

MODEL OVERVIEW

The Medicare Care Choices Model (MCCM) offers eligible Medicare beneficiaries the option to receive supportive services from participating hospices while continuing to receive treatment for their terminal condition through fee-for-service Medicare. Beneficiary enrollment started on January 1, 2016 when the first cohort of hospices began implementing MCCM, followed by a second cohort on January 1, 2018. The model runs through December 31, 2020.

MCCM is designed to

- Increase access to supportive care services provided by hospice
- Improve quality of life and beneficiary/family satisfaction with care at the end of life
- Inform new payment systems for the Medicare and Medicaid programs



PARTICIPANTS

MCCM eligibility criteria

- Diagnosis of advanced cancer, congestive heart failure, chronic obstructive pulmonary disorder, or HIV/AIDS;
- Prognosis of 6 months to live documented by a certificate of terminal illness signed by the beneficiary's physician;
- Continuous Part A and B enrollment in prior 12 months; no election of the Medicare or Medicaid hospice benefit in the last 30 days; at least 1 hospital encounter in the past 12 months; 3 office visits in the past 12 months; and residence in a traditional home, not a long-term care facility, in the last 30 days.

85 MCCM hospices (60%) of the original 141 participants remained in the model as of June 30, 2019. Withdrawals slowed as MCCM matured and evolved and the experiences of hospices in the model improved over time. **Reasons for withdrawal, based on interviews with those hospices:** Leadership changes, difficulty with enrollment/eligibility criteria, adequacy of MCCM payment, and data reporting requirements.

Hospices that withdrew from the model were similar to hospices that remained in MCCM; however, MCCM hospices were notably different from all hospices nationally in terms of non-profit ownership status (69% MCCM versus 20% non-MCCM), large size (77% MCCM versus 28% non-MCCM), and experience (52% of MCCM hospices were founded prior to 1990 versus 10% of non-MCCM hospices).

4,465 beneficiaries enrolled in MCCM out of over 16,000 beneficiaries referred as of May 31, 2019. Eight hospices enrolled more than half of all MCCM beneficiaries. **Reasons for low enrollment:** Many referrals did not meet MCCM eligibility criteria.

Beneficiaries who enrolled in MCCM were similar in age to unenrolled MCCM-eligible decedents (average age 78 years). However, MCCM enrollees were more likely than unenrolled MCCM-eligible decedents to have cancer (58% versus 39%), more likely to have lower predicted health care costs as measured by hierarchical condition category scores (2.2 versus 2.7), less likely to be from a rural location (12% versus 19%), less likely to be Black (9% versus 12%), and less likely to be dually eligible for Medicare and Medicaid (6% versus 16%). These differences suggest that beneficiaries in MCCM are not as acutely ill or socioeconomically disadvantaged as the MCCM-eligible population not in the model. Future impact analyses will account for these differences.

FINDINGS

Implementation



- Participating hospices varied in the effectiveness of their implementation process. Learning activities, including training webinars and peer-based interactions, facilitated implementation.
- Oncologists referred 37% of enrollees to the model and internists/family medicine doctors referred another 51%.
- MCCM enrollees had an average of 10 encounters per month while enrolled in MCCM. Nearly 75% of encounters occurred in person and 25% by phone.

Quality



- Caregivers reported care consistent with enrollees' goals, and services that met enrollees' needs. Most indicated that they would recommend *MCCM* to friends and family.

Lessons Learned



- Prior experience with a palliative care program facilitated MCCM implementation because staff were familiar with the goals of supportive services and could draw from established referral sources.
- Cohort 2 hospices learned from the experiences of their peers in cohort 1, who had two years of implementation experience by the time cohort 2 hospices joined the model. Cohort 2 hospices adopted best practices on how to integrate MCCM into their organizational infrastructure and service lines.

83% of enrollees elected the Medicare hospice benefit after an average of 78 days in the model and 37 days prior to death.

14% died while enrolled in MCCM with access to supportive services through the model.

90% of caregivers indicated that the transition to hospice happened at the right time, that the beneficiary or caregivers were involved as much as they wanted to be in the hospice decision, and that the MCCM team did not pressure them to elect hospice.

"It (MCCM) gave her the support she needed while still getting treated for her cancer. It helped her have a better quality of life for the time she had left until she made the decision about full hospice.... It made it much easier to start hospice."

--Caregiver of MCCM enrollee

KEY TAKEAWAYS

Findings to date indicate that the Medicare Care Choices Model is achieving its objective to increase access to supportive care services for hospice-eligible beneficiaries. Maturation and evolution of the model led to increased beneficiary enrollment, expanded care delivery, and improved participant experience. Enrolled beneficiaries and caregivers reported a high degree of satisfaction with MCCM. The model offered a bridge to the Medicare hospice benefit for over 4 out of 5 MCCM enrollees, as well as counseling, symptom management, and supportive care to beneficiaries who might not otherwise have access to these services. Future reports will provide results on the impact of the model on Medicare expenditures, utilization, and quality of care.