Project Report

Evaluation of the Medicare Advantage Value-Based Insurance Design Model Test: 2020 to 2023

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About This Project Report

This report presents RAND researchers' findings from their evaluation of the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model test for 2020 through 2023, initiated by the Center for Medicare and Medicaid Innovation (Innovation Center). The VBID Model allows participating MA parent organizations (POs) to offer supplemental benefits, financial and nonfinancial incentives to beneficiaries, hospice benefits (the Medicare 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 and surveys of participating POs and hospices. We also report findings on the estimated association between VBID and a variety of key outcomes. A separate appendix volume 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.

Because many aspects of the model and the evaluation have remained constant over time, passages of text found in this report may closely echo passages from prior evaluation reports (Eibner et al., 2023; Khodyakov et al., 2022).

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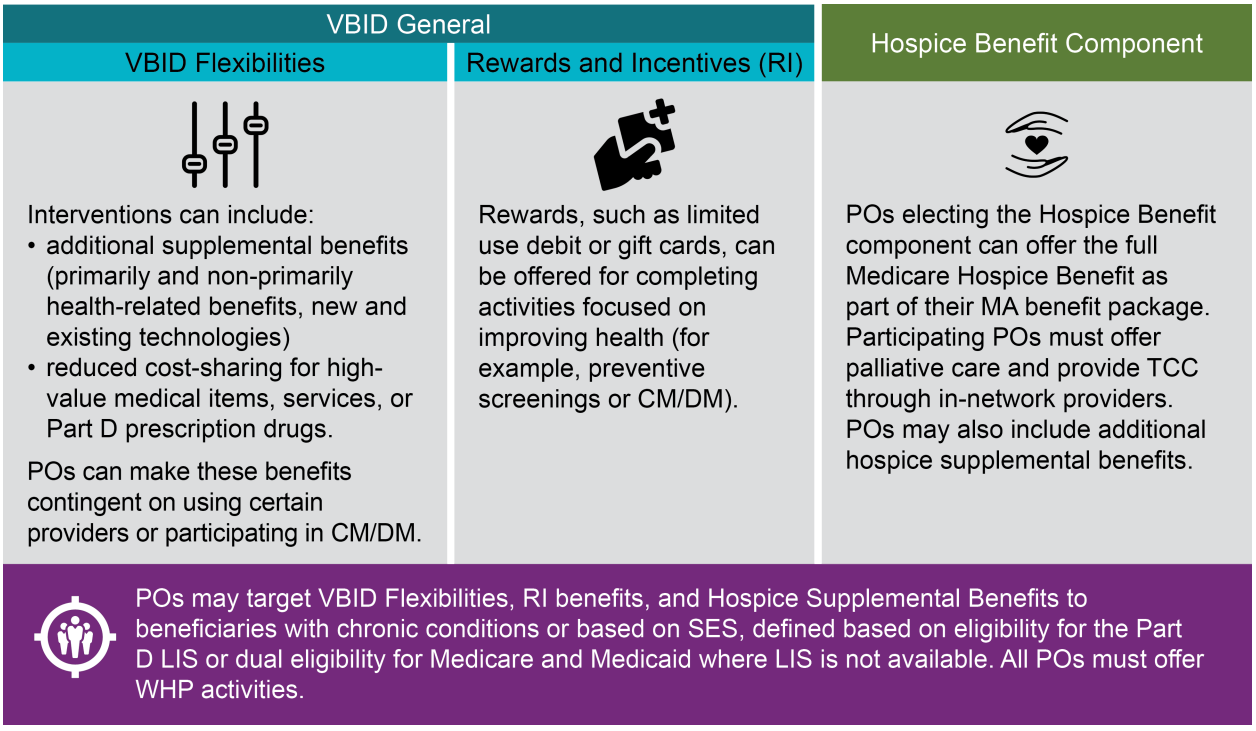
Summary

In 2020, the Center for Medicare and Medicaid Innovation, part of the Centers for Medicare & Medicaid Services (CMS), introduced Phase II of the Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model test.[1] Designed to improve quality and reduce costs in MA plans, this voluntary model allows participating insurers, known as parent organizations (POs), to target certain benefits, such as reduced cost-sharing or supplemental benefits to enrollees, based on socioeconomic status (SES) or one or more chronic conditions. Phase II of the model also enabled MA plans to offer hospice benefits directly to enrollees. (Outside VBID, hospice care is carved out of MA and offered through Original Medicare.) VBID aims to encourage beneficiaries to use high-value care, engage in healthy behaviors, and take proactive steps to support their health. In 2023, the model had two main components: VBID General and the Hospice Benefit component (see Figure S.1).

