variables used for entropy balancing, the use of more-flexible controls for COVID-19, and changes in our approach to selecting the tolerance for entropy balancing. Notwithstanding differences in statistical significance between the estimates in the 2022 report and those in the current report, the estimates from this report have the same sign, are similar in magnitude, and fall within the 95% CIs of the estimates from the previous report (Khodyakov et al., 2022). See Appendix C for further discussion of methodological changes between our 2022 Evaluation Report and the present study.

## *Mechanisms Explaining VBID General Impacts on Plan Bids*

Although we did not find statistically significant evidence that VBID General implementation was associated with changes in the MAPD bid, we note that the small and statistically insignificant estimates shown in Figure 7.1 reflect opposite-signed impacts on MA and Part D bids in 2021 and 2022 (Appendix L provides full results). We estimate that VBID General reduced the MA bid by \$9.08 in 2021 ( $p < 0.01$ , 95% CI:  $-\$14.39$  to  $-\$3.77$ ). Statistically insignificant estimates for 2020 and 2022 also suggest reductions in the MA bid but do not rule out the possibility that there was no effect: the estimated change in the MA bid associated with VBID General implementation was a statistically insignificant \$2.55 reduction ( $p = 0.48$ , 95% CI:  $-\$9.63$  to  $\$4.53$ ) in 2020 and was a statistically insignificant \$3.89 reduction ( $p = 0.06$ , 95% CI:  $-\$7.92$  to  $\$0.15$ ) in 2022. Compared with the MA bids that would have been expected in the absence of VBID General implementation, these estimated effects represent decreases in the MA bid of 0.3% in 2020, 1.1% in 2021, and 0.4% in 2022.

Meanwhile, we estimate that VBID General interventions were associated with increases in the Part D bid in 2021 and 2022 by amounts that were similar in magnitude (but opposite in sign) to the estimated impacts on the MA bid. VBID General increased the Part D bid by \$8.19 in 2021 ( $p < 0.01$ , 95% CI:  $\$6.43$  to  $\$9.96$ ) and by \$3.09 in 2022 ( $p < 0.01$ , 95% CI:  $\$1.44$  to  $\$4.74$ ). In comparison to the Part D bids that would have been expected in the absence of VBID General implementation, these estimated effects represent increases of 25.2% in 2021 and 8.8% in 2022. The estimated change in the Part D bid associated with VBID General implementation in 2020 was close to zero and statistically insignificant ( $-\$0.14$ ,  $p = 0.86$ , 95% CI:  $-\$1.73$  to  $\$1.44$ ).

## *PO Perspectives*

Survey results of 26 POs presented in Table 7.1 show that most model test participants did not think that their implementation of VBID General intervention(s) affected their MA or Part D bids in 2022 (15 and 16 POs, respectively). Among the minority of POs reporting an impact on MA bids, six POs reported a decrease, and five reported an increase. There was less variation in PO perspectives on the impact of their VBID General interventions on Part D bids, with eight POs reporting an increase and only two POs reporting a decrease.

**Table 7.1. Survey Results of PO Perspectives of VBID General Impact on Bids**

	Decrease	No Impact	Increase
MA bids	6	15	5
Part D bids	2	16	8
Plan administrative costs	1	8	16

SOURCE: Author analysis of the following PO survey question: "How will (or has) BDI component (for example, VBID Flexibilities, Rewards and Incentives programs, Cash Rebates) affect(ed) the following outcomes in 2022?"

During the interviews, PO representatives explained that they thought that the bids would either experience no net change or increase in the near term. Representatives of several POs that offered Part D interventions, including POs E, P, AG, and AP, noted that drug-focused interventions often cause the Part D bid to increase and the MA bid to decrease: “The natural thought would be if we have better adherence to the drugs, it will basically bring down the Part C side. And since we’re paying for more drugs, it would raise [the bid] on the Part D” (PO E).

Moreover, PO AG representatives noted that they deliberately worked to decrease their MA bid to generate additional MA rebate dollars to cover the cost of the increased Part D premiums:

It’s the expectation that with reduced cost sharing to the member or just making the medications more accessible . . . utilization [will increase] and thus the Part D bid [will increase]. And so that was the thought behind that assumption. And then in terms of the Part C bids, we would expect that then with the Part D bids going up . . . we would be paying for that with rebates. To generate as much savings relative to the benchmarks [needed] to generate rebates to support that increased Part D bid, there would be reduced margin on the Part C side and thus a lower bid on the Part C side.

PO AA explained that reduced cost sharing for Part D drugs required plans to increase their bids:

[I]n the bid, we assumed around two dollars PMPM increase in plan payments. And actually, based on PDE data through June, we’re seeing a similar \$1.95 PMPM increase in cost of covering the reduced member cost sharing. That doesn’t include any shifts in member behavior. I think we need more data to run out and have a chance to analyze that. But just in terms of the shifting of responsibility from those small copays from the member to the plan, we’re seeing that play out similar to expected in the bid.

For administrative costs, the majority of POs responding to the question (16 of 25) reported an increase in 2022, eight reported no impact, and one reported a decrease (Table 7.1). Representatives of POs B and L noted in interviews that increased administrative costs could be attributed to investments in call centers and CM programs. POs R and AD also remarked that working with vendors to deliver card-delivered benefits increased these costs.

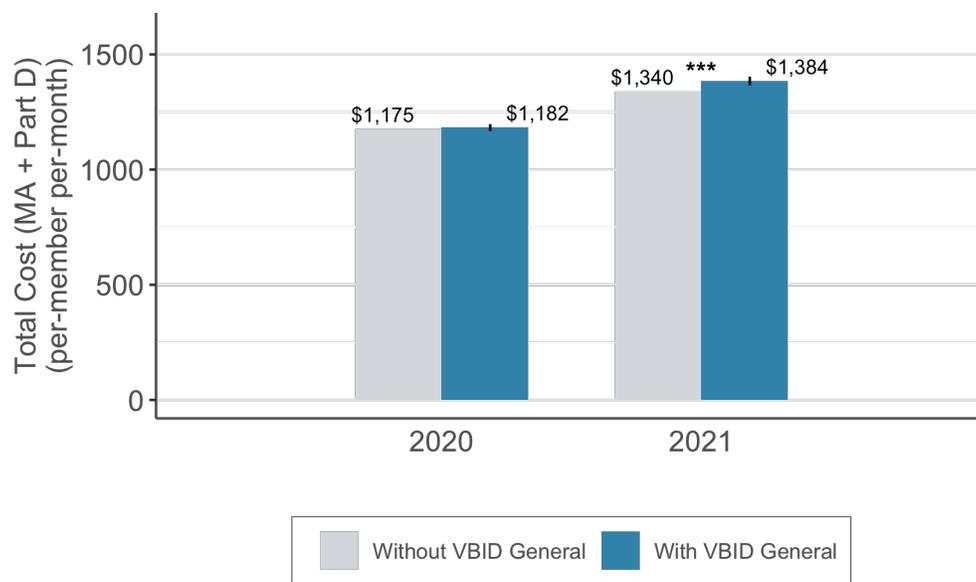
## Costs to CMS

To calculate the total costs to CMS associated with payments to MAPD plans, we summed MA and Part D costs to Medicare. MA costs to Medicare were derived from the bid data provided by OACT, while Part D costs to Medicare were calculated using a combination of several CMS data sources. MA costs to Medicare constitute roughly 90% of the total cost to Medicare for MAPD plans in our sample, so the effects of VBID General implementation on total costs to Medicare are likely driven by its effect on MA costs. We analyzed total costs to Medicare for the 2017–2021 contract years, with VBID General implementation beginning in

2020 or later. Costs to Medicare for 2022 were not available at the time of this writing because of data lags associated with some components of Part D costs.

We found no evidence that VBID General was associated with increased costs to Medicare in 2020, but VBID General was associated with an increase in costs to Medicare in 2021 (Figure 7.2). In 2020, VBID General was associated with a statistically insignificant increase of \$7.43 PMPM ( $p = 0.33$ , 95% CI:  $-\$7.64$  to  $\$22.50$ ) in total costs to Medicare. In 2021, VBID General was associated with a larger and statistically significant increase of \$44.90 PMPM ( $p < 0.01$ , 95% CI:  $\$25.81$  to  $\$63.99$ ) in total costs to Medicare. In comparison to the costs to Medicare that would have been expected in the absence of VBID General implementation, these estimated effects represent increases in the costs to Medicare of 0.6% in 2020 and 3.4% in 2021.

**Figure 7.2. Estimated Association Between VBID General Interventions and Total (MA + Part D) PMPM Costs to CMS**



SOURCE: RAND analysis of CMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in VBID General with a weighted sample of comparison plans. The number of participating plans included in the analyses was 386, and the total effective sample size (including participating plans and weighted comparison plans) was 1,100. The black line(s) shown represent the 95% CI for the estimated effect of VBID on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level.

### *Mechanisms Explaining VBID General Impacts on Costs to CMS*

Increases in costs to CMS associated with VBID General implementation in 2021 were largely driven by MA costs to CMS. In 2021, VBID General implementation was associated with a statistically significant increase in MA costs to CMS of \$34.49 PMPM ( $p < 0.01$ , 95%

CI: \$16.08 to \$52.91) and a marginally statistically significant increase in Part D costs to CMS of \$4.36 PMPM ( $p = 0.05$ , 95% CI:  $-\$0.02$  to  $\$8.75$ ). The estimated change in MA costs was larger than that estimated for Part D costs; although these estimated effects represented similar percentage increases compared with the costs to CMS that would have been expected in the absence of VBID General implementation (a 2.9% increase for MA costs to CMS and a 2.8% increase in Part D costs to CMS), MA costs are, on average, much higher than Part D costs and therefore have a greater influence on total costs to CMS.

In analyses that examined specific components of MA and Part D costs to Medicare, we found that the increase in MA costs in 2021 appeared to be driven by increased MA rebates and increases in the projected MA risk score, whereas the increase in Part D costs in 2021 was driven primarily by LIS payments. Please consult Appendix L for detailed results.

The evidence on the relative importance of MA and Part D costs to CMS is less clear in 2020: The point estimate for the change in MA costs to CMS associated with VBID General was positive (\$4.52 PMPM,  $p = 0.58$ , 95% CI:  $-\$11.42$  to  $\$20.45$ ), while the point estimate of the change in Part D costs to CMS associated with VBID General was slightly negative ( $-\$0.29$  PMPM,  $p = 0.89$ , 95% CI:  $-\$4.45$  to  $\$3.87$ ), but neither estimate was statistically significant. Moreover, these estimates are too imprecise to support strong conclusions about the contributions of MA and Part D costs to the statistically insignificant changes in costs to CMS estimated for 2020.

Because costs to Medicare for Part D are not yet available for 2022, total costs to CMS could not be analyzed for 2022. However, MA costs to CMS were available and can be examined to provide some early evidence about how we might expect to find that total costs to CMS changed with VBID General implementation. As in 2021, we found that VBID General implementation was also associated with increased MA costs to Medicare in 2022, driven by higher MA rebates and higher projected MA risk scores (Appendix L). In comparison to the MA costs to Medicare that would have been expected in the absence of VBID General implementation, the estimated change in MA costs to CMS in 2022 represents an increase of 1.9%.

## PO Perspectives on ROI

From the perspective of a PO, the MA and Part D costs to Medicare that we analyzed in this report represent a major component (though not all) of revenues from MAPD plans. This evaluation report does not examine the costs to POs of operating MAPD plans, and, thus, we were unable to measure or analyze quantitatively how VBID General implementation affected POs' profits. However, our interviews with PO representatives did capture some perspectives on how they expected VBID General to affect profits—that is, whether VBID General implementation would yield a positive ROI.

PO representatives had mixed perspectives on whether they would see an ROI from VBID General participation. Representatives of PO B, which is one of a few remaining Phase I model test participants, said that they are starting to see some ROI from its CM program, but it has taken several years:

The control group started out with much lower cost [to the PO]. But as we see this trajectory year over year, the control group is now exceeding the cost of the intervention group. So, I would argue that the VBID benefits in general are showing a longer-term impact when you look at the population from an overall cost perspective.

PO U representatives also reported seeing some ROI: “We believe in our game; we’re not losing money. The money we invested into the VBID, the benefits, the MTM, and the rewards is paying for itself.” Representatives of PO N, which implemented a variety of RI programs for chronic conditions, said that early detection of some conditions can be very cost effective:

For the money we’ve put out here, if we identify two breast cancers in Stage I instead of Stage IV, we’ve paid for the program, right? Even a few cases that we catch earlier in the disease state can really substantially reduce our cost in the medical side.

In contrast, other POs did not think that they would experience meaningful ROI. PO AD representatives felt that this was particularly true for its Cash Rebates intervention because it was only implemented for one year. PO AE representatives explained that the size of the targeted group could also affect the ROI:

Unless you’re targeting high-risk . . . patients to support all of what could benefit them, any other segmentation does run the risk that you’re not getting the benefit for the broadest category. Therefore, the ROI is not going to be the same.

Nonetheless, PO Q representatives noted that there were nonfinancial benefits to their model participation, which could be as important as ROI:

From my perspective, we’ve had the opportunity to create a partnership with a really forward-thinking provider; and that’s really accelerated some of the work that happens throughout the organization with our provider relationships.

## Summary

We did not find evidence that VBID General was associated with changes in MAPD bids. This finding is largely consistent with PO expectations: Most reported not expecting impact. Some POs that did report changes noted that an increase in the Part D bid might be offset by decreases in the MA bid, an observation that is consistent with our DD results for MA and Part D bids. For example, representatives of PO AG noted that they strategically decreased their MA bid to be able to use MA rebate dollars to cover the cost of increased Part D premiums.

Although bids did not meaningfully change, VBID General interventions were associated with an increase in costs to Medicare in 2021, driven largely by increases in MA costs to Medicare. We analyzed MA and Part D bids on a risk-adjusted or *standardized* basis, while our measures of MA and Part D costs to Medicare reflect total amounts that are not risk-adjusted. Therefore, changes in MA and Part D risk scores can contribute to a divergence between the effects of VBID General interventions on plan bids and the effects of VBID General implementation on costs. Despite the absence of large changes in MAPD bids associated with VBID General implementation, we found that MA costs to Medicare rose because VBID General interventions were associated with both larger MA rebates and higher MA risk scores. These changes are broadly consistent with quality-of-care findings using Star Ratings (which affect the MA rebate paid to plans) and health outcomes findings using beneficiary-level risk scores (which adjust CMS payments to account for the expected medical spending of the enrollees).

Effects of VBID General implementation on Part D costs to Medicare can also diverge from effects on Part D bids because of changes in costs to Medicare for LIS and reinsurance payments to plans. In fact, average LIS and reinsurance payments to plans are both several times larger than the average direct subsidy. Therefore, we would expect changes in the Part D bid to make a relatively small contribution to changes in Part D costs to Medicare associated with VBID General implementation.

## Chapter 8. Beneficiary Cost Outcomes

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### Key Findings

- VBID General interventions were associated with statistically significant increases in MAPD premiums, largely driven by increases in the Part D premium:
    - \$2.25 PMPM (9.1%) in 2021 ( $p = 0.01$ , 95% CI: \$0.48 to \$4.03)
    - \$1.33 PMPM (5.7%) in 2022 ( $p = 0.01$ , 95% CI: \$0.39 to \$2.27).
  - Costs for mandatory supplemental benefits (MSBs) also increased by a statistically significant amount for plans participating in VBID General:
    - \$11.86 PMPM (23.6%) in 2021 ( $p < 0.01$ , 95% CI: \$7.65 to \$16.06)
    - \$16.15 PMPM (28.6%) in 2022 ( $p < 0.01$ , 95% CI: \$12.93 to \$19.37).
  - Increases in MSB costs did not result in commensurate increases in premiums. PO representatives explained that plans used MA rebates to buy down premiums to remain competitive.
  - PO representatives indicated that D-SNPs passed the increased Part D premium costs to Medicare because CMS covers all or part of the beneficiary premium cost for LIS-eligible beneficiaries.
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VBID General implementation may affect not only plan-level financial outcomes but also cost outcomes for beneficiaries. Total premiums may increase if plan bids increase as a result of VBID General implementation. Additionally, CMS required that the cost of VBID Flexibilities, including supplemental benefits offered through the model, be included in MSB costs, which are generally paid for via increased premiums. These premium increases may be offset by MA rebates if plans choose to use those rebates to reduce the MA premium, the Part D premium, or both.

To estimate these beneficiary cost outcomes, we examined associations of VBID General implementation with changes in **total premiums** (for MA and Part D coverage), as well as changes in the cost of **MSBs**, which include VBID-enabled supplemental benefits. Plan-level premiums were drawn from the Health Plan Management System (HPMS) data on approved plan benefits and reflect the final amount that beneficiaries would expect to pay if enrolling in the plan, before application of any LIS premium subsidies. MSB costs were drawn from the OACT bid data described in Chapter 7 and reflect a PMPM amount. We conducted these analyses at the plan level because these costs are generally the same for all beneficiaries enrolled in the same plan. The results of these analyses provide insight into the effect of VBID General on the costs that beneficiaries faced when enrolling in plans that participate in VBID General. We previously reported the effect of VBID General implementation on premiums and MSB costs in 2020 and 2021 but have updated the methods used and present results for all three years (2020 through 2022) here.

## Premiums

We found that VBID General participation was not associated with changes in the total monthly MAPD premium in 2020 but was associated with increases in the total premium in 2021 and 2022 (Figure 8.1). Specifically, we found an increase in the total premium of \$2.25 ( $p = 0.01$ , 95% CI: \$0.48 to \$4.03) in 2021 and an increase of \$1.33 ( $p < 0.01$ , 95% CI: \$0.39 to \$2.27) in 2022. In comparison to the MAPD premium that would have been expected in the absence of VBID General implementation, these estimated effects represent increases in the MAPD premium of 9.1% in 2021 and 5.7% in 2022.

**Figure 8.1. Estimated Association Between VBID General Interventions and MAPD Premiums**



SOURCE: RAND analysis of CMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in VBID General with comparison plans. The number of participating plans included in the analyses was 773, and the total effective sample size (including participating plans and weighted comparison plans) was 2,325. The black line(s) shown represent the 95% CI for the estimated effect of VBID General on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level. Numbers reported in this figure may not consistently sum to the estimates presented in the text due to rounding.

These increases reported above appear to be driven by increases in the Part D premium, which increased by an estimated \$3.14 ( $p < 0.01$ , 95% CI: \$2.11 to \$4.16) in 2021 and an estimated \$1.39 ( $p < 0.01$ , 95% CI: \$0.61 to \$2.17) in 2022. In comparison to the Part D premium that would have been expected in the absence of VBID General implementation, these estimated effects represent increases in the Part D premium of 19.4% in 2021 and 7.8% in 2022.

Changes in the MA portion of the premium were smaller than changes in the Part D premium and statistically insignificant in 2020 and 2022. However, in 2021, the MA premium

decreased by an estimated \$1.69 ( $p = 0.01$ , 95% CI:  $-\$2.93$  to  $-\$0.44$ ). This decrease likely offset the somewhat larger increase in the Part D premium for this year.

Please consult Appendix L for additional detail.

### *PO Perspectives*

None of the 26 POs that participated in VBID General and completed our survey reported increases in MA premiums for 2022. For Part D premiums, most POs reported no impact; however, four reported increases (Table 8.1).

**Table 8.1. Survey Results for VBID General Impact on Premiums (N = 26)**

	Decrease	No Impact	Increase
MA premiums	0	26	0
Part D premiums	0	22	4

SOURCE: Author analysis of the following PO survey question: “How will (or has) Benefit Design Innovations (BDI) component (for example, VBID Flexibilities, Rewards and Incentives programs, Cash Rebates) affect(ed) the following outcomes in 2022?”

Some participating POs may have used MA rebates to buy down premiums to remain competitive in their market. A PO Q representative explained:

Our flagship plan is also a zero-dollar premium, as many are in the industry. I think that no impact is actually a very positive thing. We’re able to invest [rebate dollars] more deeply in these benefits, in these members, and it’s not leading to any increase in premiums.

Plans can pass Part D premium costs for beneficiaries with LIS status on to Medicare, because CMS covers all or part of the beneficiary premium for LIS-eligible beneficiaries. A representative of PO L, which reported increasing its Part D premium, explained, “The Part D premium does increase on these because of the cost sharing going down. But again, because these are duals, they’re LIS-eligible. Most of our members aren’t paying that Part D premium, even though it’s going up.”

