

OVERVIEW

Since 2021, the voluntary Medicare Advantage (MA) Value-Based Insurance Design (VBID) model has allowed MA insurers to offer a hospice benefit within their plans. Outside VBID, hospice care is not included in MA plans' benefit packages and is paid through traditional Medicare. The Hospice Benefit component consolidates responsibility and accountability for the cost, quality, and outcomes of MA beneficiaries in hospice with the intent of aligning service use with beneficiary needs and preferences, reducing use of acute care services, and lowering costs of care at the end of life.

Insurers participating in the Hospice Benefit component:

- must offer palliative care, such as 24/7 access to interdisciplinary care teams
- must offer transitional concurrent care (TCC), which allows beneficiaries selecting in-network hospices to continue receiving some curative care after they elect hospice
- may offer hospice supplemental benefits, such as reduced cost sharing for hospice drugs and inpatient respite care.

This document summarizes evaluation results for the Hospice Benefit component of the VBID model based on available 2021 and 2022 data. A companion document focuses on the evaluation results for other components of the VBID model.

Beneficiaries may choose to access one or more of palliative, transitional concurrent, or hospice care when they become eligible



Note: Six-month prognosis qualifies a beneficiary for hospice care.

FINDINGS

PARTICIPANTS

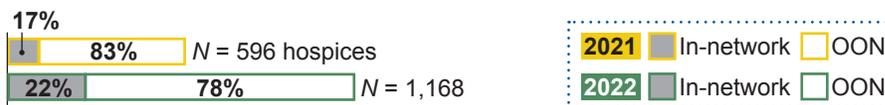
- In 2022, 13 **INSURERS** participated, offering hospice benefits in 109 **PLANS** (MA only or combined MA and Part D [MAPD] plans). More than half of these plans were new to the model in 2022.
- In comparison to nonparticipants, participating insurers tended to have higher average plan enrollment and were more likely to be national organizations.
- Compared with nonparticipating plans, participating plans had a higher proportion of beneficiaries who were dually eligible for Medicare and Medicaid and—due to high model participation in Puerto Rico—a higher proportion of beneficiaries who were Hispanic.

HOSPICE NETWORKS

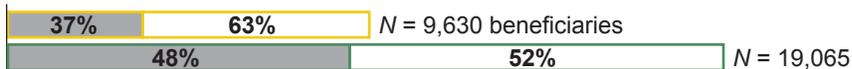
Participating insurers must contract with hospices to establish a hospice network. In 2022, beneficiaries could elect to receive care from out-of-network (OON) hospices with no additional cost sharing.

IN-NETWORK HOSPICES were larger than OON hospices and were more likely to be part of a chain. Hospices joined insurers' networks primarily to maintain long-term business viability, expressing concern that being left out of a network could result in hospice closure.

More than 1,100 **HOSPICES** provided care to at least one hospice-eligible VBID beneficiary in 2022.



In 2022, almost half of VBID **BENEFICIARIES** receiving hospice care chose in-network hospices, up from 37% in 2021.



BENEFITS AND SERVICES

Uptake of services through the Hospice Benefit component continued to be low in 2022.



Use of **PALLIATIVE CARE** was lower than insurers expected



Less than 1% of beneficiaries electing hospice received **TCC**



About 6.5% of beneficiaries electing hospice received one or more **HOSPICE SUPPLEMENTAL BENEFITS**

IMPLEMENTATION EXPERIENCES

INSURERS' implementation challenges were greater for new participants than continuing ones and included:

- administrative processes
- communicating with hospices
- creating and maintaining a hospice network.



Implementation challenges expressed by **HOSPICES** included:

- additional administrative processes, especially claims submission
- insurers' reporting requirements
- few beneficiaries referred for TCC.



OUTCOMES

The Hospice Benefit component was not associated with changes in hospice enrollment or care patterns in 2021.

However, participation was associated with a small, statistically significant increase in **CARE QUALITY** (about 3% in 2021), as assessed by a summary measure of caregiver-reported hospice care experiences based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. This finding appears to be driven primarily by reported care experiences for beneficiaries who live in Puerto Rico.

Participation was also associated with lower **MAPD BIDS** (about 3%, 2021 and 2022), increased **MANDATORY SUPPLEMENTAL BENEFITS (MSB) COSTS** (about 29% in 2021 and a marginally significant 12% in 2022), and a marginally statistically significant reduction in **MAPD PREMIUMS** (about 17%, 2021).

MSB costs increased while premiums were held constant or decreased because participating plans received larger MA rebates and allocated a substantial share of those rebates to spending on MSB costs.

Hospice Benefit Component Outcomes, 2021–2022

OUTCOME	UNIT	2021	2022
CAHPS (care quality)	Beneficiary	+2.59 points (0.39, 4.79)	Not assessed
MAPD bids	Plan	-\$18.39 PMPM (-\$31.98, -\$4.80)	-\$23.23 PMPM (-\$34.58, -\$11.89)
MSB costs	Plan	+\$12.18 PMPM (\$2.72, \$21.63)	+\$5.82 PMPM (-\$1.02, \$12.66)
MAPD premiums	Plan	-\$4.49 (-\$9.37, \$0.39)	No change

Note: 95% confidence intervals shown in parentheses. Statistically significant values shown for 2021 in **yellow** (or **light yellow** for marginal significance) or for 2022 in **green** (or **light green** for marginal significance).

KEY TAKEAWAYS

- Hospice Benefit component participation is growing, but uptake of palliative care, TCC, and hospice supplemental benefits continued to be low in 2022.
- Hospices and new insurers reported substantial implementation challenges, but insurers with more than one year of experience with VBID reported fewer challenges, suggesting that implementation is becoming easier over time.
- The proportion of beneficiaries receiving care from in-network hospices grew from 2021 to 2022.
- Participation in the Hospice Benefit component was not associated with changes in hospice enrollment in 2021.
- Participation in the Hospice Benefit component was associated with reductions in combined MAPD bids in 2021 and 2022 and reductions in combined MAPD premiums in 2021.