Figure S.1. 2023 VBID Model Components



NOTE: CM/DM = care management or disease management; LIS = low-income subsidy; TCC = Transitional Concurrent Care; WHP = Wellness and Health Care Planning.

[1] Phase I of the MA VBID Model test, which was available in a subset of states and for a limited set of chronic conditions, ran from 2017 to 2019 and is not assessed in this report.

VBID General includes VBID Flexibilities, such as VBID-enabled supplemental benefits and reduced cost-sharing, and Rewards and Incentives (RI) programs. The Hospice Benefit component included Palliative Care, Transitional Concurrent Care (TCC), additional Hospice Supplemental Benefits, and the full Medicare Hospice Benefit. All model participants must offer Wellness and Health Care Planning (WHP) activities, which focus on improving awareness and the availability of advance care planning, to all enrollees in their VBID-participating plans.

Over time, some model components were added or eliminated; the types of participants and their interventions also changed. To illustrate, a subcomponent of VBID General that enabled POs to share MA rebates more directly with beneficiaries in the form of cash was offered only in 2021 and 2022. The Hospice Benefit component was added in 2021, but CMS decided to discontinue that component after 2024, citing operational challenges and limited participation (CMS, 2024).

RAND researchers are conducting a multiyear, mixed-methods evaluation of the VBID Model. Our evaluation is designed to determine whether VBID Model benefits improve care quality, for example, by increasing adherence to prescribed medication. It also aims to determine whether the model can lower costs, for example, by reducing expensive complications that can result from unmanaged or suboptimally managed chronic conditions, the inadequate use of preventive care, or missed opportunities for healthy behavior. In this report, we describe the results from four of the model's eight performance years, 2020 to 2023, and report those results separately for VBID General and the Hospice Benefit components.

VBID Model Participants and Their Interventions

VBID General

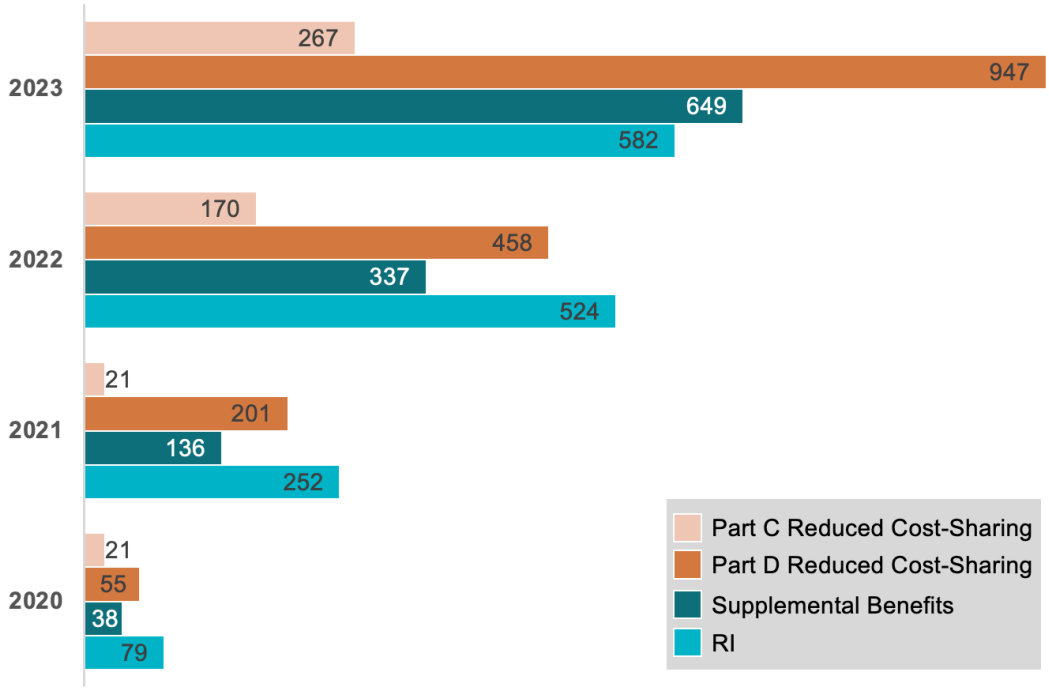
In 2023, 46 POs participated in VBID General, which represents more than a three-fold increase since 2020. Over time, several POs increased the intensity of their participation by adding new plans to the model test, while others decided not to continue their model participation. Compared with nonparticipants, POs that participated in VBID General had higher average enrollment, were more likely to be located in areas with higher MA penetration, and had greater geographic reach as measured by the share offering plans in nine or more states.