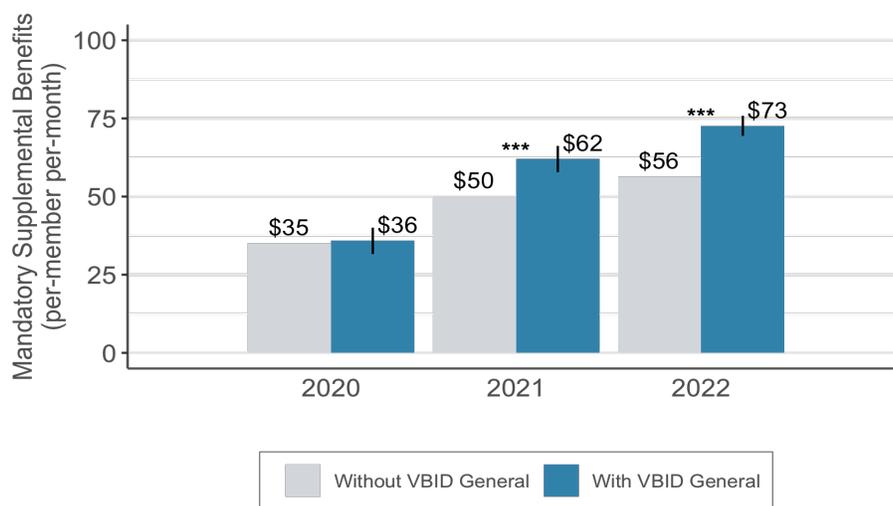
### Supplemental Benefits

We found no association between VBID General participation and MSB costs in 2020, but we found that VBID General implementation was associated with statistically significant increases in MSB costs in both 2021 and 2022 (Figure 8.2). Specifically, VBID General implementation was associated with an increase in MSB costs of \$11.86 ( $p < 0.01$ , 95% CI: \$7.65 to \$16.06) in 2021 and an increase of \$16.15 ( $p < 0.01$ , 95% CI: \$12.93 to \$19.37) in 2022. In comparison to the MSB costs that would have been expected in the absence of VBID

General implementation, these estimated effects represent increases in MSB costs of 23.6% in 2021 and 28.6% in 2022.

This finding suggests that plans participating in VBID General increased the value of their supplemental benefit offerings in 2021 and 2022 as a result of VBID General implementation, though these increases could also reflect the additional costs of the VBID Model offerings, which were incorporated into the MSB costs. Additional descriptive statistics on specific supplemental benefit offerings in 2022 are provided in Appendix L.

**Figure 8.2. Estimated Association Between VBID General Interventions and MSB Costs**



SOURCE: RAND analysis of CMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in VBID General with comparison plans. The number of participating plans included in the analyses was 773, and the total effective sample size (including participating plans and weighted comparison plans) was 1,768. The black line(s) shown represent the 95% CI for the estimated effect of VBID on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without VBID General” group indicate when the associations were not statistically significant at the 0.05 level.

### *PO Perspectives*

PO representatives mentioned two main strategies for handling the increased costs of supplemental benefits in a way that avoided premium increases. The first was to reduce their MA bid to maximize the amount of rebate dollars available to cover the cost of VBID-enabled supplemental benefits. “To do that, we need to decrease the MA bid to expand the bid to benchmark range to generate the rebate,” PO P representatives explained. “That way, we’re not passing on increased premiums to the members or increasing cost for CMS.” The second strategy was to reduce the number of other supplemental benefits to make room for VBID-enabled supplemental benefits. A PO AP representative said:

The trade-off would come from not removing a benefit but making some trade-offs. For example, reducing an OTC quarterly allowance from \$300 to \$200, so we could offer the cash card in that plan and give that member a little more flexibility on how they can spend those funds.

## Summary

Our analyses indicate that VBID General was associated with statistically significant increases in MAPD premiums in 2021 and 2022, largely driven by increases in the Part D premium. For beneficiaries with LIS status, these premium increases may have been passed on to Medicare in the form of low-income premium subsidy (LIPS) payments and, therefore, did not affect beneficiaries financially. Although only four POs reported increasing Part D premiums in 2022, many POs entered more than one plan into the model test. Therefore, it is unclear whether survey responses from PO representatives generalize across all of their plans. One PO acknowledged that higher Part D premiums for low-income beneficiaries would increase costs for the federal government rather than enrollees.

We also found that VBID General was associated with increased MSB costs in both 2021 and 2022, which could reflect costs associated with offering supplemental benefits through the model test or could reflect other VBID General–related costs that were priced as MSB costs. Because beneficiary premiums generally must pay for the cost of MSBs, it is notable that premiums did not increase commensurately with increased MSB costs. PO representatives noted that they used a variety of strategies to avoid passing higher MSB costs onto enrollees in the form of higher premiums, including reducing the value of other benefits and buying down additional premiums with rebate dollars.

## **PART II: HOSPICE BENEFIT COMPONENT**

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## Chapter 9. Participants, Interventions, Hospice Networks, and Implementation Experiences

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### Key Findings

- Hospice Benefit component participation increased from nine POs in 2021 to 13 POs in 2022.
- POs participating in the Hospice Benefit component in 2022 had higher average plan enrollment and were more likely to be national organizations than nonparticipants.
- Relative to nonparticipating plans, a higher proportion of enrollees in Hospice-participating plans were dual eligibles. Participating plans also had a higher proportion of enrollees who were Hispanic, due to high model participation levels in Puerto Rico.
- The range of palliative care services offered was similar across POs, with some POs contracting with in-network hospices to provide palliative care and others contracting with non-hospice palliative care providers and groups.
- TCC offerings varied by PO. Some covered all treatments; others limited TCC to certain types of services, such as dialysis, or determined TCC benefits on a case-by-case basis. Most POs limited their TCC benefit to 30 days; others did not impose a cap on the number of days.
- Six participating POs offered a hospice supplemental benefit that eliminated cost sharing for inpatient respite care and hospice drugs and biologicals. Six POs offered other types of hospice supplemental benefits, such as a \$500 yearly care assistance allowance and additional in-home respite care.
- In 2022, 1,168 hospices across all POs provided care to at least one VBID beneficiary, up from 596 hospices in 2021.
- About 22% of hospices that provided care to VBID beneficiaries electing hospice were in network, up from 17% in 2021. These hospices tended to be larger and were more likely to be part of a chain than OON hospices.
- Hospices cited four main reasons for joining PO networks: long-term business viability; increasing care options at the end of life, particularly through TCC; wanting to be at the forefront of changes to hospice care in MA; and expanding on existing relationships with POs.
- POs and hospices shared concerns regarding administrative processes and implementation of TCC and hospice supplemental benefits. POs (particularly those new to the model) also reported challenges with communication and creating hospice networks, whereas hospices noted challenges with PO reporting requirements and oversight, as well as identification and referral of beneficiaries to TCC services.

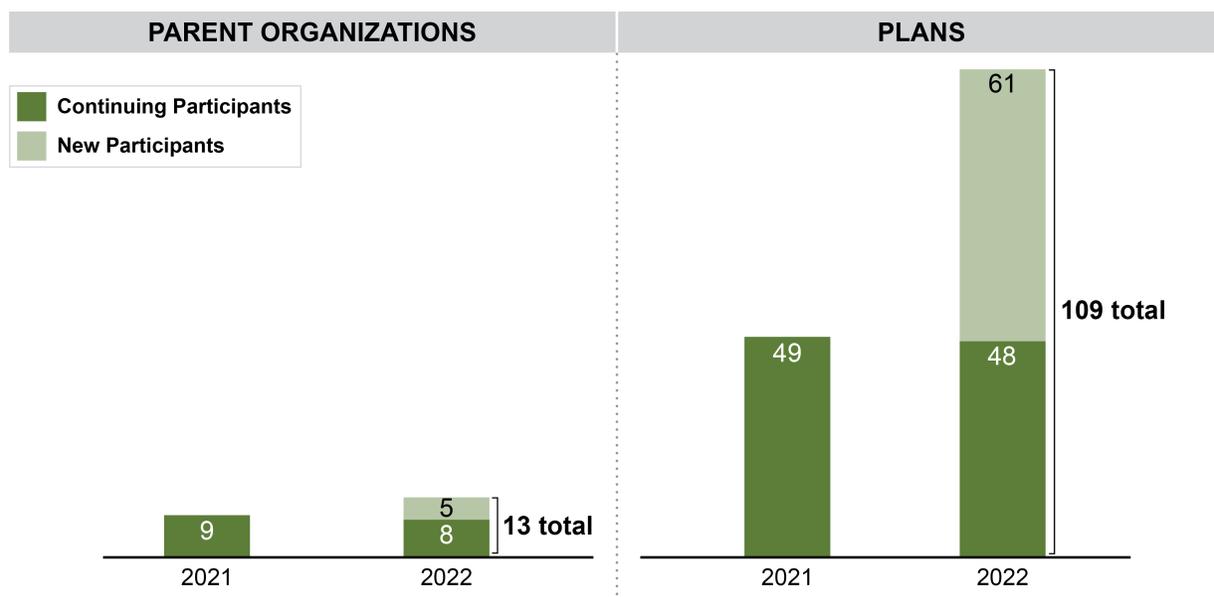
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This chapter uses PO and plan characteristics data to describe 2022 VBID Model participants that implemented the Hospice Benefit component, with a specific focus on the difference between Hospice-participating and nonparticipating POs and plans. Using model application materials and results of PO and hospice survey and interview data, this chapter also summarizes the Hospice Benefit component interventions that VBID participants implemented in 2022, characterizes PO hospice networks, and describes implementation experiences and challenges reported by both POs and hospices. Appendix A provides details on PO and hospice surveys and interviews.

## Characteristics of Participating POs and Plans

Thirteen POs participated in the Hospice Benefit component in 2022, increasing from nine POs in 2021, with five new POs entering the model and one PO leaving the model between 2021 and 2022. Participating POs offered the Hospice Benefit component across 109 plans; these plans had 1,025,093 enrollees in 2022 (Figure 9.1). In comparison to eligible nonparticipating POs, those participating in the Hospice Benefit component had higher average plan enrollment (1,140,000 versus 191,772,  $p < 0.01$ ) and were more likely to be national organizations (38.5% versus 8.3%,  $p < 0.01$ ). Hospice-participating POs otherwise operated in service areas with similar characteristics to nonparticipants, specifically the MA penetration rate and the median income.

**Figure 9.1. Number of POs and Plans Participating in the Hospice Benefit Component, 2021–2022**



SOURCE: RAND analysis of participating plan intervention documents.

Although POs participating in the Hospice Benefit component generally had similar reasons for joining the VBID Model by participating in VBID General (Chapter 2), some PO representatives also noted appreciating the opportunity to provide high-quality palliative and end-of-life care. A PO AI representative stated that palliative care is “part of our mission.” Representatives of some POs that continued their model participation from prior years, like PO H, indicated that they chose to expand implementation of the Hospice Benefit component in additional plans in 2022 without making changes to the benefit design because they wanted to let the benefit offerings mature and because they did not have enough experience to know what to change.

In comparison to nonparticipating plans, Hospice-participating plans were more likely to be D-SNPs (18.4% versus 7.3%,  $p < 0.01$ ) and to offer a \$0 premium (66.1% versus 54.4%,  $p < 0.05$ ). Participants also had similar average maximum OOP limits and were slightly more likely to operate in rural counties (9.9% of counties in the service area were rural versus 6.7%,  $p < 0.01$ ). A higher proportion of their enrollees were dual eligibles (25.4% versus 20.5%,  $p < 0.10$ ), while a smaller proportion were LIS-eligible (19.7% versus 26.8%,  $p < 0.05$ ). While the average age of participating plans' enrollees was the same and they had the same proportion of male enrollees, participating plans had a lower proportion of enrollees who were non-Hispanic White (44.8% versus 61.4%,  $p < 0.01$ ) and a higher proportion who were Hispanic (27.8% versus 9.9%,  $p < 0.01$ ). This is explained by high levels of Hospice Benefit component participation in Puerto Rico: Beneficiaries residing in Puerto Rico accounted for 55% of those enrolled in Hospice-participating plans in 2021 (333,330 of 607,959) and 31% of those enrolled in 2022 (314,528 of 1,025,093), as the number of U.S. mainland participants grew.

In comparison to all Hospice-participating plans, Hospice-participating plans in the mainland U.S. were less likely to be D-SNPs (11.1% versus 18.4%) and to offer a \$0 premium (56.8% versus 66.1%), more likely to operate in rural counties (12.6% versus 9.9%), have lower average total enrollment (8,772 versus 9,404 beneficiaries), have lower proportions of enrollees who were Hispanic (7.8% versus 27.8%), have higher MA bids (\$837.1 versus \$726.8) and Part D bids (\$45.9 versus \$42.6), and have lower MSB costs (\$43.7 versus \$58.8) and MA rebate dollar amounts (\$161.4 versus \$192.7).

Overall, Hospice-participating plans were more likely to participate in other initiatives (PDSS Model, offering UF, SSBCI, and/or new PHRSB). Appendix G provides more detail.

## Hospice Interventions Implemented

### *Palliative Care Services*

All Hospice-participating POs are required to offer non-hospice palliative care services. The Clinical Guidelines for Quality Palliative Care by the National Coalition for Hospice and Palliative Care define *palliative care* as care that “focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care” and “attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness” (National Consensus Project for Quality Palliative Care, 2018). CMS requires all model participants to “have a strategy around access and delivery of palliative care services for enrollees with serious illness who are either not eligible for or who have not chosen to receive hospice services” (CMS, 2021c). However, CMS allows POs to define the criteria that beneficiaries must meet to receive these palliative care services, the types of health care providers to deliver these services, and intensity with which these services are provided.

In the model test applications, all Hospice-participating POs stated that they would offer all aspects of palliative care noted in the Calendar Year 2022 Request for Applications, including palliative care consults, comprehensive care assessments from an interdisciplinary care team, 24/7 access to that care team, care planning, ACP, psychological and spiritual supports, pain management services, access to social and community resources, medication reconciliation, and caregiver support. Four POs (G, L, X, and AN) reported having palliative care services available through their preexisting contracts with hospices and noted that palliative care services delivered as part of the VBID Model were the same as those offered outside of the model. Two POs (X and AN) reported owning their own palliative care programs, and two other POs (G and L) reported contracting with or referring to non-hospice palliative care providers.

### *TCC Services*

Hospice-participating POs are also required to offer TCC to beneficiaries who are eligible for hospice, elect to receive hospice care from an in-network hospice, and wish to receive both hospice services and curative care. CMS allows POs to define their own TCC beneficiary eligibility criteria (for example, specific diagnoses), as well as the types of non-hospice services covered (CMS, 2021c). Some POs, including POs V, X, and AJ, covered all treatments as part of TCC; PO M covered all outpatient services as part of the TCC benefit. These POs generally wanted to avoid any restrictions on what is covered as part of the TCC benefit to minimize confusion regarding the covered services (PO X) and to limit the anxiety of transitioning to hospice as much as possible (PO AJ). A PO AJ representative said:

We just thought it would make a more seamless experience for our members if we continued to offer the services that they had for 30 days, no matter what those services are, and it also would give our providers a chance to be able to have really great goals of care conversations around those services without our members having to have anxiety about dropping anything.

Other POs, however, limited TCC benefits to certain types of services. For example, PO AN focused the TCC benefit on dialysis, noting that doing so removed what it saw as a specific barrier to hospice transition and that this focus also helped certain patients elect hospice care. A PO AN representative said:

I don't want to call it the low-hanging fruit, but there was a gap for these members, and many of our members had expressed that they wanted to . . . they would love to go to hospice, but they just want to continue dialysis, so that was why we chose it.

Other POs wanted to address specific needs of their beneficiary population and chose a number of services to be covered as part of the TCC benefit based on their discussions with providers (PO V) or by mirroring an existing palliative care program (POs M and V). The most

common covered services included chemotherapy or radiation therapy, dialysis, paracentesis, infusions, blood transfusions, and lab testing associated with these services.

The remaining eight POs determined TCC plans on a case-by-case basis and designed their TCC benefits according to what they thought would be most useful to encourage transitions to hospice, as well as what would be financially sustainable.

On the survey, eight POs stated that they offer 30 days of TCC, and three indicated that they do not have a predetermined maximum number of TCC days. The POs that chose not to cap TCC length did so to be flexible in addressing patient needs, to make TCC easier to accept for the patient, and to better support their members. A PO G representative said:

We don't have a maximum. . . . Each member is going to be going through their individual journey. . . . We honestly really believe that we needed to make sure that we did not put guard rails or a set number of days on how they could receive TCC.

The POs that limited TCC to 30 days followed the advice of their hospice providers about what would be clinically appropriate (PO AI), made this decision based on what they believed to be the model standard (PO L), or followed a CMS recommendation (PO R). However, several of these POs stated that they are somewhat flexible with TCC treatments extending past 30 days on a case-by-case basis (POs M, P, and R), assuming that this is part of tapering therapies (POs R and M) or to address an unanticipated care need (PO P). A PO R representative said:

We decided to give a time of 30 days. It's not necessarily if the patient needs . . . step down of the treatment. [If] it's going to take 40 days, 45 days, of course, we are going to accept it. But we needed to establish at least a 30-day time frame to control which type of treatment can be included in the program.

After one year of involvement in the model test, most POs noted that they still had limited experience with providing TCC services, so minimal benefit changes were made based on experiences with the model. PO V representatives noted that they did not change the benefit but rather clarified it so that providers and the PO were on the same page about what was included. While most PO representatives noted having the same qualifying conditions for TCC, PO V noted that they changed the list of covered services for 2022 after identifying necessary ancillary services to existing TCC services. A PO V representative said:

In the beginning, we had basic things on there like chemotherapy and dialysis, but then we got the question: "In order to do this chemotherapy, we have to draw labs to see how this is going, right, so who's responsible for that?" So, then we added labs related to the therapy services.

### *Hospice Supplemental Benefits*

POs may offer hospice supplemental benefits to beneficiaries who elect hospice. POs may choose to limit these hospice supplemental benefits to beneficiaries who receive hospice care from an in-network hospice as part of the model test. Hospice supplemental benefits could

include items and services that extend beyond those included in the traditional Medicare Hospice Benefit, such as additional respite care or access to additional in-home services. CMS allows model-participating POs to target these benefits based on chronic conditions or SES. Eight of the 13 POs participating in the Hospice Benefit component offered hospice supplemental benefits in 2022. Of these, six eliminated cost sharing for inpatient respite care and for hospice drugs and biologicals. One PO offered a \$500 yearly care assistance allowance to address patient needs. Some POs offered other types of supplemental benefits, including additional in-home respite care days, emergency response systems, meals, transportation, in-home support, and a readmission prevention program. Although POs could have targeted hospice supplemental benefits to beneficiaries based on chronic conditions or SES, none chose to do so. Moreover, POs generally did not change their hospice supplemental benefit offerings in 2022.

## Approaches to Introducing Beneficiaries to Hospice Benefit Component Services

PO representatives described four main approaches to introducing Hospice Benefit component services, which varied in terms of how they engaged beneficiaries in this process.

First, PO L offered beneficiaries an optional pre-hospice consultation with care navigators administered by its palliative care program vendor. Navigators also work with providers to make a TCC plan and explain care options. Although PO L representatives indicated that most beneficiaries electing hospice took advantage of this pathway to Hospice Benefit component services, they also described other approaches to identifying eligible members and connecting them with the appropriate services:

Hospice providers identify members that may be eligible for Transitional Concurrent Care through the . . . consult/evaluation process. Many hospices also have a home health division or partner that has been educated to identify VBID-eligible members and evaluate for potential eligibility of Transitional Concurrent Care services that may allow for a timelier transition to hospice (for example, home health patient that is receiving radiation therapy and is delaying hospice election until remaining radiation treatments are completed). [The plan] identifies members that may be eligible for palliative care when a member is discharging from hospice due to extended prognosis or revocation. Members eligible for hospice are also identified during the pre-hospice consultation process. If a member contacts [the plan] for a pre-hospice consult and is ready for hospice care, a referral to hospice is facilitated.

In addition, PO Y representatives indicated that they were going to begin a new initiative to review “upstream utilization” of “other services” and get the palliative care team to contact hospice-eligible beneficiaries earlier in their disease progression. However, the introduction of a pre-hospice consultation was “still in discussion phase” for that PO.

Second, PO G representatives expanded on an existing CM program and long-standing community relationships to create a “more upstream palliative care program” that introduces care conversations and a management process, such that “the care managers and other clinicians working with members can more readily help our members access services.” Representatives noted that doing so helped beneficiaries better understand their care options and helped introduce hospice in the course of their disease progression, which “has delivered quite a bit of value to our members.”

Third, representatives of POs G, P, V, W, and AJ reported that they were educating providers to encourage earlier conversations about hospice or ACP. PO W representatives said that they were focusing on the message that members may choose hospice sooner with TCC. Representatives of PO V mentioned educating providers regarding the three diagnoses eligible for their TCC program, noting that providers are their biggest source for hospice referrals. A representative described offering to coordinate a patient review with providers to help them make earlier referrals to hospice if appropriate:

If a patient comes to the hospice program and the provider is not sure at that time—is this patient eligible for palliative care, is this patient eligible for hospice—we would help . . . that review in coordination with the provider and get that referral to the appropriate service line or send a nurse to evaluate that patient. So, we have a process for that that’s been going on for a long time and helps our patients get screened earlier.

PO P created a decision tree for providers to help facilitate conversations between providers and patients regarding care options, including TCC. A PO P representative stated:

For a new provider, [there is] some initial confusion or concern about what fits in [the TCC] bucket and what does not. We spent a lot of time in helping to think about that from a decision tree perspective. Start with what you’re considering and kind of walk through this process to understand it a little bit better.

Fourth, PO X representatives reported having a new education initiative and an identification system that they believed would be more successful for identifying beneficiaries eligible for palliative care. PO X representatives described shifting from a system that relied on beneficiaries’ scores on the Palliative Performance Scale to an algorithm using claims to make an early identification of beneficiaries eligible for palliative care through VBID:

Our first version [of beneficiary identification process was] rushed out to support the organization in an early phase of the model, but after we released [the Hospice Benefit component], we continued to work on it basically to improve it and to figure out how we can find more innovative ways to create other types of predictors from our claims data warehouse. We actually just released that a couple of months ago and we expect the performance of the model to greatly improve and that the clinical teams will realize it in the referrals, the palliative care, and subsequently into hospice.

Nonetheless, a PO X representative noted that there was no opportunity to introduce palliative care earlier for some beneficiaries because of sudden changes to their disease course, as they can “have this big event and they catapult into high risk, they get into palliative care, and then they expire quickly after.”

Despite the efforts described by POs to promote Hospice Benefit component services, representatives of Hospices K, N, R, S, T, W, and Y reported that they were receiving few to no referrals of VBID beneficiaries to their hospices for TCC or hospice. They also reported that POs were not providing enough education to case managers and referring physicians on how to identify VBID beneficiaries potentially eligible for Hospice Benefit component services. A representative from Hospice N described being concerned that their PO did not provide any outreach to potentially eligible beneficiaries about palliative care, noting that such outreach can improve the likelihood that the beneficiary enters palliative care:

The model [we use to offer palliative care] is different according to the expectations of the health insurance. For example, I have one [PO] that gives me a list of 3,000 patients, and I have to sort that list, identify what patients are at a higher risk, higher need. And then, I am the first contact with that [beneficiary]. . . . Sometimes, [beneficiaries] call the insurance and nobody there knows about this program. I also have this other experience [outside VBID] where I [get a referral for a] patient—the insurance has already talked to the patient, they have already presented the [palliative care] program—the possibility of that patient being admitted in the program is much higher.

## Hospice Networks

Hospice-participating POs are also responsible for setting up hospice networks for the purposes of the VBID Model (CMS, 2021c). Outside of the VBID context, POs typically negotiate favorable rates with in-network providers and encourage beneficiaries to use these providers by setting less-favorable rules for OON care. In 2021 and 2022, model test requirements did not allow POs to enforce such network requirements, and POs were required to pay OON hospices full FFS rates. However, TCC was available only to beneficiaries who selected in-network hospices; POs could also choose to limit the use of hospice supplemental benefits to beneficiaries who selected in-network hospices. In 2022, continuing POs (that is, POs that participated in 2021 and continued in 2022) could implement a formal consultation program that required beneficiaries to have a consult prior to accessing care at an OON hospice. Starting in 2023, CMS has adopted a phase-in approach for POs to develop and meet network adequacy standards for hospice providers.

### *Characteristics of In-Network and Out-of-Network Hospices*

In 2022, 1,168 hospices across all POs provided care to at least one VBID beneficiary, compared with 596 hospices in 2021 (Table 9.1). More than one-fifth (22.3%) of hospices were in network in 2022, up from 17.3% in 2021. Fifty-four hospices (4.6%) provided care as an in-

network hospice to beneficiaries from one participating PO and as an OON hospice for another PO. In general, in 2022, POs' beneficiaries received care from a larger number of OON hospices (ranging from nine [PO AI] to 342 [PO L]) than from in-network hospices (ranging from zero [PO AI] to 74 [PO L]).

**Table 9.1. Number of In-Network and Out-of-Network Hospices Delivering Care to at Least One VBID Beneficiary, by PO**

PO	2021	2021	2021	2022	2022	2022
	All Hospices (N)	In-Network Hospices (N, %)	OON Hospices (N, %)	All Hospices (N)	In-Network Hospices (N, %)	OON Hospices (N, %)
PO G	N/A	N/A	N/A	92	12 (13.0%)	80 (87.0%)
PO L	N/A	N/A	N/A	416	74 (17.8%)	342 (82.2%)
PO M	24	10 (41.7%)	14 (58.3%)	20	10 (50.0%)	10 (50.0%)
PO P	273	46 (16.8%)	227 (83.2%)	325	59 (18.2%)	266 (81.8%)
PO R	51	2 (3.9%)	49 (96.1%)	53	2 (3.8%)	51 (96.2%)
PO T	36	19 (52.8%)	17 (47.2%)	N/A	N/A	N/A
PO V	71	4 (5.6%)	67 (94.4%)	85	4 (4.7%)	81 (95.3%)
PO W	76	4 (5.3%)	72 (94.7%)	78	8 (10.3%)	70 (89.7%)
PO X	9	2 (22.2%)	7 (77.8%)	12	2 (16.7%)	10 (83.3%)
PO Y	30	13 (43.3%)	17 (56.7%)	27	14 (51.9%)	13 (48.1%)
PO Z	88	3 (3.4%)	85 (96.6%)	90	3 (3.3%)	87 (96.7%)
PO AI	N/A	N/A	N/A	9	0 (0.0%)	9 (100.0%)
PO AJ	N/A	N/A	N/A	126	64 (50.8%)	62 (49.2%)
PO AN	N/A	N/A	N/A	18	8 (44.4%)	10 (55.6%)
Total <sup>a</sup>	596	103 (17.3%) <sup>b</sup>	493 (82.7%)	1,168	260 (22.3%) <sup>c</sup>	908 (77.7%)

SOURCE: RAND analysis of data submitted by POs as part of the VBID Model.

NOTE: N/A = not applicable because PO did not participate in that time period.

<sup>a</sup> Totals reflect the distinct number of hospices, deduplicating hospices that provide care to beneficiaries from more than one PO.

<sup>b</sup> Total includes 11 hospices that were in network for one PO and also provided OON care for at least one other PO.

<sup>c</sup> Total includes 54 hospices that were in network for one PO and also provided OON care for at least one other PO.

As in 2021, in-network hospices in 2022 tended to be larger than OON hospices (Table 9.2). For example, 42.7% of in-network hospices served 500 or more beneficiaries every year, while 30.0% of OON hospices were that large ( $p < 0.01$ ). A similar proportion of in-network and OON hospices operated in rural areas (8.5% versus 8.6%) and were for-profit (68.1% for both in-network and OON hospices). Likewise, similar to 2021, a substantially higher proportion of in-network hospices were part of a chain (41.2% versus 23.1%;  $p < 0.01$ ).

**Table 9.2. Characteristics of In-Network and Out-of-Network Hospices Providing Care to at Least One VBID-Participating Beneficiary, 2022**

<b>Characteristic</b>	<b>In-Network Hospices<sup>a</sup> (N = 260) (N, %)</b>	<b>OON Hospices<sup>a</sup> (N = 962) (N, %)</b>	<b>Significance</b>
Size (number of Medicare beneficiaries per year) <sup>b</sup>			<0.01
<50	6 (2.3)	97 (10.1)	
50–100	11 (4.2)	96 (10.0)	
101–249	64 (24.6)	260 (27.0)	
250–499	68 (26.2)	192 (20.0)	
500+	111 (42.7)	289 (30.0)	
< 1% of hospice decedents in freestanding hospice inpatient unit <sup>c</sup>	197 (75.8)	708 (73.6)	0.35
Hospice provides care in rural area <sup>d</sup>	22 (8.5)	83 (8.6)	0.83
Ownership <sup>e</sup>			0.34
For-profit	177 (68.1)	655 (68.1)	
Nonprofit	58 (22.3)	195 (20.3)	
Other	25 (9.6)	93 (9.7)	
Part of a hospice chain <sup>f</sup>	107 (41.2%)	222 (23.1%)	<0.01
Provides care to beneficiaries from more than one PO	54 (20.8%)	169 (17.6%)	0.97

SOURCE: RAND analysis of data submitted by POs as part of the VBID Model.

NOTE: Rows for some characteristics do not add up to 100% because of missing data for a small number of hospices.

<sup>a</sup> In-network hospices include hospices that cared for at least one beneficiary enrolled in a plan participating in VBID Hospice. Hospices can count toward both columns because of varied network engagement with different POs. Columns reflect the distinct number of in-network and OON hospices.

<sup>b</sup> Hospice size was obtained from the 2021 Medicare hospice claims files and was defined as the number of patients, including decedents, live discharges, and patients still under care.

<sup>c</sup> The 2021 Medicare hospice claims files were used to calculate the percentage of patients in a freestanding hospice inpatient unit.

<sup>d</sup> Hospices were defined as rural if more than 80% of patients in the 2021 Medicare hospice claims files lived in a rural zip code and the December 2021 Provider of Services file indicated that the hospice was rural.

<sup>e</sup> Ownership was obtained from the December 2021 Provider of Services file. “Other” includes government and other profit statuses.

<sup>f</sup> Chain status was determined based on web searches.

To examine the types of hospices that POs included in their VBID networks, we compared the characteristics of in-network hospices with those of all other hospices that were in a PO’s service area, regardless of whether the hospice delivered care to any VBID beneficiaries (Appendix M). Forty-six in-network hospices delivered care to no VBID beneficiaries in 2022.

In-network hospices tended to be larger than other hospices in a PO’s service area. Across all POs, 40.2% of in-network hospices were chains; however, this proportion varied widely across POs, from zero to 60.7%. Caregiver reports of hospice care experiences from the CAHPS Hospice Survey were similar in in-network hospices and other hospices in POs’ service areas. The CAHPS Hospice Survey, administered to family caregivers after the death of a hospice patient, assesses hospice team communication, timeliness of care, respectful treatment, help for pain and other symptoms, emotional and spiritual support, and training the family to care for hospice patients at home (CAHPS Hospice Survey, undated).

## *Reasons for Becoming an In-Network Hospice Provider*

As in 2021, the hospice representatives interviewed in 2022 highlighted four main reasons for joining POs' networks, often citing more than one reason.

First, representatives of both in-network and OON hospices planning to join networks indicated that being an in-network provider was critical to their hospices' long-term viability, ensuring that they would be able to care for MA beneficiaries should the hospice carve-in expand (Hospices N, X, Y, AD, AE, AF, and AG). As a representative of in-network Hospice N described it, "We cannot be left out." This rationale for joining a PO's network was particularly salient for hospices serving markets with high MA penetration, such as Puerto Rico, and for hospices not owned by a PO.

Second, in-network hospice representatives expressed interest in increasing options for care at the end of life, particularly through TCC (Hospices R, S, Z, and AC). A representative of Hospice AC, a chain that includes both in-network and OON hospices, noted that being an in-network hospice allows them to offer TCC, which provides additional care options to their patients:

There's so many patients that we would love to take care of, and they need a little bit more additional time. Especially when they get the news that they have a terminal illness. . . . They're not necessarily ready to give up everything right that second. . . . I think with this program, it's just easier for them to process that they are terminal, that they have a six-month prognosis, and [that they can get] the additional services that VBID can provide them.

Third, hospice representatives described wanting to be at the forefront of changes to hospice care in MA and to apply their expertise to help shape these policy changes (Hospices R, S, and AG). A representative of Hospice AG, an OON hospice seeking to enter a hospice network, described it this way:

We want to make sure that we're not only just in-network, but, because [VBID is] so new to hospice [care], that we can be a part of helping shape how that should look. So, working with the payer as a true partner and saying we're the experts in palliative care, we're the experts in hospice, and help them shape what this should look like, so patients can receive the best care moving forward.

Finally, representatives of three in-network hospices (Hospices L, M, and R) noted that joining a PO's network helped them expand their existing relationships with POs. Prior relationships ranged from shared ownership arrangements with POs to having contracts with POs for non-Medicare hospice services.

## *Contracts Between POs and Hospices*

The majority of in-network hospices (Hospices M, N, R, S, T, and W) indicated that there were no changes to the terms of their VBID contracts with POs from 2021 to 2022 and that no changes were planned for 2023. A Hospice R representative described the situation as follows:

There was a conversation, but there was no contract negotiation. It was: “Do we want to continue to be partners? Are you satisfied? Are you happy with our performance?” So, we had that sort of conversation about whether we want to continue. But in terms of detail, like adding specific or changing legal language in the contract, et cetera, it was just sort of a renewal, if you will.

However, some hospices noted that they had hoped that contracts would be updated in the future to increase reimbursement rates (Hospices M, S, and Y), add hospice supplemental benefits (Hospice T), or switch to a timelier and more convenient payment process (Hospice AD).

In describing their current contracts, seven of the in-network hospices we interviewed (Hospices K, L, N, R, W, Y, and AC) indicated that their POs were paying them less than the FFS rate for hospice services (between 5 and 15% less, according to the hospices that specified an amount). Five hospices (Hospices M, S, T, Z, and AD) indicated that their POs were paying them the full FFS rate. Payment terms sometimes differed for hospices within the same PO’s network. As in 2021, representatives of one hospice (Hospice T) reported that the hospice would be eligible for a bonus if it exceeded certain quality measure thresholds (for example, achieving certain CAHPS Hospice Survey benchmarks); however, they noted that the hospice had not been eligible for the bonus yet.

### *Hospice Perspectives on Future VBID Participation*

Representatives of six in-network hospices (Hospices M, N, S, T, W, Z) and one chain with in-network and OON hospices (Hospice AC) indicated that they intend to expand their participation in the Hospice Benefit component by becoming part of the networks of additional POs. As a Hospice T representative explained, “We’re open for census-generating [opportunities] and access to referrals, for sure.” A Hospice W representative also said that participating in additional PO networks would help fulfill the hospice’s “commitment [to] serve the entire community.”

Similarly, Hospice Y representatives discussed a plan to join the network of a different PO operating in their service area, noting that the hospice would not plan to renew its existing PO contract if it continued to receive few referrals and if the payment terms remained unfavorable.

Representatives of the other in-network hospices (Hospices K, R, and AD) indicated that they intended to stay in the same POs’ networks in the future. Representatives of in-network Hospice K did express concerns, however, about ongoing participation in their PO’s network if payment and other terms of their contract did not improve:

I think my next step is going to be to sit down with [PO representatives] . . . and just say: “Hey, can you work with us? Can we make this viable? Because it’s not.” And if that doesn’t go anywhere, then I think we have to take a hard look at just saying we’re not playing in the VBID space any longer. I hate to do that because there’s a chance that this becomes law, and then we’re going to be forced into that space. And we want to be able to influence that in a way that’s going to be best for patients and families. But I’m only going to take a financial

beating for so long to be able to do that. And if we can't get value by taking this loss, by working with [PO], then why am I taking that? There's just no reason to go through that if we can't see value for patients and families and if we can't get actual change.

OON hospices expressed mixed levels of enthusiasm for joining POs' networks in 2023 and beyond. Representatives of two hospices (AB and AE) conveyed strong interest in joining networks. Hospice AB representatives indicated that they are seeking to be in-network with all POs in their service area: "We don't have a choice. . . . How are you going to get the patients if you're not in-network?" In contrast, representatives of Hospices G and AA expressed more caution about joining POs' networks. A Hospice G representative said:

I think if the right opportunity came along that was within our service area that would help us get our arms around certain clusters of patients or certain areas where there's a significant need for our services, then we're not opposed to it. I don't think it's fair to say that we're actively seeking this but again, I think if the right call came through, we're absolutely happy to get to the table.

As in 2021, representatives of two OON hospices (G and X) noted that reduced reimbursement rates would prevent them from participating in POs' networks. Representatives of OON Hospices X and AA also cited the administrative steps of the model test as a barrier to their future participation. A Hospice X representative said:

The rates are key . . . the other thing would of course be the administrative requirements. Do we have to get prior authorization? . . . Could it delay care to this very vulnerable population?

Representatives of Hospice AA also noted that their small hospice would find it burdensome to file different paperwork and follow different billing procedures for VBID beneficiaries than for other patients.

## Implementation Experiences

Hospice-participating POs had different perspectives on the ease of implementing the model. Four POs (M, P, X, and AN) reported that implementation was a small lift, while three other POs, all of which were new to the Hospice Benefit component in 2022, described it as a major lift (G, L, and AJ). Representatives of two POs (V and AI), one continuing its VBID participation and another one new Hospice Benefit component participant in 2022, reported that their experiences were "somewhere in the middle" (PO AI) of small and major lifts.

In general, continuing Hospice Benefit component participants relied on existing workflows and processes that were previously implemented, resulting in an easier implementation lift. For example, a representative from PO X described building off existing processes from 2021 to implement VBID in 2022:

We've continued a lot of the work in the interventions that were implemented last year. . . . In terms of lift, it wasn't a heavier lift. I think we've put a lot of

effort into making enhancements, adjusting workflows just to ensure that we identify all the integration points. It's a very seamless process internally, and then ultimately seamless for the members and caregivers.

In contrast, a representative from PO AJ, a new Hospice Benefit component participant, considered implementation to be a heavy lift and discussed the need to keep track of many moving pieces, including data analytics, communication, and beneficiary experience:

There's tremendous gravity associated with pulling off implementation of the Hospice [Benefit component] VBID program and . . . making sure that we're working closely with our health care informatics teams to be getting that feedback in terms of how this is going as a whole. There's this sort of multilevel looks that we've been introducing since the start of the year when the program began, where we're paying close attention to what's happening daily with providers, provider communication, and provider customer service, what's happening daily with members and what members are facing, and files that we're receiving from CMS.

## Implementation Challenges

### *PO Perspectives*

As in 2021, we sent PO representatives a pre-interview survey and asked them to rate challenges they experienced while implementing the Hospice Benefit component. Below, we describe the results provided by representatives of 12 of the 13 POs that implemented the Hospice Benefit component in 2022 and supplement them with findings from our interviews with the representatives of 11 POs. Table 9.3 provides a summary of survey responses about implementation challenges and notes differences in reported challenges between continuing and new POs to the Hospice Benefit component in 2022. The results are organized along four categories of challenges: administrative processes, communication and training, care delivery, and creating and maintaining a hospice network.

Administrative processes seem to be the most challenging aspect of Hospice Benefit component participation, given that many administration processes received a median rating of “moderate” on a five-point scale that ranges from 1 = “not at all” to 5 = “a great deal.” Across categories, new POs reported experiencing greater challenges than continuing POs, which suggests that there is a learning curve.

**Table 9.3. PO Survey Responses on Hospice Benefit Component Implementation Challenges (N = 12)**

<b>Implementation Challenges</b>	<b>Not at All</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Considerably</b>	<b>A Great Deal</b>	<b>Not Applicable</b>	<b>Median (All POs; N = 12)</b>	<b>Median (Continuing POs; N = 7)</b>	<b>Median (New POs; N = 5)</b>
<b>Administrative processes</b>									
Identifying beneficiaries eligible for palliative care, TCC, or hospice	3	4	3	1	0	1	Slightly	Slightly	Slightly
Receiving notices of election (NOEs) in a timely manner	0	5	4	0	3	0	Moderately	Slightly	A Great Deal
Reporting data as part of model participation activities	1	4	2	3	2	0	Moderately	Slightly	Considerably
Processing hospice claims	0	3	7	1	1	0	Moderately	Moderately	Moderately
Distinguishing care related and unrelated to terminal condition during claim adjudication	0	6	2	1	3	0	Slightly/moderately	Slightly	Considerably
Tracking care plans for beneficiaries in hospice	2	1	3	2	2	2	Moderately	Moderately	Considerably
Working with vendors or subcontractors that help implement your VBID intervention(s)	2	4	4	0	0	2	Slightly	Slightly	Moderately
<b>Communication and Training</b>									
Training providers about availability of palliative care, TCC, or hospice	1	5	3	1	2	0	Slightly/moderately	Slightly	Moderately
Communicating with hospices about beneficiary eligibility and claims processing	0	4	4	2	2	0	Moderately	Slightly	Considerably

<b>Implementation Challenges</b>	<b>Not at All</b>	<b>Slightly</b>	<b>Moderately</b>	<b>Considerably</b>	<b>A Great Deal</b>	<b>Not Applicable</b>	<b>Median (All POs; N = 12)</b>	<b>Median (Continuing POs; N = 7)</b>	<b>Median (New POs; N = 5)</b>
Communicating with beneficiaries about their potential eligibility for palliative care, TCC, or hospice	3	5	2	1	0	1	Slightly	Slightly	Slightly
Communicating with beneficiaries about the benefits of receiving care from in-network hospices	1	5	2	1	0	3	Slightly	Slightly	Slightly/moderately
<b>Care Delivery</b>									
Provision of hospice supplemental benefits to eligible beneficiaries	3	3	1	0	0	5	Slightly	Slightly	Not at all
Managing transitions between palliative, TCC, and hospice care	2	7	1	1	1	0	Slightly	Slightly	Slightly
Coordinating TCC between hospices and other care providers	1	4	2	0	2	3	Slightly	Slightly	A Great Deal
<b>Creating and Maintaining a Hospice Network</b>									
Establishing a network of hospices	2	3	2	2	2	1	Moderately	Slightly	Considerably
Negotiating hospice payments	2	4	0	2	0	4	Slightly	Slightly	Slightly/moderately
Promoting hospice network adequacy	4	3	1	2	2	0	Slightly	Slightly	Moderately

SOURCE: RAND analysis of 2022 PO survey data.