POs that participated in 2023 offered VBID interventions in 1,218 plans, which represents more than an eight-fold increase in the number of VBID General plans since 2020. There were 5,282 MA plans available during the 2023 open enrollment period (Freed et al., 2022), which means that nearly one-quarter of MA plans in the country participated in VBID General that year. The share of VBID General participants that were Dual Eligible Special Needs Plans (DSNPs) increased from 27.8% in 2020 to 49.7% in 2023. Most VBID-participating plans (99.4%) were MA plans with prescription drug benefits (MAPD plans), as opposed to MA-only plans. By comparison, 89.9% of eligible, nonparticipating plans were MAPDs.

Between 2020 and 2023, the number of beneficiaries in plans that participated in VBID General increased from 1.2 million to 8.9 million, and the number of targeted beneficiaries increased from 263,000 to 5.3 million. Enrollees in VBID General plans had a lower average age compared with enrollees in nonparticipating plans.

In 2023, reduced Part D cost-sharing was the most common VBID General intervention (N = 947), followed by VBID-enabled supplemental benefits (N = 649), RI programs (N = 582), and Part C reduced cost-sharing (N = 267) (see Figure S.2). The majority of plans (70%) offering at least one supplemental benefit intervention in 2023 included both primarily health-related supplemental benefits, such as allowances for over-the-counter items and transportation to medical appointments, and non–primarily health-related supplemental benefits, such as grocery and utilities allowances. Grocery allowances, which typically are loaded on restricted-use debit cards, were the most-offered VBID General non–primarily health-related supplemental benefit in 2023 (635 plans offered at least one intervention with a grocery allowance). Although RI was the most common VBID General intervention in previous years, 90% of plans offering RI interventions in 2022 were entered by a single PO.

Figure S.2. Plans Implementing Selected VBID General Interventions, 2020–2023



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses.

The Hospice Benefit Component

The number of POs participating in the Hospice Benefit component increased from nine in 2021 to 15 in 2023. Participating POs were less likely than nonparticipating POs to offer plans in one or two states and more likely to offer plans in nine or more states (a measure of geographic reach) than nonparticipating plans. POs also offered plans in areas with higher MA penetration and had higher average enrollment compared with nonparticipating plans.

From 2021 to 2023, the number of plans participating in the Hospice Benefit component more than doubled, increasing from 52 to 112. The number of beneficiaries enrolled in these plans also doubled, increasing from 602,277 in 2021 to 1.2 million in 2023.

In 2023, Hospice Benefit component plans were less likely to be preferred provider organizations, more likely to offer Part D benefits, and more likely to be DSNPs compared with nonparticipating plans. Likely due to the fact that a higher proportion of participating plans were DSNPs, participating plans also had a higher percentage of enrollees who were dual eligible for Medicare and Medicaid (because these beneficiaries are eligible to enroll in DSNPs).

By design, all Hospice Benefit component participants had to offer Palliative Care, TCC, and the full Medicare Hospice Benefit. The majority of POs (N = 11) that participated in the Hospice Benefit component in 2023 also offered optional Hospice Supplemental Benefits, such as zero-dollar cost-sharing for hospice drugs and biologicals, inpatient respite care, and additional caregiver support, among other benefits.