## Administrative Requirements

From the PO perspective, such administrative processes as tracking care plans and processing hospice claims continue to pose moderate implementation challenges, especially for new model participants. In particular, PO representatives described having to change their process for receiving NOEs in a timely manner. A representative from PO AI, a new PO in 2022, reported that they had to set up a special mailbox for NOEs and often had to “chase” hospice providers for the NOE. In addition, representatives from PO L, a continuing PO that added a Hospice Benefit component intervention in 2022, discussed the need to have their organization’s “systems basically reconfigured to accommodate those claims.”

Representatives from both new and continuing POs also explained how revocation of hospice (that is, when a beneficiary no longer wishes to receive hospice benefits) for a beneficiary in VBID contributes to additional implementation challenges compared with administration of hospice for commercial plans (POs W, AI, and AN). Although representatives from POs AI and AN were under the impression that revocations are occurring as frequently and for the same reasons as before the VBID Model, PO AI representatives noted that there was a delay in POs receiving notices of revocation because these are sent to Medicare directly rather than to the PO. As with NOE tracking, POs have implemented new strategies, including creating new information systems for revocation notification by a hospital or provider (PO W) and provider education (PO AI). However, some POs reported still facing additional administrative burden as a result of revocation and reelection.

Generally, POs reported that identifying beneficiaries eligible for palliative care, TCC, or hospice was less of a challenge in 2022. In 2021, POs considered beneficiary identification to be a moderate challenge, but in 2022 it was considered a slight challenge by both new and continuing POs. Lastly, new POs rated working with vendors or subcontractors as moderately challenging, while continuing POs rated it as slightly challenging.

## Communication and Training

Overall, POs rated issues related to communication and training as slightly challenging in 2022. New POs rated communicating with hospices about beneficiary eligibility and claims processing and training providers around the availability of palliative care, TCC, or hospice as considerable challenges; in contrast, continuing POs rated these issues as slightly challenging. A representative from PO V described some providers’ lack of awareness about VBID by saying that they “may or may not be fully aware of the VBID Model, or they may not really always capture when that patient is eligible for hospice in a timely manner.”

Communicating with beneficiaries remained a slight challenge for both new and continuing POs in 2022, including communicating with beneficiaries about their potential eligibility for TCC, palliative care, and hospice, as well as communicating with beneficiaries about the benefits of receiving care from in-network hospices. POs also described acceptance of the need

for end-of-life care as a barrier to engaging in discussions around hospice care, which can be emotionally and/or culturally challenging for beneficiaries and their family members. A representative from PO AN described a lack of understanding around hospice care:

Some people hear about it [hospice] and it's: "Oh, we're just letting them die and we're not going to do anything" versus "We're providing a higher quality of end-of-life care for you that lessens the suffering and improves the individual's quality." I don't think that's really well understood by the majority of people in this country.

### Care Delivery

Overall, POs rated care delivery processes as slightly challenging, largely consistent with 2021 findings. For example, representatives from three POs reported that the provision of hospice supplemental benefits to eligible beneficiaries was slightly challenging. Representatives from PO AJ, a new model test participant, reported that getting the Hospice Benefit component running was labor intensive and that they would turn to supplemental benefits later, whereas representatives of PO L, also new to the Hospice Benefit component in 2022, noted that adding in supplemental benefits would be too costly given the expected costs of implementing TCC.

For both new and continuing POs, managing transitions between palliative care, TCC, and hospice care was slightly challenging. New POs reported a great deal of challenges with coordinating TCC between hospices and other care providers, whereas continuing POs noted that this was slightly challenging. POs also reported that the model test has the additional complexity of needing to determine which of the services provided were related or unrelated to a terminal condition, as well as when each service was provided, to determine benefit eligibility. For example, a representative from PO AN described challenges related to transitions and TCC particularly for patients who receive dialysis and noted a need to track information to ensure that the dates match for dialysis treatments as part of TCC.

### Creating and Maintaining a Hospice Network

While representatives from continuing POs generally considered the process of hospice network building, negotiating hospice payments, and ensuring network adequacy to be slightly challenging, representatives of new POs rated these activities as moderate to considerable challenges. A representative from PO AI, a new model participant, stated that establishing a hospice network was more complicated than it seemed particularly because of the definition of TCC:

[Consultants and lawyers from hospices] wanted more specific language on the Transitional Concurrent Care and, and it's really not so easy to just put a list together. It's based on the individual member's needs. And it could be different in every situation, so, you know . . . we can't tell you on every case what it's going to be.

A representative from PO X, a continuing model participant, felt that they had to educate hospices during the contract negotiation process on the differences between working with Medicare directly and contracting with POs:

Part of it is that the agencies are so accustomed to dealing with Medicare, but this is a change for them, so they need to be educated about the whole VBIID program and why it's necessary to establish this new agreement and then reassure them that nothing is changing so far as the process is concerned, the way that they bill and so forth. But they're dealing with us rather than Medicare; that seems to be a bigger struggle.

In keeping with hospices' reports that they had not renegotiated their contracts with POs from one year to the next, several continuing POs noted that they did not experience any challenges with payment negotiations this year because they have not updated their contracts with in-network hospices.

### *Hospice Perspectives*

Hospices reported three specific challenges in 2022: a burdensome billing process that resulted in delayed payments, more PO oversight of hospice care delivery, and challenges implementing TCC and hospice supplemental benefits. Two of these challenges (the billing issue and the difficulty implementing TCC and hospice supplemental benefits) parallel challenges raised by POs. While the challenges that hospices reported in 2022 were similar to those reported in 2021, hospice representatives reported that challenges diminished during their second year of implementation.

### **Billing Processes and Payments**

Similar to POs' reports regarding administrative effort required to participate in the Hospice Benefit component, representatives from 12 hospices described experiencing significant administrative burden. Claims submission to both POs and Medicare was the most commonly mentioned issue because doing so often required manual data extraction to submit NOEs and claims to the PO. A representative from Hospice AD reported, "It's been a burden on our biller from manually adding information, because our software does not talk to [the PO's system] the way they need it to."

Some hospices reported improvements in their claims submission process in 2022, which they attributed to working closely with POs to resolve issues. However, four OON hospices (AA, AB, AE, and AF) reported significant delays in receiving payments compared with the two-week turnaround by Medicare. These delays, which ranged from a few weeks to up to six months, have created cash flow problems that exacerbated existing financial issues faced by some hospices. A Hospice AB representative said, "Right now for a hospice company, it's very important—especially after the labor costs increased so much—to have those payments come on a timely basis."

As in 2021, hospice representatives still felt that the process of resolving originally denied claims was labor intensive and time consuming. Hospice R, S, and T representatives, however, felt that ongoing communication with POs helped resolve most of these issues. A representative from Hospice R said, “It’s actually a little smoother because the first year, you’re kind of sort of figuring it out. There was a lot of data that had to be collected and that was actually very cumbersome . . . and then that was streamlined.”

#### PO Reporting Requirements and Oversight

Representatives from five in-network hospices reported challenges with PO reporting requirements and oversight. The most common concern was related to administrative burden associated with reporting, as hospice representatives had to manually extract data, create new reporting templates, submit regular reports, and sometimes attend case conferences (that is, discussions of individual patient cases conducted to facilitate CM) to meet various PO requirements. Hospice K representatives reported having to submit different types of reports and deliver some of them on a daily basis:

We still have multiple FTEs [full-time equivalents] of individuals who are dedicated to monitoring data, extracting data, creating reports of data. This is on a weekly, monthly, and quarterly cycle. Actually, daily, weekly, monthly, quarterly cycle because in hospice, it’s a daily reporting that they do back to [the PO]. . . . I don’t know how a hospice that doesn’t have the size and scope of ours could even pretend to survive in this environment, especially when you’re looking at having nine payers, not one.

In-network hospices M, S, and T reported having regular case conferences with POs to discuss VBID beneficiary cases, noting that this could become burdensome if the number of VBID beneficiaries increases. A Hospice S representative noted: “We do [have] actual interdisciplinary team [meetings] with them. We go through every member that’s on service . . . . And so, it can be quite labor-intensive.” Although Hospice T representatives agreed that these case reviews are important, they noted that the process could be streamlined to reduce duplications with other types of reporting required by the PO:

Having separate conferences to discuss these VBID patients with the health plan is like an additional process that we have to do. I’m hoping that if they can get alternative reporting, like we send out our care plan discussions from our [interdisciplinary group] meetings, that they can have it. That would be, I think, better. . . . I just feel like there’s a duplication.

#### Transitional Concurrent Care and Hospice Supplemental Benefits

Representatives from eight in-network hospices reported challenges with implementing TCC and delivering hospice supplemental benefits, echoing PO-reported challenges related to care delivery. Most of the hospices’ concerns stemmed from small volumes of TCC referrals to the hospice, driven by a perceived lack of engagement from the POs in proactive identification

of beneficiaries most likely to benefit from TCC and explaining the benefits of TCC. Hospice W representatives said that they

went through the 104 [beneficiaries receiving hospice services] and none of the beneficiaries had been contacted or was aware of their benefits as related to being on service with hospice. . . . There was no inherent communication that we can determine that [the PO] reached out to the member.

Similarly, hospice representatives argued that TCC benefits were underused due to such implementation challenges as issues with defining the TCC benefit and providing education to providers on how to identify and refer these beneficiaries to TCC services. Representatives from Hospices L, R, S, W, and AD noted issues with defining what is and what is not included in TCC. Hospice L representatives also complained about not having enough cases of and experience with TCC to sufficiently define it with their PO and to know what services will and will not be covered. A Hospice R representative described this lack of clarity as leading to underuse of TCC:

The concurrent care part of the VBID Model is floundering. It's not well understood. . . . And whether it's just not understanding or [PO] doctors not understanding or the word's not out or whatever, we've had very, very few patients who have taken advantage of that and utilized what we would have called aggressive care or active care for their end-stage diagnosis.

Hospice K representatives reported having continued difficulties with implementing such hospice supplemental benefits as in-home respite services, noting that it was difficult to coordinate staff, particularly given workforce shortages. Hospice W representatives similarly reported that their PO required that in-home respite care be provided by a certified nursing assistant, which limited the pool of available staff. This hospice also felt that the home modification benefit was “not practical.” Representatives of Hospice Z—a new VBID participant—noted that they did not have the bandwidth to set up a data and logistics system to implement any hospice supplemental benefits yet but planned to do so in future years of model test participation.

Hospices with contracts with multiple POs reported challenges associated with variability in the Hospice Benefit component services that each PO offers. Each contract has a unique set of TCC services, hospice supplemental benefits, and eligibility requirements, which increase hospices' administrative burden. A representative from Hospice S said:

One of the challenges is the variability between the actual payer contracts. So, everything from supplemental benefits that the payer can offer vary from payer to payer, and also the transitional concurrent services vary from payer to payer.

## Summary

In 2022, 109 plans from 13 POs participated in the Hospice Benefit component, more than double the number of plans that participated in 2021. Five new POs began participating in 2022, while one PO left the model between 2021 and 2022.

In comparison with nonparticipants, 2022 Hospice-participating POs had higher average enrollment and were more likely to be national organizations; they were located in areas with similar MA penetration and median income levels as nonparticipating POs. A higher proportion of enrollees were dual eligibles, but a smaller proportion were LIS-eligible. Participating plans had a lower proportion of enrollees who were non-Hispanic White and a higher proportion who were Hispanic than nonparticipating plans, because of high levels of Hospice Benefit component participation in Puerto Rico.

The range of palliative care services offered was similar across POs, with some contracting with in-network hospices to provide palliative care and others relying on contracted palliative care providers or groups. While some POs covered all treatments as part of TCC, others limited TCC benefits to certain service types or determined TCC plans on a case-by-case basis. Most POs limited TCC to 30 days, but some did not impose a cap on the benefit. Six POs offered a hospice supplemental benefit that eliminates cost sharing for inpatient respite care and hospice drugs and biologicals. Six POs offered other types of hospice supplemental benefits, such as a \$500 yearly care assistance allowance and additional in-home respite care days.

Across all POs, 1,168 hospices provided care to at least one VBID beneficiary in 2022, compared with 596 hospices in 2021. Approximately one in five of these hospices were in-network, and these hospices tended to be larger and more likely to be part of a chain than OON hospices. Hospice care experiences were similar in in-network hospices and other hospices in POs' service areas. As in 2021, hospices cited many reasons for joining PO networks, including ensuring that they would be able to care for MA beneficiaries, should the Hospice Benefit component be expanded throughout MA; increasing care options at the end of life, particularly through TCC; wanting to be at the forefront of changes to hospice care in MA; and expanding on existing relationships with POs.

Most POs did not change the terms of their contracts with hospices from 2021 to 2022. The vast majority of hospices in our sample indicated their intent to continue or begin contracting with participating POs. However, some hospices expressed reservations about lower reimbursement rates than Medicare Hospice and burdensome administrative processes.

Participating POs, particularly those new to the Hospice Benefit component and in-network hospices, described challenges with the model's administrative processes, especially claims processing. Some hospices noted that their payments were often delayed, placing a strain on cash flow. In-network hospices also described challenges in defining TCC and identifying beneficiaries eligible for it and noted that variability in POs' benefit designs increased administrative burden for hospices participating in more than one PO network.

## Chapter 10. Beneficiary Experiences, Utilization, and Care Quality

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### Key Findings

- Use of Hospice Benefit component services in 2022 was similar to 2021.
    - Across all POs, a total of 5,673 beneficiaries received palliative care. This was lower than most POs' expectations.
    - TCC and hospice supplemental benefit uptake was very low: Across all POs, a total of 152 beneficiaries received TCC, and 1,233 received any hospice supplemental benefit.
    - Of all beneficiaries enrolled in plans participating in the Hospice Benefit component, 19,065 (approximately 1.9%) received hospice care.
    - Almost half of VBID beneficiaries who enrolled in hospice received care from an in-network hospice (47.8%), an increase from 37.3% in 2021.
  - We found no association between Hospice Benefit component implementation and changes in hospice enrollment or care patterns in 2021.
  - We found a small to medium, statistically significant increase in a summary measure of caregiver-reported hospice care experiences in 2021 (2.59 points,  $p = 0.02$ , 95% CI: 0.39 to 4.79), meaning that caregivers of VBID beneficiaries who died while receiving hospice care reported experiences that were, on average, more positive than those reported by caregivers of comparison beneficiaries. This finding appears to be driven primarily by reported care experiences for beneficiaries who live in Puerto Rico.
  - We could not fully account for underlying differences between hospice-eligible and comparison beneficiaries in our analysis of 2021 data, so it is possible that our estimates either overstate or understate true effects attributable to the Hospice Benefit component, beyond uncertainty represented in CIs.
  - Hospice representatives indicated that hospice supplemental benefits offered by their POs that reduce or eliminate cost sharing do not meaningfully change OOP costs for beneficiaries, because, even outside the Hospice Benefit component, the hospices never charge patients copays for hospice services or medications.
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In this chapter, we report observations from interviewed POs, hospices, and beneficiaries regarding Hospice Benefit component services in 2022, and we use data reported by POs to CMS as part of model monitoring activities to describe **utilization of palliative care, TCC, and hospice supplemental benefits**. We use lists of network hospices provided by POs to CMS and preliminary hospice claims data for 2022 to describe **hospice utilization** at both in-network and OON hospices across POs.

We also used DD modeling to compare outcomes of interest in the period before and after the Hospice Benefit component's introduction (2019 and 2021, respectively, excluding 2020 due to COVID-19). These regression analyses focused on **hospice enrollment and care patterns** using data from Medicare hospice claims files and **caregiver-reported hospice care experiences** based on data from the CAHPS Hospice Survey.

## Palliative Care

### *Palliative Care Utilization*

Palliative care utilization was much lower than most POs expected in 2022. In 2022, a total of 5,673 beneficiaries received palliative care or care from a similar program, with individual POs serving between 63 beneficiaries (PO Y) and 2,178 beneficiaries (PO L; Table 10.1). Across all POs, the proportion of all beneficiaries enrolled in Hospice-participating plans who received palliative care ranged from 0.1% in PO AJ to 17.7% in PO AI. Among those beneficiaries who received palliative care, the average number of days in care was 133.2, with a range from 2.8 (PO Z) to 218.5 (PO X) days. As in 2021, the wide variation in number of beneficiaries and length of palliative care use might be related to beneficiary diagnoses, the setting in which the care is delivered (for example, hospital, outpatient, or home), the types of services provided, and variation in the types of services and encounters that POs include when reporting palliative care utilization to CMS.

**Table 10.1. Number of Beneficiaries Receiving Palliative Care and Palliative Care Length of Stay, by PO**

PO	2021	2021	2021	2022	2022	2022
	Number of Beneficiaries	Average Number of Days	Percentage of Beneficiaries	Number of Beneficiaries	Average Number of Days	Percentage of Beneficiaries
PO G	N/A	N/A	N/A	121	90.9	0.4
PO L	N/A	N/A	N/A	2,178	165.5	0.7
PO M	178	49.0	0.7	185	44.6	0.7
PO P	720	128.7	0.5	964	106.9	0.6
PO R	446	206.8	0.5	356	109.7	0.4
PO T	308	123.1	2.6	N/A	N/A	N/A
PO V	80	53.7	0.4	97	93.0	0.5
PO W	357	105.5	0.2	849	167.9	0.4
PO X	82	162.8	2.7	203	218.5	4.1
PO Y	0	N/A	0.0	63	34.2	0.2
PO Z	425	3.0	1.1	269	2.8	0.7
PO AI	N/A	N/A	N/A	175	98.6	17.7
PO AJ	N/A	N/A	N/A	102	3.5	0.1
PO AN	–	–	–	111	141.4	0.5
All POs	2,596	111.4	0.4	5,673	133.2	0.6

SOURCE: RAND analysis of data submitted by POs as part of the VBID Model.

NOTE: N/A = not applicable because PO did not participate in that time period. The dash for PO AN in 2021 indicates that the PO had data quality issues that prevented it from accurately reporting the number of beneficiaries receiving palliative care during 2021.

## *PO and Hospice Perspectives*

PO perspectives on palliative care utilization varied substantially. Although half ( $N = 6$ ) of the 12 POs responding to our survey noted that palliative care utilization increased or was expected to increase in 2022, five reported that it did not change, and one PO stated that it decreased. During the interviews, representatives of one new and one continuing Hospice-participating PO reported that palliative care utilization was “right on track” (PO V and PO AJ). PO W representatives attributed its increase in palliative care utilization to educating providers about benefits of palliative care. A PO X representative reported implementing an intervention to educate beneficiaries and their family members about Hospice Benefit component benefits and another one to help identify beneficiaries. The representative described the resulting increase in palliative care utilization as proof of success:

For 2022 through June, we’ve already exceeded the number of members enrolled into palliative care for the entire year of 2021. . . . All the efforts and strategies that we’ve put in place have certainly contributed to the increase in the numbers of members that have enrolled in palliative care.

That said, PO M representatives reported that the uptake of palliative care was still lower than expected and suspected that the pandemic was affecting this trend without knowing why this might be the case. A representative said:

I really don’t have a number that I could, you know, to compare it to. Just my gut was I thought we’d have better engagement. But as the year is going on and the education is going out to providers, we are seeing more people take advantage of it.

Representatives from some hospices also noted an increase in uptake. Hospice N representatives reported a substantial increase in the number of beneficiaries to whom they delivered palliative care, which they attributed to an expansion of their service area prompted by market information received through participation in a PO network. This information encouraged them to open a new office to reach more patients. A representative said:

[VBID Hospice] provided me access to a list of patients that [sic] were located all over the [geographic area]. . . . it’s not like I’m having this tremendous influx of patients due to VBID, but because we are now covering a larger territory. When the VBID [Model] started, we went out and talked about VBID and explained to people that we were part of this network . . . [talked to] providers. So that allowed us to increase our census.

However, as described in the 2021 report (Khodyakov et al., 2022), Hospice K representatives reported very limited impact on palliative care utilization attributable to the Hospice Benefit component. In a 2022 interview, a representative of this hospice added, “Referral patterns have not changed, and our volume in palliative care has been minimal, if any. So, we have not seen growth in the VBID population.”

## *Beneficiary and Caregiver Experiences*

As part of our evaluation activities, we conducted 33 semi-structured interviews with beneficiaries who received palliative care as part of the VBID Model in 2021 and/or their caregivers. We identified these beneficiaries based on the information Hospice-participating POs submitted to CMS. Our interviewees were from eight POs (M, P, R, T, V, W, X, and Z). We were able to speak with 19 beneficiaries and 15 caregivers (we interviewed caregivers if beneficiaries were deceased or too ill to participate in the interview.) Interviews focused on beneficiary and caregiver experiences with palliative care, including referrals, location and mode of delivery, description of a typical visit, strengths and areas for improvement in terms of the support provided, and discussions around hospice care. Appendix B provides additional information about our sampling and methods.

Interviewed beneficiaries and caregivers described different referral sources to palliative care. More than one-third (39%,  $N = 13$ ) of participants reported that they learned about palliative care from a specialist, such as an oncologist, a PCP, or a social worker. One-third (33%,  $N = 11$ ) reported learning about palliative care after an acute event, such as a hospitalization. As one caregiver put it: “When we were in the hospital, the doctors there suggested the palliative care for his pain, and because it was so ongoing and it was so great, that they helped us get all that kind of straightened out, but they felt like that would help.”

Among our interviewees, 27% ( $N = 9$ ) reported hearing about palliative care from their health plan. For example, one beneficiary said: “Well, my daughter told me that the health plan called her to offer me that service. And my daughter, well, anything that is for my health, she takes it.”

Beneficiaries and caregivers fell broadly into one of the three categories of awareness and understanding of palliative care. First, less than half of our interviewees (42%,  $N = 14$ ) understood both the term *palliative care* and what care and services were included as part of palliative care.

Second, 27% ( $N = 9$ ) of interviewees were neither familiar with the term *palliative care*, nor did they understand what palliative care entailed.<sup>8</sup> As one beneficiary candidly noted: “Look, I am going to be very honest. I don’t know what *palliative* means.” Our interviewees often did not know which services they received would be considered palliative care and struggled to differentiate specialties among their providers. Another beneficiary described confusion about palliative care and who on the care team was involved in providing this care:

I don’t know what it’s [palliative care] supposed to entail. I did have a nurse come to change the bandage occasionally on my wound that I had, to me that’s home health care . . . and palliative care I still don’t know what that is supposed

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<sup>8</sup> In two cases, we were unable to interpret the participants’ awareness and understanding of palliative care from their responses.

to entail. Is it supposed to entail these nurses that came to my house? Is it supposed to entail the therapists that came to my house?

Finally, the third group of roughly one-quarter of interviewees included those who either did not recognize the term *palliative care* but described palliative care services correctly (15%,  $N = 5$ ) or confirmed that they were familiar with the term *palliative care* but did not know what palliative services entailed (9%,  $N = 3$ ). Regardless of their awareness or understanding of palliative care, two beneficiaries described their dislike of the term *palliative care* because it was considered “depressing.”

Participants often talked broadly about their health care experiences and with a variety of health care providers. They reported on overall experiences with the interdisciplinary nature of the care they received, including care from specialists (for example, pulmonology, oncology), home health aides, and other providers, such as physical therapists, social workers, or nurse practitioners. These included direct care for assistance with ADLs (for example, showering, toileting, bathing) in addition to help with ordering medical supplies, such as catheters, gloves, or home equipment. One beneficiary described some of these additional services received: “They helped me bathe, they kept up the switches, they change the bandages . . . the dressing on the cuts, help me learn how to get in and out the bed.”

In describing a typical palliative care visit, the majority (73%,  $N = 24$ ) of beneficiaries and their caregivers reported receiving this type of care in the home. A smaller number of interviewees (33%,  $N = 11$ ) reported receiving care in a clinic or doctor’s office, and 24% ( $N = 8$ ) reported receiving care in a hospital. We note, however, that some reported receipt of care in more than one location. While all interviewees reported receiving care in person, 21% ( $N = 7$ ) also reported receiving care by phone, and 15% ( $N = 5$ ) reported using a video call to engage with providers. Visits often included a provider who took vital signs, ordered bloodwork and other tests, changed wound dressings, and discussed and checked medications. Some interviewees mentioned that a social worker provided emotional support or counseling and that a chaplain offered spiritual care, such as prayer. Our interviewees reported variation in the length of time of receipt of palliative care, ranging from four days to the past ten years. Such variation could be explained by some beneficiaries and caregivers including nonpalliative care services in their estimates.

Our interviewees provided very positive feedback about what they thought was the palliative care they received and were more likely to highlight the quality of that care as opposed to the types of services received. Beneficiaries and their caregivers generally appreciated that providers were compassionate and caring, were attentive to the beneficiary’s needs, listened carefully, and were clear in their explanations. For example, one caregiver described how the beneficiary’s provider helped them understand the beneficiary’s condition: “They give me an understanding of what’s going on and helped me to do for him better around here.” Most interviewees (85%,  $N=28$ ) also mentioned feeling that their provider understood what was important to them and noted that they could trust their provider.

Because palliative care is a multidisciplinary specialty focused on providing physical, emotional, and spiritual support, we describe satisfaction with three main components of palliative care: pain and symptom management, psychosocial support, and social and spiritual support. First, beneficiaries noted that they were pleased that their provider helped them with their physical needs, most notably by providing support for pain and symptom management. Interviewees appreciated that their providers checked their pain and often adjusted their medications to help with pain and symptoms related to their life-limiting illness. One beneficiary described how their provider helped them with their pain and coordinated their medication: “Well, they always check my pain level. . . . I would tell them if I was having pain, they got in contact with my doctor about the medication increase, decrease, or changes on the medication.”

Interviewees also described support from their providers for their psychosocial and emotional well-being. Providers were generally attuned to their needs and offered suggestions and advice for improving the beneficiary’s quality of life. In addition, a few beneficiaries discussed the emotional challenges they faced coping with a life-limiting illness and how a social worker provided psychosocial support. One beneficiary described receiving emotional support from their provider:

Well, they [providers] tell me that despite this [condition] I have my life to live for. There is no cure, I don’t have my legs which is what I’d want, but I have life, I have an excellent mother that cares for me, and I have lots to be thankful and live for. And that was really good to hear, that I can learn to live with this, and despite the negative there are positive things in my life, that I can find other things that bring me joy.

While less commonly mentioned than the above two domains, roughly a third of our interviewees (36%,  $N=12$ ) described positive experiences with members of their interdisciplinary care team, including social workers and chaplains who provided social and spiritual support as part of their serious illness care. A beneficiary described positive interactions not only with the nurse who provided medical care but also with social workers and the chaplain:

All the social workers are very caring. The nurse cares for me, she stays a little while to speak with me. The chaplain prays with me. . . .The chaplain asks if I have gone to church, how my faith is, he knows I am a very faithful person, he prays with me a while, and prays for me.

Of the 33 individuals we interviewed, 42% ( $N = 14$ ) reported that they had a conversation about hospice care with a provider, either their primary care or palliative care provider (note that these 14 beneficiaries were not the same as the 14 identified as having an understanding of palliative care, above). Some participants recalled conversations with a provider about hospice care at the onset of their serious illness or diagnosis, which for some was a few years prior. As one beneficiary noted, they initially had a conversation upon learning about their diagnosis:

“Well, we had talked about [hospice care] because, like I said, the diagnosis was pretty horrific, so we knew we wanted to make sure everything was in place.”

Some interviewees noted their anxiety or ambivalence regarding hospice care because they were aware that it meant that they would be at the end of their life. Furthermore, some reported that they or their family members were “not ready” for hospice care, signaling that transitioning to hospice may indicate an acceptance of ending curative treatment. For example, a caregiver stated: “I feel that that [hospice] would be if the person wants to be in their last days, like if they have a serious condition like cancer and that they’re dying.” Similarly, another caregiver described the beneficiary’s lack of readiness to discuss hospice care:

Well, one of the earlier visits, [the provider] brought the booklet to talk about end of life. We do have a living will and a power of attorney for health care and all that kind of thing, but this is one that we hadn’t filled out, and for [beneficiary name], it was very difficult to talk about that just about death or what he would want done. So, it seemed like every time she would come, and she would bring up the subject: “Had you thought about it?” He goes: “No, I’m still not ready to talk about that.”

Other caregivers recalled family members who had received hospice care in the past but noted differences with the current beneficiary’s situation. One caregiver described their mother’s experience with hospice: “My mom had hospice, but I thought that’s just right when you die, get ready to die, so I never brought it up or anything.”

## Transitional Concurrent Care

As in 2021, POs reported that few beneficiaries received TCC in 2022 (Table 10.2). In data submitted to CMS, ten of the 13 POs that participated in the Hospice Benefit component in 2022 indicated that fewer than ten beneficiaries used TCC in 2022. Across all POs, 0.8% of beneficiaries electing hospice received TCC, ranging from zero (POs R, X, Z, AI, and AN) to 10.3% (PO M). As in 2021, PO M had the highest rate of beneficiaries who received TCC, which may be due to the PO’s prior experience with expanded benefits for serious illness care and the absence of restrictions to TCC by diagnosis; the PO with the second highest rate of TCC, PO Y, also did not restrict TCC by diagnosis.

**Table 10.2. Number of Beneficiaries Receiving TCC and TCC Length of Stay, by PO**

PO	2021	2021	2021	2022	2022	2022
	Number of Beneficiaries	Percentage of Beneficiaries in Hospice Care	Average Number of Days	Number of Beneficiaries	Percentage of Beneficiaries in Hospice Care	Average Number of Days
PO G	N/A	N/A	N/A	3	0.7	8.3
PO L	N/A	N/A	N/A	24	0.4	20.3
PO M	82	12.1	3.5	74	10.3	2.2
PO P	10	0.3	25.4	9	0.2	25.1
PO R	0	0.0	0	0	0	0
PO T	1	0.3	17.0	N/A	N/A	N/A
PO V	12	2.9	63.8	6	1.6	46.2
PO W	2	0.1	73.5	2	0.1	33.0
PO X	1	0.9	21.0	0	0	0
PO Y	38	5.4	38.4	31	4.6	4.2
PO Z	0	0.0	0	0	0	0
PO AI	N/A	N/A	N/A	0	0	0
PO AJ	N/A	N/A	N/A	3	0.2	9.7
PO AN	–	–	–	0	0	0
All POs	146	1.5	20.2	152	0.8	9.2

SOURCE: RAND analysis of data submitted by POs as part of the VBI Model.

NOTE: N/A = not applicable because the PO did not participate in that time period. The dash for PO AN in 2021 indicates that the PO had data quality issues that prevented it from accurately reporting the number of beneficiaries receiving TCC during 2021.

### *PO and Hospice Perspectives on TCC Utilization*

Similar to 2021, most POs (P, V, X, Y, and AJ) reported that they “haven’t had a big population with TCC” (PO V). For many POs (L, M, P, X, V, AJ, and AN), utilization was lower than expected. As a PO P representative put it:

In our initial planning, we expected TCC to be a lot. We prepared for TCC to be a much higher utilized service, and it’s been interesting. . . . it’s shown to be supportive in helping keep the member on hospice, but just not a high enough volume to really think about that in a way that can be inclusive of the whole population, so a little low for us.

Similarly, in-network hospices continued to indicate that they cared for no or very few TCC patients (Hospices L, N, and R). This year, representatives of Hospice L stated that they observed lower TCC utilization despite their efforts to boost enrollment.

PO representatives gave a number of potential reasons for low TCC utilization. One explanation was that beneficiaries using TCC were those who would have selected hospice anyway had TCC not been available. A PO M representative said:

It was not our observation that members were electing hospice because TCC was available. They were electing hospice and then gained access to TCC. So, I think that is consistent with that utilization level.

Other explanations cited a lack of acceptance or understanding of TCC among family members (POs R, X, and AI) and a lack of knowledge among providers about TCC eligibility criteria and available services (POs V and AN). As described in Chapter 9, hospice representatives also suggested that providers need more education about which beneficiaries were eligible for TCC and said that a clearer definition of TCC from CMS could help to promote use of these benefits. However, representatives of one continuing PO observed that while educating providers about the benefits of palliative care appears to have increased utilization of palliative care, the same has not been true for TCC (PO W). PO M representatives attributed this to the pandemic but could not identify why that might be the case. Other reasons cited include a mismatch between the eligible diagnoses for TCC and the diagnoses of eligible beneficiaries in the service area (PO V), beneficiaries electing care from OON hospices (PO V), beneficiaries not having any curative services to continue within the 30 days prior to election (PO L), and the need for referring providers and hospices to coordinate with one another to determine when and how TCC will be used (PO P). A PO P representative explained:

[TCC] requires the engagement of the hospice before you can really discuss it in order to align on how it would be used, and then it kind of creates a disconnect psychologically for the patient after they sign a NOE to think about adjusting for additional curative care.

PO Y anticipated that it could guide more members to TCC with consultations, but not until in-network hospice providers have higher patient volume with which to be more engaged in TCC. Three POs mentioned that they are tracking TCC statistics and anticipate having more data in the future to better understand patterns of TCC utilization (POs L, M, and AJ).

Finally, some hospices' representatives noted that declines in hospice use in their region (Hospice L) and fewer referrals to hospice in general (Hospice Y) also limited referrals for TCC.

## Hospice Supplemental Benefits

Utilization of hospice supplemental benefits was very low in 2022 (Table 10.3). A total of eight POs offered hospice supplemental benefits in 2022, with six eliminating cost sharing for inpatient respite care and hospice drugs and biologicals and six offering other types of hospice supplemental benefits. A total of 875 beneficiaries across five POs (G, V, X, Z, and AJ)

received reduced cost sharing, which corresponds to 4.6% of all VBID beneficiaries who enrolled in hospice in 2022. A total of 377 beneficiaries received other hospice supplemental benefits across five POs (G, P, R, Y, and Z), which corresponds to 1.7% of all VBID beneficiaries who enrolled in hospice in 2022. These beneficiaries included 183 from PO P, which offered \$500 yearly care assistance for caregivers; 169 from PO Y, which offered a readmission prevention program, including home modifications and bathroom safety devices, transportation, and meals; and 23 from PO G, which offered in-home respite care for additional hours per month, an emergency response system, meals, and transportation.

**Table 10.3. Number of Beneficiaries Receiving Hospice Supplemental Benefits, by PO**

PO	2021	2021	2022	2022
	Reduced Cost Sharing	Other Supplemental Benefits	Reduced Cost Sharing	Other Supplemental Benefits
PO G	–	–	38	23
PO P	N/A	146	N/A	183
PO R	0	1	0	1
PO T	0	N/A	N/A	N/A
PO V	229	N/A	255	0
PO X	0	N/A	113	N/A
PO Y	0	138	N/A	169
PO Z	10	1	16	1
PO AJ	N/A	N/A	453	0
All POs	239	286	875	377

SOURCE: RAND analysis of data submitted by POs as part of the VBID Model.

NOTE: N/A = not applicable because the PO did not provide supplemental benefits or reduced cost sharing or was not a participant during that time period. POs AI, L, AN, M and W are excluded from this table because they did not offer hospice supplemental benefits in 2022. The dash for PO G indicates that the PO had data quality issues that were not resolved at the time of reporting that prevented it from accurately reporting the number of beneficiaries receiving hospice supplemental benefits during 2021.

### *PO and Hospice Perspectives on Utilization*

Low levels of hospice supplemental benefit utilization in 2022 were generally consistent with POs’ expectations. A PO G representative attributed low uptake to hospices’ unfamiliarity with this type of benefit, noting that “providing the additional [hospice] supplemental benefits isn’t something [hospices are] used to.” As a result, some hospices might have been reluctant to promote the use of these benefits among patients and their caregivers.

Hospices whose VBID patients received the \$500 yearly care assistance allowance noted that these payments were helpful to address patient needs. While interviewed hospice representatives thought that additional in-home respite care was helpful for patients in theory, hospices offering this benefit found it difficult to implement (Chapter 9). For example, a Hospice W representative noted that if their PO were to allow medical assistants or personal care workers (as opposed to certified nursing assistants) to provide in-home respite care, the

hospice’s “ability to provide in-home respite would go up dramatically. [Under the current staffing requirements] . . . it feels a little bit like bait-and-switch. Here’s this great benefit, but you’re not going to get it.”

Interviewed hospice representatives indicated that reduced or eliminated cost-sharing benefits did not meaningfully change costs for beneficiaries. Representatives of every hospice interviewed indicated that even outside of the Hospice Benefit component, their hospices never charged patients copays for hospice services or medications; therefore, reduced or eliminated cost sharing offered as a Hospice Benefit component supplemental benefit would not result in a change in beneficiaries’ OOP costs. A representative of OON Hospice G said:

We as an organization don’t collect money from patients anyway. I think as we look at our patient population, overall, do I think that this model could have an impact on just the overall expenditure of health care costs, particularly as it relates to the last six months of life? Absolutely. But as far as what a patient is actually paying out of pocket, right now we strive for that to be zero anyway.

## Hospice Care

In 2022, 19,065 VBID beneficiaries received hospice care, which corresponds to 1.9% of all beneficiaries enrolled in plans participating in the model. The proportion of beneficiaries who received hospice care in 2021 was very similar (1.6%). POs varied greatly in terms of the number of beneficiaries who received any hospice care, ranging from 52 in PO AI, a small PO that operates in a market with low hospice enrollment, to 6,296 in PO L, a large PO that was new to the Hospice Benefit component in 2022.

Of all VBID beneficiaries receiving hospice care, 47.8% received care from in-network hospices in 2022, increasing from 37.3% in 2021. The proportion of beneficiaries receiving care from in-network hospices varied widely, from zero in a PO that was new in 2022 and had just one in-network hospice (PO AI) to 98.3% in a PO that included all hospices in its service area as in-network hospices (PO M).

Most POs that participated in the Hospice Benefit component in both 2021 and 2022 had a similar proportion of beneficiaries who received hospice care from in-network hospices in both years. The notable exception was PO W, which demonstrated a large increase from one year to the next (13.6% in 2021 to 46.7% in 2022), perhaps because the PO doubled the number of hospices in its network from 2021 to 2022.

In-network hospices delivered care to a larger median number of beneficiaries per hospice than did OON hospices across all POs. To illustrate, the median number of beneficiaries who received care from in-network hospices ranged from zero in PO AI to 65.5 in PO X; the median number of beneficiaries receiving care from OON hospices ranged from 1.0 in POs M, V, X, and AJ to 8.0 in PO R (Table 10.4).

**Table 10.4. Number of Beneficiaries Receiving Hospice Care from In-Network and Out-of-Network Hospices in 2022, by PO**

Parent Organization	All Hospices	In-Network Hospices	OON Hospices	In-Network Hospices	OON Hospices
	Number of Beneficiaries	Number (%) of PO's Beneficiaries	Number (%) of PO's Beneficiaries	Median Number per Hospice (interquartile range)	Median Number per Hospice (interquartile range)
PO G	426	85 (20.0%)	341 (80.0%)	7.0 (4.5, 11.0)	2.0 (1.0, 5.0)
PO L	6,296	2,933 (46.6%)	3,363 (53.4%)	21.5 (9.0, 42.0)	2.0 (1.0, 11.0)
PO M	716	704 (98.3%)	12 (1.7%)	60.5 (32.0, 92.0)	1.0 (1.0, 1.0)
PO P	3,614	1,414 (39.1%)	2,200 (60.9%)	13.0 (5.0, 29.0)	3.0 (1.0, 8.0)
PO R	914	86 (9.4%)	828 (90.6%)	43.0 (33.0, 53.0)	8.0 (1.0, 17.0)
PO V	382	141 (36.9%)	241 (63.1%)	41.0 (25.5, 45.0)	1.0 (1.0, 2.0)
PO W	3,093	1,445 (46.7%)	1,648 (53.3%)	107.0 (64.5, 272.0)	6.5 (1.0, 39.0)
PO X	166	131 (78.9%)	35 (21.1%)	65.5 (21.0, 110.0)	1.0 (1.0, 5.0)
PO Y	672	622 (92.6%)	50 (7.4%)	20.5 (5.0, 48.0)	2.0 (1.0, 7.0)
PO Z	733	237 (32.3%)	496 (67.7%)	10.0 (3.0, 224.0)	3.0 (1.0, 8.0)
PO AI	52	0 (0.0%)	52 (100.0%)	N/A	3.0 (2.0, 7.0)
PO AJ	1,554	1,163 (74.8%)	391 (25.2%)	10.5 (2.5, 25.5)	1.0 (1.0, 6.0)
PO AN	447	144 (32.2%)	303 (67.8%)	7.0 (3.5, 29.0)	1.5 (1.0, 4.0)
All POs	19,065	9,105 (47.8%)	9,960 (52.2%)	16.0 (6.0, 39.5)	2.0 (1.0, 9.0)

SOURCE: RAND analysis of preliminary CMS hospice claims data, 2022, and data submitted by POs as part of the VBID Model.

NOTE: N/A = not applicable because the PO did not have beneficiaries who received care from in-network hospices in 2022.

### *PO and Hospice Perspectives on Hospice Enrollment*

In response to our survey, eight of 11 POs reported already seeing or expecting to see an increase in hospice utilization in 2022, with two POs reporting no change and one PO reporting a decrease in hospice utilization. Although these results are generally consistent with POs' 2021 expectations of increased hospice utilization, POs L and AN reported in interviews that the increase in 2022 was higher than expected. "For actual hospice enrollment, I actually think it's a little bit higher than what I thought it would be," said a PO L representative.