Implementation Experiences

VBID General

Most POs whose representatives we interviewed (25 of 29, 86%) considered VBID General implementation to be a relatively small lift in 2023. All POs reporting small-lift implementation offered a Part D intervention to their low-income beneficiaries or implemented VBID in DSNPs. Representatives of several POs said that their implementation experiences varied by intervention type and noted that Part D interventions were much easier to implement than card-delivered supplemental benefits (including healthy food and utilities), which required creating new workflows and working with new types of vendors.

Although POs continued to report that overall VBID General implementation was not a major lift in 2023, our survey results show that model-specific data-reporting was a moderate challenge and that working with vendors or subcontracts, communicating information about VBID benefits to beneficiaries, and administering multiple sets of benefits within a plan were considered to be slightly challenging.

The Hospice Benefit Component

Hospice-participating POs had to create and maintain a hospice network as part of the model test requirements. Some POs reported expanding the number and type of hospices in their networks in response to network adequacy requirements that were phased in for continuing POs in 2023. Although most POs we interviewed reported paying the full fee-for-service (FFS) rate for in-network hospice services, three POs (which account for the majority of VBID hospice enrollees) reported paying 5% to 15% less than the FFS rate for these services. Several hospices cited lower-than-FFS rates as their major concern about the model and noted that they agreed to join PO networks despite pay cuts to ensure that they could continue to care for MA beneficiaries and maintain their long-term business viability. These concerns were particularly salient to hospices in service areas with high MA penetration.

POs and hospices reported investing considerable effort and resources, such as hiring new staff and developing new administrative processes and lines of communication, to implement the Hospice Benefit component in the initial year of their model participation. Although most continuing POs and in-network hospices indicated that Hospice Benefit component implementation was manageable in 2023 because beneficiary volume was relatively low, they predicted that any substantial increase in the number of Hospice Benefit component-eligible beneficiaries would greatly increase implementation burden and require additional investments. In general, POs' and hospices' top implementation challenges continued to be related to administrative processes, such as the timely submission of notices of election and claims submission and adjudication. Hospices cited delayed payments, data-reporting and communication requirements that vary across POs, and the lack of a definition of Palliative Care and TCC as additional challenges. Hospices noted that it was particularly difficult to make investments to implement the Hospice Benefit component and provide care to VBID patients in the context of lower-than-FFS rates.

Associations with Key Outcomes

VBID General

We used entropy-balanced difference-in-differences (DD) regressions to estimate the effect of VBID on plan-, beneficiary-, and contract-level outcomes. When data were available, we ran analyses for all years from 2020 through 2023. However, data were not available through 2023 for all outcomes. For beneficiary-level outcomes, of which most relied on MA encounter data, we analyzed outcomes for 2020 and 2021 only.

Overall, we found that **VBID General was associated with improvements in care quality** in 2021 and 2022, **increased adherence to recommended care** in 2020 and 2021, **higher costs to CMS** in 2021 and 2022**, and reduced beneficiary out-of-pocket (OOP) costs** in 2021 (see Table S.1). Our estimates and confidence intervals (CIs) represent the incremental association of

VBID with the outcome in each year compared with what would have been expected in that year without VBID. Our methods are similar to those used for our prior evaluation report (Eibner et al., 2023); however, we adapted our beneficiary-level approach to include a broader and more representative sample of VBID-targeted beneficiaries in the analysis. We also updated our approach to improve balance on pre-period outcome trends between VBID participants and comparators.

Contract-Level Findings

VBID General was associated with a 0.20 point increase in contract-level Star Ratings in 2021 ($p = 0.02$, 95% CI [0.04 to 0.035]) and a 0.19 point increase in 2022 ($p < 0.01$, 95% CI [0.06 to 0.032]). Star Ratings range from 1 to 5, with 5 representing the highest quality, and reflect quality performance across several domains. In both 2021 and 2022, a 0.2 point increase in the Star Rating represents roughly a 5% change.

VBID-associated increases in the overall Star Rating measure appear be driven by increases in the Star Rating domain related to managing chronic conditions:

- In 2021, VBID General was associated with a 0.20 point (5%) increase ($p = 0.01$, 95% CI [0.05 to 0.36]) in the managing chronic conditions domain-level Star Rating.
- In 2022, VBID General was associated with a 0.21 point (6%) increase ($p = 0.01$, 95% CI [0.01 to 0.37]) in the managing chronic conditions domain-level Star Rating.