POs attributed increases in hospice utilization to a range of factors. In 2021, interviewed POs predicted that greater awareness among providers would increase hospice utilization (Khodyakov et al., 2022). Indeed, PO V representatives interviewed in 2022 attributed an increase in hospice utilization to provider education over the past year. That said, POs interpreted changes in hospice utilization with caution in light of available data. Representatives from POs M and Y indicated that baseline utilization data, which were collected during the COVID-19 pandemic, may not be representative. PO Y representatives further pointed to a similar increase in non-VBID hospice utilization during the time that the

Hospice Benefit component has been ongoing. A PO P representative agreed, noting that growth in hospice utilization among VBID beneficiaries

is more or less on par with the rest of our MA population. And we know that that means that it's tracking to the growth of hospice in general versus way out in front. . . . We have not seen a huge impact in growing hospice utilization overall through Hospice VBID plans.

PO AJ, which experienced a decrease in hospice utilization among VBID beneficiaries, noted that this decline was a trend across its geographic region and not necessarily attributable to the Hospice Benefit component.

Although the majority of PO representatives reported seeing an increase in hospice utilization in 2022, the majority of in-network hospices (six of ten) reported on their pre-interview surveys that the Hospice Benefit component did not have an impact on their average daily census; three reported a positive impact, and one reported a negative impact. Most hospices (seven of ten) also reported that they saw no change in the types of patients enrolled attributable to the Hospice Benefit component. However, in interviews in both 2021 and 2022, representatives of Hospice T explained that their VBID patients were higher acuity and more likely to be dual-eligible than the other patients they serve because their PO's participating plans serve these beneficiaries.

### *Regression Findings on Hospice Enrollment, Care Patterns, and Care Experiences in 2021*

We also used data from 2019 and 2021 to assess both the proportion of decedents who enrolled in hospice and the hospice care patterns and experiences of beneficiaries who enrolled in hospice. This analysis involved comparing beneficiaries in Hospice-participating plans with those in comparison plans before and after VBID implementation using DD methods. Briefly, our DD uses entropy balancing to weight characteristics among Hospice-participating and nonparticipating plans in pre- and post-intervention time periods to address differences (Appendix M). Regression results should be interpreted with caution because weighting was only able to partially resolve substantial differences in the characteristics of beneficiaries in participating and comparison plans (for example, a majority of beneficiaries who are enrolled in Hospice-participating plans live in Puerto Rico). The lack of balance introduces uncertainty in the effect estimates beyond that which is accounted for in the CIs and could lead either to overestimates or underestimates of the impact of the Hospice Benefit component on outcomes of interest. In addition, we had limited data to characterize beneficiaries' health care utilization, which reduced our ability to balance groups. Furthermore, the effects we were able to detect in our Puerto Rico-heavy VBID beneficiary group may not generalize well to beneficiaries across the U.S. mainland. Appendix M provides further detail.

Hospice care patterns of interest included length of stay, proportion of beneficiaries discharged alive (overall and for specific reasons), and proportion of beneficiaries receiving

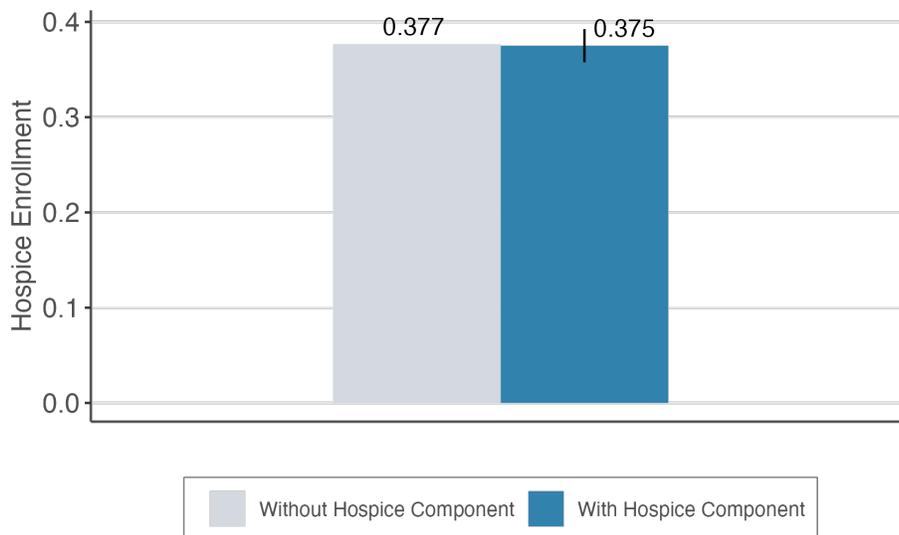
visits from professional staff in the last three days of life. Length of stay in hospice is an important outcome for two reasons: A short length of stay (operationalized here in two ways commonly used in the literature: less than three days and less than seven days) (Forst et al., 2018; Teno et al., 2012) indicates insufficient time for patients and families to fully realize the benefits of hospice (Rickerson et al., 2005), whereas a very long length of stay (operationalized here as more than 180 days) may be an indicator of inappropriate enrollment of patients into hospice based on the hospice eligibility criterion of a life expectancy of six months or less (Wachterman et al., 2011). Although being discharged from hospice alive can be a positive outcome for patients whose quality of life and prognosis improved such that they no longer need hospice services, high rates of live discharge can also indicate inappropriate overenrollment of beneficiaries in hospice. Having professional visits in at least two of the last three days of life is an established quality indicator for hospice care delivery (Teno et al., 2016). Caregiver-reported hospice care experiences, measured here by a weighted average of eight CAHPS Hospice Survey measures (Anhang Price et al., 2018), reflect the degree to which care is patient- and family-centered, a core aspect of hospice care quality. Appendix M shows weighted and unweighted outcomes for 2019 (pre-Hospice Benefit component) and 2021 (post-Hospice Benefit component).

Our regression results show that Hospice Benefit component implementation was not statistically significantly associated with hospice enrollment ( $p = 0.86$ , 95% CI:  $-0.019$  to  $0.016$ ; Figure 10.1) or hospice care patterns (Appendix M). Again, due to uncertainty in our effect estimates, it is possible that we were not able to detect important differences attributable to the Hospice Benefit component or that effect estimates are biased due to limitations in our ability to balance important covariates.

Consistent with national trends, hospice enrollment among decedents in VBID-participating plans declined between 2019 and 2021 (40.5% in 2019 [before the Hospice Benefit component] and 37.5% in 2021 [the first year of Hospice Benefit component implementation]), reflecting lower hospice use during periods when the number of deaths were higher during the COVID-19 pandemic (Medicare Payment Advisory Commission, 2023).

Rates of hospice enrollment among VBID decedents are substantially below the national average for hospice enrollment among MA decedents (53.2% in 2019 and 47.4% in 2021) (Medicare Payment Advisory Commission, 2023). Lower hospice enrollment rates are largely explained by the high proportion of 2021 VBID-participating beneficiaries who reside in Puerto Rico, a territory with hospice penetration that is among the lowest in the nation (National Hospice and Palliative Care Organization, 2018). In our data, 28.9% and 28.3% of decedents were enrolled in hospice in Puerto Rico in 2019 and 2021, respectively, compared with 53.4% and 47.3% of decedents in the mainland United States in those years.

**Figure 10.1. Estimated Association Between Hospice Benefit Component Interventions and Hospice Enrollment, 2021**

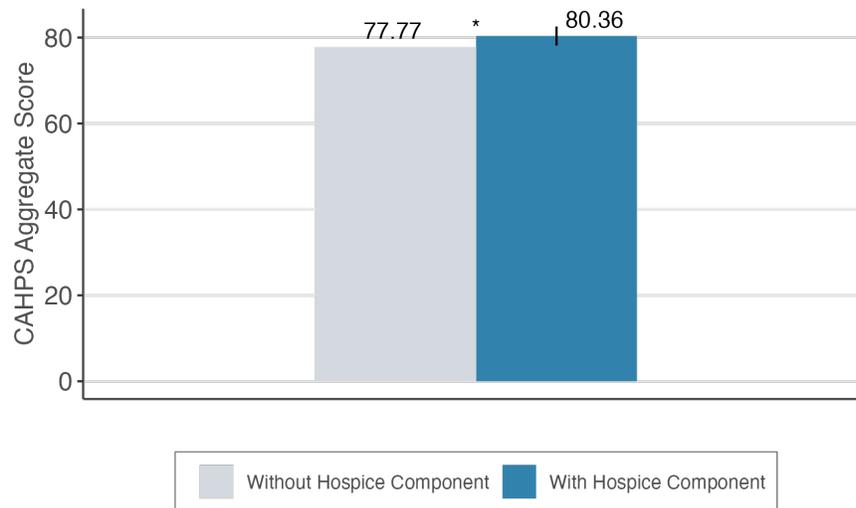


SOURCE: RAND analysis of 2019 and 2021 CMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in the Hospice Benefit component with a weighted sample of comparison plans. The number of beneficiaries in participating plans after implementation of the Hospice Benefit component included in the analyses was 23,750, and the total effective sample size (including beneficiaries in participating plans and weighted comparison plans) was 49,863. The black line(s) shown represent the 95% CI for the estimated effect of the VBID Hospice Benefit component on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without Hospice Component” group indicate when the associations were not statistically significant at the 0.05 level.

The Hospice Benefit component was associated with a statistically significant 2.59 point increase in a summary measure of caregiver-reported hospice care experiences in 2021 ( $p = 0.021$ , 95% CI: 0.39 to 4.79; Figure 10.2), meaning that caregivers of VBID beneficiaries who died while receiving hospice care reported experiences that were, on average, more positive than those reported by caregivers of beneficiaries enrolled in comparison plans after balancing on a range of characteristics (Appendix M). In unadjusted analyses, this association appears to be driven primarily by reported care experiences for beneficiaries who live in Puerto Rico. CAHPS Hospice Survey scores are scaled from 0 to 100, with differences of one, three, and five or more points considered small, medium, and large, respectively (Quigley et al., 2018). Therefore, the observed increase can be interpreted as small to medium; however, given limits to the precision of our analyses, it is possible that real differences are smaller or larger.

**Figure 10.2. Estimated Association Between Hospice Benefit Component Interventions and Summary CAHPS Hospice Survey Score, 2021**



SOURCE: RAND analysis of 2019 and 2021 CMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in the Hospice Benefit component with a weighted sample of comparison plans. The number of beneficiaries in participating plans after implementation of the Hospice Benefit component included in the analyses was 1,677, and the total effective sample size (including beneficiaries in participating plans and weighted comparison plans) was 6,065. The black line(s) shown represent the 95% CI for the estimated effect of VBID the Hospice Benefit component on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without Hospice Component” group indicate when the associations were not statistically significant at the 0.05 level.

To explore whether our results varied for subpopulations of VBID beneficiaries, we performed sensitivity analyses for the outcomes of interest that estimated DD models by residency in Puerto Rico; White, Black, and Hispanic race/ethnicity; urbanicity; and enrollment in a D-SNP. Unlike our primary analyses, it was not possible to weight on the full set of covariates for each subset due to lack of overlap between the groups being compared; therefore, these regression results rely on the DD analysis to address for potential confounding rather than the combination of DD and weighting used by our primary analyses. Similar to our primary results, these analyses generated little evidence that the Hospice Benefit component was associated with the main outcomes for these groups. For example, Hospice Benefit component implementation was not statistically significantly associated with hospice enrollment or hospice care patterns for beneficiaries who live in the mainland United States, nor was it statistically significantly associated with those outcomes for beneficiaries who live in Puerto Rico. Appendix M provides more details.

### *PO and Hospice Perspectives on Hospice Care Patterns and Quality*

More than half of Hospice-participating POs responding to the survey (six of 11) reported seeing or expecting to see increased hospice length of stay in 2022; two POs reported no

change, and one reported decreased length of hospice stay. In interviews, a PO L representative attributed increased hospice use to earlier referral and enrollment through pre-hospice consultation. PO AJ representatives hypothesized that beneficiary consultation earlier in the course of disease progression provided education about palliative care, TCC, and goals of care.

Similarly, six of the 11 hospices surveyed reported that the Hospice Benefit component had or will have no impact on length of stay in 2022, with three hospices reporting a small impact and two reporting a big impact. Hospice T representatives attributed a small increase in length of stay to earlier election or palliative care availability, and Hospice Z representatives attributed a big increase in length of stay to earlier interaction with the patient or the option to get TCC. A Hospice M representative indicated that length of stay has increased, but the hospice did not have enough data to determine whether this is due to the Hospice Benefit component or other factors.

A representative of Hospice L, which observed a decreased length of stay, expressed disappointment in this result: “Length of stay has also continued to decline even though we’ve done a lot of [education] efforts this year proactively having road shows and PowerPoint presentations with specialty [care providers who refer to hospice].”

In addition to discussing hospice length of stay, some hospice representatives reported ways in which they believed that the Hospice Benefit component is having a positive effect on hospice care quality. Representatives of four in-network hospices (N, R, T, and AC) noted that the model promoted collaboration between the PO, the hospice, and others involved in patient care. In particular, interdisciplinary group meetings allowed for information sharing (Hospice N) and promoted better medication management (Hospice T); working “in tandem” with a care manager from the PO also helped provide better care to patients (Hospice AC).

## Summary

Similar to the first year of the Hospice Benefit component (2021), in the first half of 2022, palliative care utilization was lower than expected by most POs, very few beneficiaries used TCC or hospice supplemental benefits, and the proportion of VBID beneficiaries receiving hospice care was similar to previous years.

Although palliative care utilization was low, in interviews, beneficiaries who received palliative care and their caregivers described overall positive experiences with this care, noting that they received help for pain and other symptoms, psychosocial support, and spiritual and social support. Some of these interviewees were not clear on what the term *palliative care* meant or what this type of care included, suggesting important opportunities for beneficiary education. This unfamiliarity with the term *palliative care* is not surprising given previous studies demonstrating a lack of awareness from the perspective of patients or conflation of palliative care with hospice care (Hadler et al., 2020; Maciasz et al., 2013; Trivedi et al., 2019).

POs and hospices attributed low uptake of TCC in part to lack of knowledge among providers about which beneficiaries were eligible for TCC; they also noted that some family members did not accept or understand TCC.

Hospice representatives reported that, although it was used infrequently, a hospice supplemental benefit of a \$500 annual care assistance was helpful to address patient needs and that tweaks to POs' requirements could increase the uptake of additional days of in-home respite care. However, representatives also noted that reduced or eliminated cost sharing for inpatient respite care and hospice drugs and biologicals—the hospice supplemental benefit most commonly offered by POs—does not meaningfully change OOP costs for beneficiaries because hospices typically do not collect cost-sharing payments from patients anyway.

Hospice enrollment among VBID beneficiaries was much lower than the national average, likely due to the high proportion of these beneficiaries residing in Puerto Rico, an area with low hospice penetration. Our regression results showed no association between the Hospice Benefit component implementation and hospice enrollment or care patterns in 2021. We found a small to medium, statistically significant increase in CAHPS Hospice Survey summary scores that represent caregiver-reported hospice care experiences; we would expect reported hospice care experiences to be similar for VBID and comparison beneficiaries because interviewed hospice representatives did not report providing care differently to VBID beneficiaries compared with other patients. Regression results should be interpreted with caution because balancing could not fully compensate for substantial differences in the characteristics of beneficiaries in participating and comparison plans in 2021, when a large majority of beneficiaries who were enrolled in Hospice-participating plans lived in Puerto Rico. Our ability to estimate model effects is expected to improve over time as the model expands and more POs from the mainland volunteer to participate.

## Chapter 11. Plan-Level Financial Outcomes

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### Key Findings

- Hospice Benefit component implementation was associated with lower MAPD bids in both 2021 and 2022:
    - \$18.39 PMPM (2.6%) decrease in 2021 ( $p = 0.01$ , 95% CI:  $-\$31.98$  to  $-\$4.80$ )
    - \$23.23 PMPM (2.9%) decrease in 2022 ( $p < 0.01$ , 95% CI:  $-\$34.58$  to  $-\$11.89$ ).
  - We found no association between Hospice Benefit component implementation and changes in costs to Medicare in 2021 (the only year for which data were available).
  - Hospice Benefit component implementation was associated with a \$12.18 PMPM (29.1%) increase in MSB costs in 2021 ( $p = 0.01$ , 95% CI:  $\$2.72$  to  $\$21.63$ ). We also found a marginally significant association with higher MSB costs in 2022 ( $\$5.82$ ,  $p = 0.10$ , 95% CI:  $-1.20$  to  $\$12.66$ ).
  - Hospice Benefit component implementation was associated with a marginally significant \$4.49 reduction (17.0%) in MAPD premiums in 2021 ( $p = 0.07$ , 95% CI:  $-\$9.37$  to  $\$0.39$ ) but was not associated with a change in MAPD premiums in 2022.
  - MSB costs increased while premiums were held constant or decreased because plans participating in the Hospice Benefit component received larger MA rebates and allocated a substantial share of those rebates to spending on MSB costs.
- 

In this chapter, we describe the impact of Hospice Benefit component implementation on **plan bids, premiums, MSB costs, and costs to Medicare**. Hospice Benefit component participation could affect these plan-level financial outcomes through several mechanisms. Changes in the frequency or timing of hospice election might affect average MA and Part D spending by plans. If such changes were anticipated by plans, they could be priced into the MA and Part D bids. Costs associated with hospice supplemental benefits and palliative care not covered by Medicare are priced into the MSB costs, so changes in these benefit offerings could affect MSB costs. Any changes to bids and MSB costs could have implications for premiums and costs to Medicare. Other mechanisms, such as changes in beneficiary enrollment, might also lead to Hospice Benefit component impacts on costs to Medicare.

In analyses not reported here, we examined several additional outcomes related to enrollment and plan bids among Hospice-participating plans, including plan-level enrollment among all beneficiaries (not just Hospice Benefit component-eligible beneficiaries) and the overall Star Rating in contracts with at least one Hospice-participating plan. We found that Hospice Benefit component implementation was associated with neither a change in plan-level enrollment nor a change in contract-level Star Rating at conventional levels of statistical significance. Those results are reported in Appendices I and J.

Analyses of plan-level financial outcomes in this chapter use the DD methods described in Appendix C: We combined a DD research design that isolated within-plan changes in outcomes over time with entropy balancing meant to make the comparison group more similar to the group of VBID-participating plans.

As discussed in Chapter 9, plans implementing the Hospice Benefit component were heavily concentrated in Puerto Rico, were more likely to be D-SNPs, and differed from eligible nonparticipating plans on a number of other characteristics. These differences were especially pronounced for plans that implemented the Hospice Benefit component in 2021. As a result, our entropy balancing approach was able to achieve acceptable balance only for about 30 of the 70 characteristics we considered. Because plans that implemented the Hospice Benefit component beginning in 2022 were more comparable to nonparticipating plans, we were able to achieve balance on all characteristics for all plan-level financial outcome models.

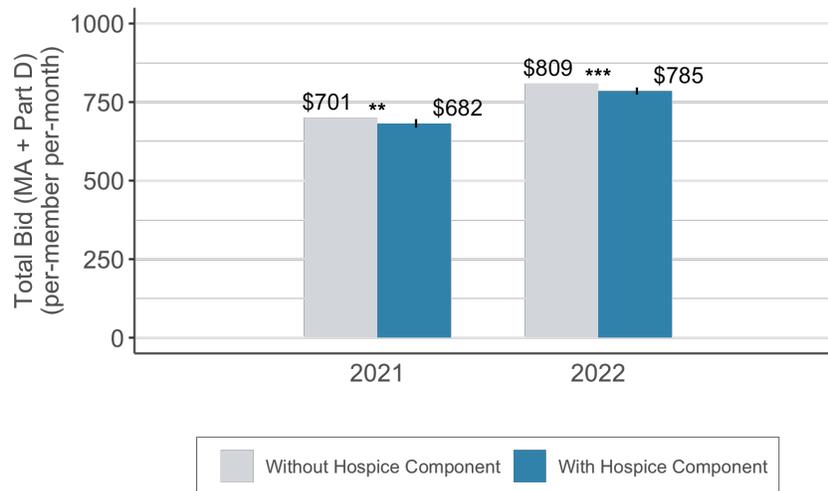
The challenges in achieving balance for plans that first implemented the Hospice Benefit component in 2021 (*2021 implementors*) mean that results for this cohort are more reliant on the parallel trends assumption (that is, that plan outcomes in participating and nonparticipating plans would have changed in a similar way in the absence of the intervention) than findings reported in other chapters or findings for plans that first implemented the Hospice Benefit component in 2022 (*2022 implementors*). All the results presented in this chapter for 2021 should be viewed cautiously due to this caveat. Results for 2022, however, reflect an average of results for 2021 and 2022 implementors. To provide readers with a better sense of how to interpret the 2022 results, throughout this chapter, we discuss whether the effects reported for 2022 are driven by 2021 implementors, 2022 implementors, or both. Results for all outcomes shown in this chapter are reported separately by implementation cohort in Appendix L.

### *Plan Bids*

The Hospice Benefit component was associated with reductions in MAPD bids in both 2021 and 2022 (Figure 11.1). In 2021, the Hospice Benefit component was associated with an \$18.39 decrease ( $p < 0.01$ , 95% CI:  $-\$31.98$  to  $-\$4.80$ ) in the standardized MAPD bid. In 2022, the Hospice Benefit component was associated with a \$23.23 decrease ( $p < 0.01$ , 95% CI:  $-\$34.58$  to  $-\$11.89$ ) in the standardized MAPD bid. In comparison to the MAPD bid that would have been expected in the absence of Hospice Benefit component implementation, these estimated effects represent decreases in the MAPD bid of 2.6% in 2021 and 2.9% in 2022.

We caution, however, that these statistically significant changes in MAPD bids are driven primarily by the 2021 implementors. Estimates for 2022 implementors are also negative but are statistically insignificant ( $-\$4.68$ ,  $p = 0.52$ , 95% CI:  $-\$18.83$  to  $\$9.47$ ; Appendix L).

**Figure 11.1. Estimated Association Between Hospice Benefit Component Interventions and MAPD Bids**



SOURCE: RAND analysis of CMS Bid data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in the Hospice Benefit component with a weighted sample of comparison plans. The number of participating plans included in the analyses was 93, and the total effective sample size (including participating plans and weighted comparison plans) was 1,625. The black line(s) shown represent the 95% CI for the estimated effect of the Hospice Benefit component on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without Hospice Component” group indicate when the associations were not statistically significant at the 0.05 level.

### *Mechanisms Explaining Hospice Benefit Component Impacts on Plan Bids*

Decreases in MAPD bids that were associated with the Hospice Benefit component were driven by decreases in MA bids in both 2021 ( $-\$18.70$ ,  $p < 0.01$ , 95% CI:  $-\$30.87$  to  $-\$6.53$ ) and 2022 ( $-\$23.01$ ,  $p < 0.01$ , 95% CI:  $-\$33.95$  to  $-\$12.06$ ). In comparison to the MA bid that would have been expected in the absence of Hospice Benefit component implementation, these estimated effects represent decreases in the MA bid of 2.9% in 2021 and 3.0% in 2022. The change in MA bids in 2022 was driven primarily by 2021 implementors; estimates for 2022 implementors were also negative but were not statistically significant ( $-\$4.87$ ,  $p = 0.50$ , 95% CI:  $-\$19.11$  to  $\$9.37$ ).

These reductions in MA bids may have been partially offset by higher Part D bids in both 2021 and 2022. Hospice Benefit component implementation was associated with a marginally statistically significant increase in the Part D bid ( $\$2.63$ ,  $p = 0.09$ , 95% CI:  $-\$0.39$  to  $\$5.65$ ) in 2021 and a statistically significant increase in the Part D bid ( $\$2.78$ ,  $p = 0.03$ , 95% CI:  $\$0.26$  to  $\$5.30$ ) in 2022. In comparison to the Part D bid that would have been expected in the absence of Hospice Benefit component implementation, these estimated effects represent increases in the Part D bid of 5.6% in 2021 and 6.5% in 2022. The change in Part D bids in 2022 was

driven primarily by 2021 implementors; estimates for 2022 implementors were small and not statistically significant (point estimate \$0.23,  $p = 0.90$ , 95% CI:  $-\$3.26$  to  $\$3.72$ ).

We examined changes in components of the MA bid to gain additional insight into the factors that may have accounted for changes associated with Hospice Benefit component implementation. Decreases in the MA bid were driven by statistically significant reductions in the projected cost of providing Medicare-covered services in 2021 and 2022. However, we caution that these results were driven entirely by the 2021 implementation cohort: Estimated changes in the projected cost of providing Medicare-covered services for the 2022 cohort were estimated to be small and statistically insignificant. Appendix L provides more details.

### *PO Perspectives*

Eight of 12 POs that completed our survey reported that administrative costs had increased or would increase due to Hospice Benefit component implementation. In interviews, representatives of seven of 12 POs reported that they made changes to their claims processing system to support participation in the model, and representatives of one PO (AJ) reported that administrative costs would increase for each additional contract with a hospice.

Representatives of two POs, however, noted that the Hospice Benefit component appears to be lowering the cost of care for those receiving hospice (PO R) and palliative care (PO X). PO R representatives stated that, prior to Hospice Benefit component implementation, hospices sometimes separately billed the PO for items and services, such as durable medical equipment or medications, that are already paid for under the hospice per diem, a practice known as “duplicate billing” or “duplicate payments.” But under the Hospice Benefit component, this practice has decreased because the PO has closer oversight of hospices’ activities. PO X representatives attributed care costs dropping by one-third among VBID beneficiaries (compared with those eligible but not enrolled in palliative care in the last year of life) in part to lower emergency room expenses. That said, both PO R and PO X representatives pointed out that there are few beneficiaries receiving Hospice Benefit component services, so these cost savings have not had a great impact on the bottom lines of these POs.

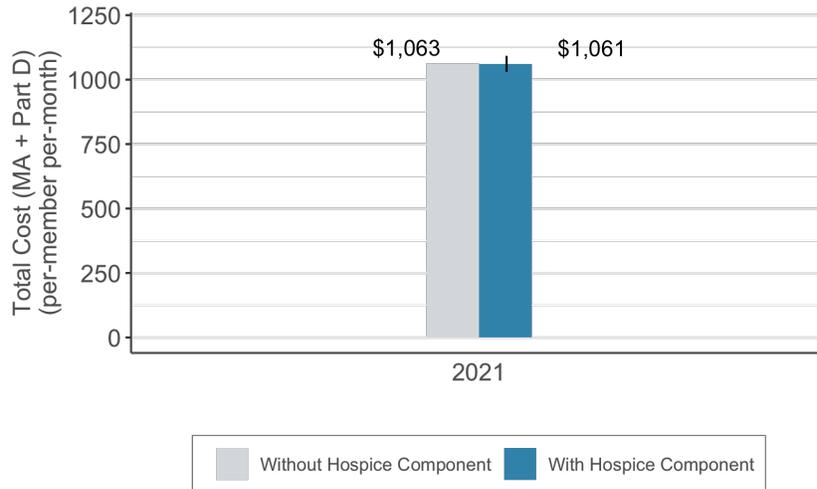
### **Costs to CMS**

In 2021, we found no statistically significant association between Hospice Benefit component implementation and costs to CMS ( $-\$1.77$  PMPM,  $p = 0.91$ , 95% CI:  $-\$32.73$  to  $\$29.19$ ). Changes in MA costs to CMS and Part D costs to CMS in 2021 were also not statistically significant (Appendix L). The data on Part D costs to CMS were not available for 2022 at the time of writing.

MA costs to CMS were available for 2022. While the point estimate was negative, we found no statistically significant association between Hospice Benefit component implementation and MA costs to CMS for 2022 ( $-\$18.62$  PMPM,  $p = 0.13$ , 95% CI:  $-\$42.71$

to \$5.48). Estimates for 2022 were similar for 2021 implementors (-\$13.94,  $p = 0.49$ , 95% CI: -\$53.91 to \$26.03) and 2022 implementors (-\$23.00,  $p = 0.14$ , 95% CI: -\$53.75 to \$7.75).

**Figure 11.2. Estimated Association Between Hospice Benefit Component Interventions and Costs to CMS**



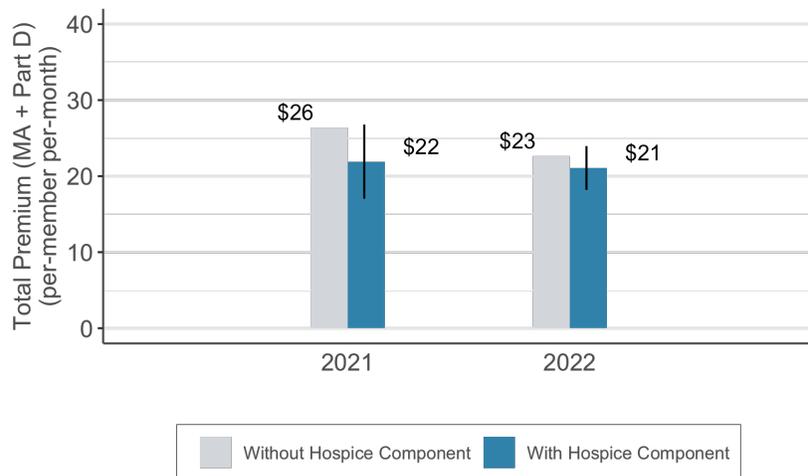
SOURCE: RAND analysis of CMS Bid, PDE, and HPMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in the Hospice Benefit component with a weighted sample of comparison plans. The number of participating plans included in the analyses was 45, and the total effective sample size (including participating plans and weighted comparison plans) was 868. The black line(s) shown represent the 95% CI for the estimated effect of the Hospice Benefit component on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without Hospice Component” group indicate when the associations were not statistically significant at the 0.05 level.

## Premiums

In 2021, Hospice Benefit component participation was associated with a marginally significant decrease of \$4.49 ( $p = 0.07$ , 95% CI: -\$9.37 to \$0.39) in the total monthly MAPD premium, driven (by definition) by 2021 implementors. In 2022, Hospice Benefit component participation was not associated with changes in the total monthly MAPD premium (-\$1.55,  $p = 0.29$ , 95% CI: -\$4.43 to \$1.34). Estimates for 2022 were statistically insignificant for both 2021 and 2022 implementors. In comparison to the total monthly MAPD premium that would have been expected in the absence of Hospice Benefit component implementation, these estimated effects represent increases in the total monthly MAPD premium of 17.0% in 2021 and 6.8% in 2022. On their own, neither MA premiums nor Part D premiums were associated with Hospice Benefit component implementation in 2021 or 2022.

**Figure 11.3. Estimated Association Between Hospice Benefit Component Interventions and MAPD Premiums**



SOURCE: RAND analysis of HPMS data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in the Hospice Benefit component with a weighted sample of comparison plans. The number of participating plans included in the analyses was 93, and the total effective sample size (including participating plans and weighted comparison plans) was 1,612. The black line(s) shown represent the 95% CI for the estimated effect of the Hospice Benefit component on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without Hospice Component” group indicate when the associations were not statistically significant at the 0.05 level.

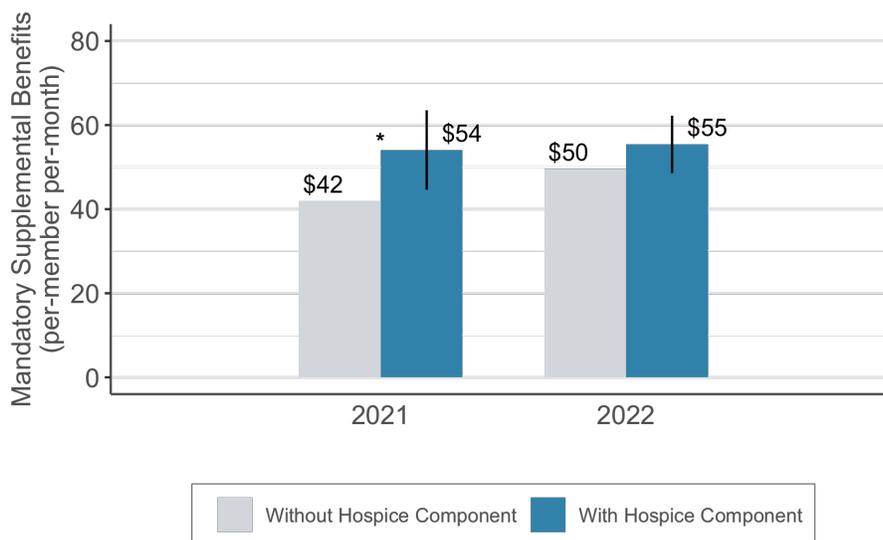
## Supplemental Benefits

Participation in the Hospice Benefit component was associated with a statistically significant \$12.18 PMPM increase in MSB costs in 2021 ( $p = 0.01$ , 95% CI: \$2.72 to \$21.63) and a marginally significant \$5.82 increase in 2022 ( $p = 0.10$ , 95% CI:  $-\$1.02$  to \$12.66). In comparison to the MSB costs that would have been expected in the absence of Hospice Benefit component implementation, this effect represents a 29.1% change in 2021 and an 11.7% change in 2022.

These increases in MSB costs may reflect that CMS required hospice supplemental benefits offered as part of the model, as well as home-based palliative care not covered as a Medicare-covered service, to be priced as MSBs. MSB costs are paid for by beneficiaries through the MA premium unless plans use the MA rebate to finance MSBs. In analyzing plans’ MA rebate allocations, we confirmed that Hospice Benefit component participation was associated with large increases in the amount of MA rebate dollars allocated to the cost of MSBs. These increases in the MA rebate allocation to MSB costs were statistically significant in both 2021 and 2022 and were larger in magnitude than the estimated increases in MSB costs. Increases in the MA rebate allocation to MSB costs in 2021 may have been facilitated by the fact that Hospice Benefit component participation was associated with an increase in the MA rebate in

that year. Appendix L provides additional information on the MSBs offered by Hospice-participating plans in 2022.

**Figure 11.4. Estimated Association Between Hospice Benefit Component Interventions and MSBs**



SOURCE: RAND analysis of CMS Bid data.

NOTES: \*\*\*, \*\*, and \* represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing plans participating in the Hospice Benefit component with a weighted sample of comparison plans. The number of participating plans included in the analyses was 93, and the total effective sample size (including participating plans and weighted comparison plans) was 860. The black line(s) shown represent the 95% CI for the estimated effect of the Hospice Benefit component on the outcome from our DD models. CIs that overlap with the estimated mean for the “Without Hospice Component” group indicate when the associations were not statistically significant at the 0.05 level.

## Summary

For both 2021 and 2022, we found that Hospice Benefit component participation was associated with reductions in the MAPD bid that were driven by reductions in the MA bid. Decreases in the MA bid were driven by statistically significant reductions in the projected cost of providing Medicare-covered services in 2021 and 2022. POs’ participation in the Hospice Benefit component could reduce spending on Medicare-covered services if participation reduced acute care spending through earlier or more frequent hospice election among seriously ill patients. ACP, which is a required element of all VBID interventions in the current model test, could have a similar effect. It is important to note, however, that bids are set prospectively and reflect the expectations of POs and their actuaries about the model’s effects. These expectations may change as POs accumulate data to retrospectively assess the model’s effects on spending and other outcomes.

Despite reductions in MAPD bids, we did not find evidence that Hospice Benefit component implementation was associated with changes in the costs to Medicare in 2021. We could not evaluate costs to Medicare for 2022 because Part D cost data were not final as of this writing (January 2023).

Furthermore, Hospice Benefit component implementation was associated with higher MSB costs in 2021 and 2022 but not with higher MAPD premiums. In fact, MAPD premiums fell in 2021 by a marginally significant \$4.49 ( $p = 0.07$ , 95% CI:  $-\$9.37$  to  $\$0.39$ ), although this result was driven entirely by 2021 implementors, who were somewhat different from comparators due to a large proportion of participants in Puerto Rico. Supplemental analyses reported in Appendix L showed that plans shielded beneficiaries from increases in MSB costs by financing these costs through the MA rebate, a strategy that may have been facilitated by increases in the MA rebate deriving from lower MA bids.

Compared with the findings on changes in plan-level financial outcomes associated with VBID General (reported in Chapters 7 and 8), results presented in this chapter should be interpreted with caution because the large observable differences between plans implementing the Hospice Benefit component in 2021 and the comparison group of eligible nonparticipants prevented us from balancing the preimplementation characteristics of these groups of plans. Results for 2021 reflect only the 2021 implementation cohort, while results for 2022 reflect averages of the 2021 and the 2022 cohort, which had better balance. As noted above, the 2021 cohort drove the 2022 findings that Hospice Benefit component implementation was associated with reduced MAPD bids and higher MSB costs.

## **PART III: LOOKING AHEAD**

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## Chapter 12. PO and Hospice Perspectives on Model Expansion

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### Key Findings

- POs that participated in VBID General appreciated the ability to offer targeted benefits, especially to low-income beneficiaries, and stated that such benefits can help improve care quality and reduce costs.
  - Some POs warned that offering targeted benefits requires a large enough pool of eligible beneficiaries to offset the fixed administrative costs of delivering these benefits. Zip code-based targeting was proposed as an additional strategy to address members' health-related social needs.
  - While POs participating in the Hospice Benefit component generally expressed enthusiasm for expansion of the Hospice Benefit component to the broader MA population, some noted that they would need to change their VBID benefits to ensure sustainability as the model scales up.
  - Hospices expressed hopes that Hospice Benefit component expansion would ease beneficiaries' transition to hospice, improve quality care through enhanced communication and care coordination, and decrease costs and unnecessary acute care utilization through increased access to palliative care and earlier hospice enrollment.
  - As in 2021, hospices expressed concerns about potential unintended consequences of Hospice Benefit component expansion, including reduced financial viability of hospices, decreased patient access to hospice care, and negative effects on hospice care quality and costs. To counteract these concerns, hospices offered multiple suggestions, including that CMS establish model-wide minimum definitions of palliative care and other Hospice Benefit component services, a minimum payment rate for hospice services, and standardized indicators for assessing quality of care.
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Using the results of our interviews with PO, in-network hospice, and OON hospice representatives, this chapter summarizes their perspectives on incorporating VBID General and Hospice Benefit component benefits into a standard MA benefit design. It also presents their suggestions for ways to improve the benefit targeting process (within or outside the model) and strategies for making the VBID Model more attractive to hospices.

### PO Perspectives on VBID General

In discussing VBID General and its potential to become a standard MA benefit design, representatives of participating POs reported appreciating the ability to customize their plan benefits by offering certain benefits only to those who need them the most. POs were particularly excited about SES-based targeting. According to PO AP representatives, “introducing this sort of flexibility into what we can offer on a plan level [outside of VBID] is very positive. To be able to address some of these SDOH [social determinants of health] concerns at the member level is a very positive member experience and a positive outlook on a member’s health care.” According to PO AG representatives, targeted benefits offer an important pathway toward improving care quality and reducing costs because doing so “is going to force [POs] and the market to really find benefits and create benefit structures that are targeted, very targeted, and really helpful to help outcomes and reduce costs.”

Still, PO representatives raised some concerns about model expansion. For example, PO E representatives felt that benefit targeting could work only if there were enough beneficiaries eligible to receive these benefits and suggested that expanding SES-focused benefits in non-D-SNPs may depend on whether there is a critical mass of low-income beneficiaries in these plans. Although PO representatives were generally pleased with the “positive trajectory” of VBID Flexibilities, some wanted to learn more about efficacy of offering targeted benefits based on chronic conditions or SES before expanding them (PO Q). Others, such as PO AA representatives, remarked that beneficiaries may not be aware of benefits despite efforts to target them, a concern that was corroborated by our interviews with beneficiaries.

Moreover, based on their VBID General participation experiences, PO representatives argued that plans implementing targeted benefits need to be aware of additional administrative costs of offering and managing these benefits. POs must also be prepared to address potential confusion among both providers and beneficiaries, which could lead to lower levels of satisfaction among their enrollees. As noted in our previous reports (Eibner et al., 2020; Eibner et al., 2018), offering targeted benefits requires plans to adjust their internal systems to be able to identify and track benefit eligibility within the same PBP. According to PO Q representatives, having too much variability in benefits “makes it harder [for beneficiaries] to shop [for the right plan] or harder [for plans] to service” a wide range of benefits. Furthermore, informing beneficiaries about the existence of these targeted benefits also increases administrative costs, especially if eligibility for these benefits is conditional on the targeted beneficiaries’ completion of certain CM/DM participation requirements. While providers could play an important role in ensuring patients’ awareness of their eligibility to receive targeted benefits, some PO representatives noted that ensuring providers’ knowledge of which benefits are offered only to certain beneficiaries in a given plan is a challenge.

In discussing how the idea of offering more targeted benefits could be expanded further, PO AH representatives suggested targeting benefits within a plan based on zip code:

Maybe we know that there’s a certain county or certain zip code where the members may not all be low-income eligible, but it is a very poor community. The flexibility of being able to do that type of thing would be great, and it would allow us to target the benefits a lot better.

## PO Perspectives on the Hospice Benefit Component

POs had different perspectives on potential expansion of the Hospice Benefit component to all of MA. On the one hand, some POs (G, M, V, and X) were optimistic that expansion of the Hospice Benefit component would bring value to the broader MA population, including greater consistency in the hospice benefits that different plans provide (that is, all plans providing TCC and hospice); increased provider awareness of TCC; and earlier, more seamless transitions to hospice. A PO V representative noted that the carve-in allows POs to have “oversight of the member and the quality-of-care piece and assuring that the beneficiary is properly enrolled at

the right place, right time.” Representatives of PO X said that although the carve-in would provide “increased access to palliative [care] and . . . preserves the integrity of the Hospice Benefit,” its implementation would require “some guard rail” to reassure hospices that “they are not going to suffer financially.”

On the other hand, one PO did not want to explicitly support carving the Hospice Benefit component into MA (PO AJ), and others said that they would need to change some of their VBID benefits. For example, PO V representatives said they would need to impose a cap on the number of days that a beneficiary can receive TCC if the number of TCC-eligible beneficiaries or diagnoses were to increase:

From a financial perspective and a clinical perspective, [TCC] would be very hard to manage on a larger scale with no end date. . . . I think the other part for scalability is diagnoses. The diagnoses we picked [for TCC eligibility] are pretty straightforward. Like, you’ve got renal and dialysis, cancer, and cancer treatment, but when you start getting into diagnoses like Alzheimer’s, or malnutrition, or other types of diagnoses that are a little harder to pinpoint in what [beneficiaries are] going to get, that could be a little bit more of a challenge.