For 2021, VBID General was also associated with a 0.38 point increase (8%) in the domain-level Star Rating related to health plan customer service ($p = 0.01$, 95% CI [0.10 to 0.65]). However, we found no statistically significant association in 2022. We also found no statistically significant association between VBID and any of the other domain-level Star Ratings that we considered in either 2020 or 2021. These additional domains included staying healthy, member experiences with the plan, member complaints, and drug safety and accuracy.

Beneficiary-Level Findings

VBID General was associated with a 0.06 point increase in targeted beneficiaries' risk scores in 2020 ($p < 0.01$, 95% CI [0.03 to 0.08]) and a 0.07 point increase in 2021 ($p < 0.01$, 95% CI [0.04 to 0.10]). These changes represent risk score increases of roughly 4% relative to what would have been expected without VBID. Although most POs we interviewed did not say that VBID affected risk scores, two POs noted that additional wellness visits and the use of health risk assessments as part of WHP could have caused risk scores to increase.

Table S.1. Associations Between VBID General and Key Outcomes, 2020–2023

Unit	Outcome	2020	2021	2022	2023
Contract	Overall Star Rating[a] (Care Quality)	Not assessed	↑ 0.20 point (0.04 to 0.35)	↑ 0.19 point (0.06, 0.32)	Not yet assessed
Beneficiary	Adherence to Cholesterol Medication	↑ +1.2 ppts. (0.4, 2.1)	↑ +0.4 ppts. (0.0, 0.8)	Not yet assessed	Not yet assessed
	Adherence to Diabetes Medication	↑ +1.1 ppts. (0.4, 1.8)	+0.4 (–0.1, 0.9)	Not yet assessed	Not yet assessed
	Adherence to Breast Cancer Screening Recommendations	↑ +2.6 ppts. (0.3, 5.0)	↑ +2.3 ppts. (0.3, 4.3)	Not yet assessed	Not yet assessed
	Part D Annual Out-of-Pocket Costs	$1 (–$7, $9)	↓ –$25 (–$16, –$33)	Not yet assessed	Not yet assessed
	Targeted Beneficiaries' Risk Scores[b]	↑ 0.06 point (0.03, 0.08)	↑ 0.07 point (0.04, 0.10)	Not yet assessed	Not yet assessed
	Inpatient Stays	↑ +3.5% (1.8, 5.1)	↑ +3.6% (1.8, 5.3)	Not yet assessed	Not yet assessed
Plan	Total Costs to CMS (PMPM)	$7 (–$10, $23)	↑ $29 ($11, $45)	↑ $25 ($6, $44)	Not yet assessed
	MA Rebates (PMPM)	↑ $6 (–$0.4, $13)	↑ $17 ($12, $23)	↑ $17 ($11, $22)	↑ $23 ($14, $30)
	Standardized MAPD Bid (PMPM)	–$4 (–$13, $5)	–$3 (–$9, $3)	↓ –$5 (–$11, $1)	↓ –$11 (–$19, –$2)
	Plan Risk Scores[b]	0.01 point (–0.01, 0.03)	↑ 0.02 point (0.00, 0.03)	↑ 0.02 point (0.00, 0.04)	Not yet assessed
	Number of Mandatory Supplemental Benefits (MSBs) Offered	–0.4 (–0.9, 0.1)	↓ –1.5 (–1.9, –1.1)	↓ –1.1 (–1.4, –0.8)	↓ –0.7 (–1.2, –0.2)
	Enrollment (% Change)	5% (-14%, 31%)	3% (–6%, 14%)	5% (–7%, 18%)	↑ 27% (8%, 51%)

NOTE: PMPM = per member, per month; ppt. = percentage point. The dark blue arrows indicate $p < 0.05$. The light blue arrows indicate $p < 0.10$. The 95% confidence intervals are shown in parentheses. The shaded cells indicate outcomes that were analyzed for the first time in this report. "Not yet assessed" means that the outcome was not analyzed in a given year but will be assessed in the future. The results for each year and outcome are derived from separate regressions. The results may differ from prior year reports due to methodological changes.