## Hospice Perspectives on the Hospice Benefit Component

Similarly to POs, hospices had different perspectives on the expansion of the VBID Hospice Benefit component. In-network and OON hospice representatives appreciated the potential of TCC to promote a “seamless transition” to hospice care “when appropriate” (Hospice AC) and ease the transition to hospice, even when beneficiaries choose not to use the curative care offered as part of TCC (Hospice Z). Representatives of OON Hospices AC, AF, and AG also noted the potential for more ACP conversations and earlier entry into hospice facilitated by the palliative care component. Others noted the potential to improve quality of care by enhancing communication (Hospice G), continuity of care (Hospice L), and care coordination (Hospice AC), as well as to decrease costs and unnecessary acute care utilization through increased access to palliative care and earlier access to hospice (Hospices Z, AC, and AG).

Based on their experiences to date, however, not all hospice representatives agreed that the Hospice Benefit component would actually bring about these benefits. For example, representatives of in-network Hospice W noted that while they hoped that the Hospice Benefit component would increase use of high-value services, the model had not met these expectations, with few beneficiaries receiving palliative care and TCC:

We believe in VBID. I think it is well-designed. I think it has the potential to have really incredible benefit[s] to the individual patient, and their loved ones, and their caregivers. I think it could make a difference in their care. We just haven’t seen it. We don’t see palliative care. We really don’t see concurrent care. And, frankly, those are the two aspects that are most attractive and potentially most impactful. In-home respite, we had one participant. Sounds

great, looks good in a brochure, doesn't translate. The same with home modification. In two years, we haven't done one home modification. So, again, sounds great. Where's the meat?

Similarly, some hospice representatives were uncertain as to whether TCC can address barriers to hospice election, given lack of beneficiary and provider understanding of TCC. They also noted that beneficiaries' barriers to understanding apply to palliative and hospice care as well (Hospices N, R, AC, and AG).

In addition to not seeing the desired effects of the model, both in-network and OON hospices expressed concerns about potential unintended consequences of VBID Hospice Benefit component expansion, which echo concerns we identified in 2021 (Khodyakov et al., 2022). Representatives from 13 of the 19 interviewed in-network and OON hospices worried that if the VBID Hospice Benefit component expands, hospices would struggle to be financially sustainable or even close down due to one or more of the following reasons:

- payment delays and claims denials (Hospices S, X, Y, and AC)
- low negotiated payment rates from POs (Hospices K, W, X, Y, and Z)
- increased administrative burden, such as communicating with multiple POs about beneficiary eligibility and claims (Hospices K, S, X, and AA)
- lower patient volume due to exclusion from PO networks (Hospice AA).

In describing the combined effects of lower rates and higher administration burden, a representative of OON Hospice W said: "To take a [payment rate] haircut for arguably more work, that has sustainability issues." Representatives of Hospices K, X, and AD speculated that POs with ownership of certain hospices might direct beneficiaries toward those hospices, thereby limiting opportunities for other hospices to participate in PO networks and provide care to VBID beneficiaries. Representatives of one in-network hospice (Hospice AD) and four OON hospices (Hospice X, AA, AE, and AG) worried that hospice closures, which they perceived to be the inevitable consequence of lower payment rates and increased administrative burden, and narrow hospice networks would negatively affect access to hospice care.

Many hospice representatives also commented on potential negative effects of a hospice carve-in on care quality. Representatives of four in-network hospices (K, R, T, and Z) and three OON hospices (G, AB, and AG) worried that expansion of the model could reduce quality of care: "It's up to [POs] to say what they are willing to reimburse," said a Hospice R representative. "There will be other hospice agencies that [take that reimbursement] . . . and maybe not give the best quality care that really the patients deserve." Representatives of three in-network hospices (K, R, and Z) and one OON hospice (AB) also noted that lower rates could affect care patterns. According to two OON hospices (G and AB) and one in-network hospice (T), payment delays or claims denials could lead to delays in care. Representatives of one OON hospice expected that in-network hospices would be selected based on cost rather than quality (Hospice AG).

## *Proposed Enhancements to the Hospice Benefit Component*

As in 2021, hospice representatives from both in-network and OON hospices identified factors that could ease and streamline implementation and expansion of the model going forward, including

- more education about the model to hospices (OON Hospices AA and AF), referring providers (Hospice S and Hospice AC), and beneficiaries (Hospice S)
- more communication from POs to hospices in their service area regarding contracting opportunities and claims submission for VBID beneficiaries (OON Hospice AF)
- removal of the requirement to submit duplicate claims to CMS and the PO (Hospice AC)
- requiring POs to provide a direct line to a staff member who can respond to claims inquiries (Hospice X).

In addition, hospice representatives provided suggestions on how to address potential unintended negative consequences of the model. First, representatives of six hospices suggested that CMS establish model-wide minimum definitions of VBID Hospice Benefit component services, including palliative care (in-network Hospices K and Z and OON Hospice AG), TCC (in-network Hospices L, S, and T), and hospice supplemental benefits (in-network Hospice S). For example, representatives of in-network Hospices K and Z felt that a CMS-issued definition of *palliative care* would help to ensure that the model “actually delivers on palliative care services instead of kind of a stripped-down version” (Hospice Z). A Hospice K representative suggested that CMS guidance could help to avoid the pitfalls posed by their PO’s six-month time limit on palliative care.

In discussing the impact of such benefit standardization, a representative of in-network Hospice S suggested that standardization would help hospices with implementation of the benefits and promote beneficiary understanding of their benefit options:

Standardization is key. So as much as CMS can start to narrow the tunnel in focus and really limit certain transitional concurrent benefits and supplemental and make them more standardized across the payers, I really think we could get into a better cadence. And I think that it would be more widely recognized with members out there if all the payers had similar language in their offerings.

Second, representatives of four hospices made several suggestions regarding PO network contracting. In-network Hospice Z and OON Hospice X representatives argued that CMS should establish a minimum payment rate for hospice services:

The biggest worry from the industry is that if there’s no protection built in by CMS to regulate the rates, other hospices, especially smaller hospices, won’t be able to compete. They won’t be able to get the same rates, which will limit hospice care. If we can get some protection associated with the rates that are negotiated, then I think that this will be an absolute revolutionary change in hospice care. (Hospice Z)

In addition, OON Hospice X representatives suggested that CMS should ensure that, in keeping with current model guidance, POs should never be permitted to impose prior authorization requirements for hospice care, and representatives of in-network Hospice AD and OON Hospice X suggested that CMS allow any interested hospice to participate in PO networks. Hospices projected that these modifications would help to promote financial sustainability of hospices as the Hospice Benefit component expands.

Finally, a representative of one OON hospice (AG) argued that “right and robust meaningful quality indicators will help provide the guardrails to make sure that there aren’t modifications to the benefit that are counterproductive to what Medicare recipients receive, in terms of end-of-life care.” This hospice representative thought that monitoring quality through standardized measures could help ensure that the quality of care delivered to beneficiaries and their families is not negatively affected by POs’ oversight of beneficiaries’ serious illness and end-of-life care.

## Summary

In discussing a possibility of including VBID General-type flexibilities as part of a standard MA benefit design, the PO representatives we interviewed generally expressed support for offering more tailored benefits, especially for low-income beneficiaries. They agreed that doing so could help them better address their enrollees’ health-related social needs. Some representatives noted some potential unintended consequences, however, including increased administrative costs and potential confusion among both beneficiaries and providers who may have a hard time understanding benefits offered by a given plan, as well as beneficiary eligibility for those benefits. Such confusion may lead to a lower level of beneficiary satisfaction with their plans. Moreover, PO representatives noted that offering targeted benefits could make sense only if plans have a critical mass of enrollees eligible to receive such benefits and if they invest resources in educating their enrollees not only about what these benefits are but also about how and why they should use them. Plans offering these tailored benefits have the potential to improve care quality and reduce costs—but only if eligible beneficiaries actually use these benefits.

When discussing potential expansion of the Hospice Benefit component to all of MA, PO representatives generally expressed enthusiastic support for expansion of the Hospice Benefit component, noting that expansion would improve consistency of services offered across MA plans and would contribute to earlier, smoother transitions to hospice. While some POs indicated that they could scale up Hospice Benefit component services without any changes, another noted that it would need to impose more restrictions on some services, such as TCC, to ensure sustainability as the model scales up.

Consistent with the POs’ view of the Hospice Benefit component, representatives of some hospices described TCC as a key feature of the Hospice Benefit component, noting the

important role of TCC in promoting a seamless transition to hospice care when appropriate. Hospices also expressed hope that the Hospice Benefit component could improve quality care through enhanced communication and care coordination and could decrease costs and unnecessary acute care utilization through increased access to palliative care and earlier hospice enrollment.

However, not all hospices agreed that the Hospice Benefit component would bring about these benefits. Many hospices expressed concerns about potential unintended consequences of Hospice Benefit component expansion, including reduced financial viability of hospices, decreased patient access to hospice care, and negative effects on hospice care quality. To counteract these concerns, hospices suggested that CMS establish model-wide minimum definitions of *palliative care* and other Hospice Benefit component services, a minimum payment rate for hospice services, and standardized indicators for assessing quality of care. Hospices also identified factors that could enhance implementation of the model going forward, including more education about the model to POs, hospices, referring providers, and beneficiaries, and administrative burdens that could be eased, such as a requirement that hospices submit claims to both CMS and POs.

## Chapter 13. Conclusion

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The VBID Model offers POs a variety of options to modify benefit design within their MA plans, and model implementation could affect numerous outcomes. Our evaluation has therefore covered a lot of territory, separately analyzing VBID General and the Hospice Benefit component; considering PO, hospice, and beneficiary perspectives; and estimating the model's association with enrollment, use of high-intensity services, contract-level quality, beneficiary-level adherence and prevention measures, health outcomes, and plan and beneficiary cost outcomes. Nonetheless, the data available to assess each outcome varied, and we analyzed some outcomes for only a single postimplementation year. Furthermore, because the coronavirus pandemic coincided with initial implementation of the model, data from the early years of implementation may not be representative. Our findings, summarized below, may change over time as additional data become available.

### VBID General Findings

Participation in VBID General grew steadily over time; POs' implementation experiences also improved with time. The VBID General interventions that POs implemented aimed to increase beneficiaries' engagement in their care, encourage the use of recommended preventive services and treatments, and promote healthy behaviors. In theory, these changes could improve beneficiaries' health and/or reduce disease progression, reduce the need for high-intensity services, and—ultimately—result in savings for taxpayers by reducing costs to CMS. Our evaluation suggests that VBID General has begun to reach the first step in this causal pathway, with improvements in contract-level quality scores and beneficiary-level measures of medication adherence. However, these improvements in quality and process outcomes have yet to translate into evidence of overall improvements in beneficiary health and lower costs to CMS. In fact, our findings suggest that VBID General was associated with higher risk scores, increases in hospitalizations, higher MAPD premiums, and greater costs to CMS.

There are several explanations for these findings. By increasing interactions with health care providers, VBID General interventions may have led to more or earlier diagnoses and treatments than would otherwise have occurred. Some PO representatives corroborated this explanation, noting that services that they offered through VBID, such as annual wellness visits, enabled providers to identify additional diagnoses, in turn leading to higher beneficiary risk scores. Inpatient stays could have been affected through a similar pathway if beneficiaries' increased engagement with primary care identified unmet need for inpatient treatment. Because our evidence comes primarily from the first year after VBID General was implemented, it is possible that these patterns may change over time. Once underlying or deferred need for

hospital services is met, for example, beneficiaries' conditions may stabilize or even improve, leading to lower use of high-intensity services down the line.

The association between VBID General participation and increases in MAPD premiums corresponds to our previous results (Khodyakov et al., 2022) and likely reflects the combination of two effects. First, Part D premiums increased because of interventions that encouraged drug adherence, such as reductions in Part D cost sharing. Second, VBID General increased spending on MSBs, which can result in a higher premium. The premium increases were small in dollar terms (\$1 to \$2 PMPM) and represented about 6% to 8% of beneficiaries' monthly premium costs, but the MSB costs increased more steeply than premiums (\$12 to \$16 PMPM). Together, these effects suggest that plans were able to finance most MSB costs through other channels—such as buying them down with MA rebates—rather than passing the costs along to beneficiaries. Furthermore, although premiums increased on average, it is not clear the extent to which enrollees shouldered this cost. For beneficiaries with LIS status, CMS pays for some or all of the Part D premium.

Although we found that VBID General was not associated with changes in MAPD bids, there was an association with increased costs to CMS. This finding reflects that bids are only one component of CMS' costs. Note that, when analyzing bids, we relied on a risk-standardized measure. However, CMS makes larger payments for beneficiaries with higher risk scores, which increased for beneficiaries targeted by the model test. Our measure of costs to CMS takes these risk-adjusted payments into account. The increased costs to CMS also reflect higher MA rebate payments to plans, which increase as bids fall and as quality ratings go up. Finally, CMS pays Part D premium costs for beneficiaries with LIS status, an increasing share of the VBID General-targeted population.

## Hospice Findings

CMS introduced the Hospice Benefit component of the VBID Model in 2021, and PO participation in this component increased in 2022. Both POs and hospices identified moderate implementation challenges with administrative processes related to notices of hospice election and claims processing. POs also noted challenges with communicating with beneficiaries. Interviewed beneficiaries and caregivers also expressed confusion about palliative care definitions, including distinctions between palliative care, home health, and hospice services. In general, POs that implemented the Hospice Benefit component for the first time in 2022 reported experiencing greater challenges than those that continued their participation from 2021, which suggests that there is a learning curve. Hospices raised concerns about payment delays and about pressure to accept lower payment rates than received under FFS Medicare to be included in POs' networks. They noted that, should the model expand, these payment issues could result in reduced financial viability of hospices and decreased access to hospice care.

By design, the Hospice Benefit component aims to improve care quality for seriously ill beneficiaries by promoting earlier and more seamless transitions to hospice through reduced care fragmentation and by offering palliative care, TCC, and hospice supplemental benefits. However, in 2022, palliative care utilization was lower than most POs expected when they applied to participate in the model; very few beneficiaries used TCC or hospice supplemental benefits, and the proportion of VBID beneficiaries receiving hospice care was similar to 2021. Although Hospice Benefit component implementation was not associated with hospice enrollment or care patterns, we found a small but statistically significant increase in a summary measure of caregiver-reported hospice experiences of care in 2021. However, because the overrepresentation of Puerto Rico beneficiaries among plans participating in the Hospice Benefit component made it difficult for us to find an adequate comparison group, this finding should be interpreted with caution.

Most of the plan-level financial outcomes that we analyzed for the Hospice Benefit component were prospective measures, including MAPD bids and premiums, that are submitted by plans and their actuaries based on expectations about costs in the coming year. We found statistically significant declines in MAPD bids in 2021 and 2022 and also in MAPD premiums in 2021. These changes could suggest that participating POs and their actuaries expected the Hospice Benefit component to reduce seriously ill beneficiaries' utilization of costly acute care services, such as inpatient stays. However, we found no statistically significant change in MAPD costs to CMS for 2021 (the only year for which data were available).

## Limitations and Threats to Generalizability

The VBID Model encompasses a wide range of VBID General and Hospice Benefit component interventions and provides participating POs with substantial flexibility to tailor these interventions based on the needs of their enrollees and their organizational goals and priorities. Although we evaluated VBID General and the Hospice Benefit component separately, participating POs offered a number of different interventions within each of these two VBID Model components. In some cases, POs varied not only in the interventions that they implemented but also in the populations that they targeted. Some POs implemented more than one VBID intervention in the same plan. The range of interventions and target populations creates a fundamental challenge for the generalizability of our evaluation results. If CMS were to expand the VBID Model, additional participants could offer benefit combinations that differ from what we evaluated in this report, leading to different results.

For VBID General, we conducted subgroup analyses for several outcomes, which generally confirmed the possibility that POs' implementation choices could result in heterogeneous impacts. For example, we found that only plans that implemented SES-based interventions experienced increases in enrollment. Even here, differences within subgroups make it difficult

to generalize. Interventions that targeted beneficiaries based on SES could have offered a wide range of benefits, such as healthy food cards, lower cost sharing, CM/DM services, or transportation.

The voluntary nature of the model also means that participating POs—and by extension their plans and beneficiaries—were selectively different from nonparticipants, which has implications for our ability to extrapolate findings. In our quantitative analyses, we attempted to isolate the causal impact of the model using rigorous statistical methods, including weighting comparators to resemble participants and implementing DD regressions. However, in an observational study such as this one, it is never possible to fully rule out the possibility that unmodeled differences between participants and comparators affected results. Furthermore, our analyses only tell us what the effect of VBID was, on average, for plans and beneficiaries that were similar to participating plans and their enrollees. Extrapolating these results to plans and beneficiaries that are different from model participants requires an additional assumption that the effect of VBID is stable across different types of beneficiaries and plans. In addition, for the Hospice regression models and for some subgroup analyses, we had difficulty achieving good balance on all of the characteristics included in our weighting algorithm.

Our beneficiary-level outcome data were limited to the first year after Phase II of the model implementation. Although we had plan-level outcome data for additional years, plan participation changed substantially each year. For example, some plans left the model after a year or two, while many new plans entered over time. As a result, for many plan-level outcomes, the associations that we estimated reflect only one year of postimplementation data for a large number of observations. If POs and providers face a learning curve to effectively implement the model (as our qualitative results suggest), the full effects of VBID could take several years to emerge. For VBID General, the short- and long-term effects of the model may also differ for conceptual reasons, because VBID General emphasizes near-term investments in health promotion and disease prevention with a goal of reducing adverse health outcomes over time.

Moreover, VBID Model implementation coincided with the COVID-19 pandemic, which had profound implications for beneficiary health outcomes and service utilization. The coronavirus affected model participants and nonparticipants alike, and we included controls for the severity of the pandemic (COVID-19 case and death rates) in our regression analyses. Nevertheless, the severity of the pandemic in 2020 and 2021 may have affected outcomes in unique ways that will not generalize to later years. For example, beneficiary responses to such incentives as reduced cost sharing may have been dampened in 2020 and 2021 because of concerns about exposure to the virus. The pandemic also disrupted quality reporting in some years, which affected some of our analyses (Appendix J).

Data timing considerations also affect our interpretation of PO, hospice, and beneficiary interview data with respect to the quantitative findings estimated in this report. Specifically,

our PO surveys and interviews were conducted in 2022, and they often reflected respondents' expectations about the model's impact for that year. In contrast, the majority of our quantitative analyses used data from earlier years. Differences between the interview results and analytic findings may reflect that respondents' expectations for the future diverged from their past experiences observed in data. Furthermore, because model participation increased over time, not all respondents interviewed in 2022 were included in the analytic sample for earlier years. Similarly, some POs left the model before 2022 and thus were not included in our interview sample.

Finally, our analysis did not attempt to account for intervention dosage and instead used an intent-to-treat approach to assess outcomes, in which all targeted beneficiaries in participating plans were considered to be treated by the intervention. However, not all targeted beneficiaries used model benefits. Our interviews with beneficiaries found that not all targeted beneficiaries were aware of the model benefits available to them, and some POs required beneficiaries to proactively complete participation requirements, such as meeting with a care manager, to receive VBID benefits. The subset of beneficiaries who fulfilled model participation requirements or who used model benefits may have had different experiences with the model than the broader group of all targeted beneficiaries analyzed in this report.

## Next Steps

Our evaluation detected some beneficial effects of the VBID Model, such as increases in quality of care in 2021, but it also uncovered some possible unintended effects. For VBID General, these effects included associations with higher risk scores and increased use of inpatient services in 2020, as well as an association with higher MAPD premiums in 2021 and 2022. For the newer Hospice Benefit component, for which POs needed to establish new referral systems, provider networks, and payment arrangements, we found limited use of model benefits and no changes in desired outcomes, such as hospice enrollment, in the first year of implementation (2021). We found no evidence that either VBID General or the Hospice Benefit component saved money for CMS. In fact, for VBID General, implementation was associated with higher costs to CMS in 2021.

These findings reflect data from at most three and in many cases only one year postimplementation, and it is likely that results will evolve as POs, hospices, and beneficiaries gain more experience with the model. Furthermore, in 2023, CMS made changes to the model that will affect outcomes in future years, including discontinuing Cash Rebates, providing POs with more guidance about how to establish adequate hospice networks, and requiring VBID General participants to offer supplemental benefits aimed at addressing health-related social needs. Finally, as the pandemic recedes, beneficiaries' engagement with the model may change, especially because many VBID interventions, such as in-home assessment and in-person provider visits, require face-to-face contact with providers. Our future reports will

consider these and other changes and will analyze additional years of data to gain a more nuanced picture of how findings evolve as POs, plans, and beneficiaries gain experience with VBID.

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