[a] Star Rating data are for measure years 2021 and 2022 and correspond with published (display year) data for 2023 and 2024.

[b] Beneficiary-level risk scores reflect measure years, and plan-level risk scores reflect payment year risk scores (diagnoses measured in year *t* are used for payment in year *t* + 1).

VBID General was also associated with increases in adherence for some drugs and the greater use of mammograms. Specifically,

- VBID was associated with a 1.2 percentage point increase in adherence to cholesterol medications in 2020 ($p < 0.01$, 95% CI [0.4 to 2.1]) and a 0.4 percentage point increase in 2021 ($p = 0.04$, 95% CI [0 to 0.8]). This represents roughly 2,100 additional people becoming adherent in 2020 and roughly 3,900 additional people becoming adherent in 2021. The number affected is larger for 2021 than for 2020, despite a smaller percentage point change because more beneficiaries were targeted by VBID in that year.
- VBID was associated with a 1.1 percentage point increase in adherence to diabetes medications in 2020 ($p < 0.01$, 95% CI [0.04 to 1.8]). This represents roughly 670 additional beneficiaries becoming adherent in 2020. We found no statistically significant association in 2021.
- VBID was associated with a 2.6 percentage point increase in adherence to breast cancer screening recommendations in 2020 (p = 0.03, 95% CI [0.3 to 5.0]) and a 2.3 percentage point increase in 2021 ($p = 0.03$, 95% CI [0.3 to 4.3]). This represents roughly 1,400 additional women receiving mammograms in 2020 and roughly 9,000 additional women receiving mammograms in 2021. Again, the estimated number of people affected is larger for 2021 than for 2020 because more beneficiaries were targeted in 2021.

Despite greater adherence, VBID General was associated with a 3.5% increase in inpatient stays (excluding coronavirus disease 2019 [COVID-19] inpatient stays) among targeted beneficiaries in 2020 ($p < 0.01$, 95% CI [1.8% to 5.1%]) and a 3.6% increase ($p < 0.01$, 95% CI [1.8% to 5.3%]) in 2021. One potential explanation for this is that VBID interventions may have uncovered a latent need for inpatient services due to increased interactions with providers and care managers. However, more research is needed to understand the root cause of this finding, especially because PO representatives did not perceive that VBID was associated with an increase in hospitalization.

VBID General was associated with a $25 decline in beneficiaries' annual Part D OOP costs in 2021 ($p < 0.01$, 95% CI [–$16 to –$33]). This finding, which represents a 24% decline in OOP drug spending, is not surprising given that reduced Part D cost-sharing was one of the most common VBID interventions.

Plan-Level Findings

VBID General was associated with an $11 per member, per month (PMPM) reduction in the standardized MAPD bid in 2023 ($p = 0.02$, 95% CI [–$19 to –$2]). This represents an approximately 1% decline in bids relative to what would have been expected without the model. VBID General was also associated with reductions in bids in earlier years; however, these associations were smaller than in 2023 and not statistically significant at conventional levels. Some participating POs described reducing their profit margins to ensure lower bids, which increased rebate dollars that they used to fund certain VBID benefits.

Despite lower standardized bids in some years, VBID General was associated with an increase in total costs to CMS of $29 PMPM in 2021 ($p < 0.001$, 95% CI [$11 to $45]) and $25

PMPM in 2022 ($p = 0.01$, 95% CI [$6 to $44]). These changes represent increases of about 2% relative to what would have been expected without the model. We could not assess total costs to CMS in 2023, because data to analyze Part D costs were not fully available when we conducted our analysis.

Costs to CMS include not only the standardized bid but also rebates paid by CMS to plans and plans' risk scores, which are used to adjust the standardized bid to reflect the anticipated average spending needs of beneficiaries enrolled in the plan. VBID General was associated with higher plan-level risk scores in some years and higher rebates in all years. The changes to risk scores represent increases on the order of 1.5%. Rebates increased by approximately 14% in 2021 and 11% in 2022, relative to what would have been expected without VBID. In our discussions with POs, some mentioned deliberately reducing profit margins to increase rebates, which they used to fund VBID benefits.

In 2023, VBID General was associated with a reduction in the average number of mandatory supplemental benefits (MSBs) offered of 0.7 ($p < 0.01$, 95% CI [–1.2 to –0.2]). Similar declines occurred in 2021 and 2022. MSBs include such extra benefits as vision care, dental care, acupuncture, and caregiver support that are not part of the basic MA benefit package; on average, VBID plans offered around 20 such benefits. When counting MSBs, we did not include VBID-enabled supplemental benefits, which may not be available to all plan enrollees. Some POs indicated that they reduced MSBs to make room for more targeted VBID benefits.

Finally, VBID General was associated with a 27% increase in enrollment in 2023 ($p < 0.001$, 95% CI [8% to 51%]). POs also reported that VBID General increased enrollment, citing zero-dollar cost-sharing for Part D drugs and VBID supplemental benefits as differentiators that contributed to enrollment gains and increased beneficiary retention rates.

The Hospice Benefit Component

We assessed Hospice Benefit component results using both descriptive analysis and entropy-balanced DD models. Our findings represent the marginal association between VBID and the outcome in each year, above what would have been expected without VBID.

In general, we found that the Hospice Benefit component had little to no association with key outcomes, such as hospice enrollment and length of stay, in 2021 and 2022 (see Table S.2). However, in interpreting the findings, it is important to note that—given relatively limited PO and beneficiary participation—it was often difficult to achieve balance in the DD models. Although our entropy-balanced approach does not require balance to ensure the validity of the results, the lack of balance increases our reliance on the assumptions that underlie the DD methodology (namely, that trends among VBID and comparison groups would have evolved in parallel without the intervention).

Table S.2. Associations Between the Hospice Benefit Component and Key Outcomes, 2021–2023

Unit	Outcome	2021	2022	2023
Beneficiary	Hospice enrollment	–1.9 ppts. (–4.5, 0.7)	–1.7 ppts. (–4.4, 1.0)	Not yet assessed
	Short stay in hospice (<7 days)	1.1 ppts. (–1.0, 3.0)	↑ 1.3 ppts. (–0.2, 2.9)	Not yet assessed
	Long stay in hospice (>180 days)	0.7 ppt. (–1.1, 3.0)	0.1 ppt. (–0.8, 1.0)	Not yet assessed
	Live discharge	–0.1 ppt. (–2.0, 2.0)	↓ –1.0 ppt. (–2.0, 0.1)	Not yet assessed
	Summary CAHPS Hospice survey score	↑ 1.9 (–0.2, 4.1)	–0.05 (–1.3, 1.2)	Not yet assessed
	Had a professional visit in 2 of the last 3 days of life	0.7 ppt. (–3.0, 4.0)	↓ –2.8 ppts. (–4.7, –0.9)	Not yet assessed
Plan	Standardized MAPD bids (PMPM)	↓ –$20 (–$36, –$5)	↓ –$16 (–$31, –$1)	–$11 (–$27, $5)
	Total costs to CMS (PMPM)	$7 (–$29, $45)	–$13 (–$45, $22)	Not yet assessed
	MAPD premiums	↓ –$4 (–$9, –$0.12)	–$1 (–$4, $2)	–$1 (–$6, $4)
	Number of MSBs offered	0.12 (–0.9, 1.1)	↑ 0.74 (–0.1, 1.6)	0.57 (–0.3, 1.4)

NOTE: CAHPS = Consumer Assessment of Healthcare Providers and Systems; ppt. = percentage point. The dark green arrows indicate $p < 0.05$. The light green arrows indicate $p < 0.10$. The 95% confidence intervals are shown in parentheses. The shaded cells indicate outcomes that were analyzed for the first time in this report. "Not yet assessed" means that the outcome was not analyzed in a given year but will be assessed in the future. The results may differ from prior year reports due to methodological changes described in the main report and the appendices.

Utilization and Quality

The number of beneficiaries in VBID-participating POs who started hospice increased to 23,828 in 2023 from 9,630 in 2021 and 19,065 in 2022. Although beneficiaries were not required to seek care from an in-network hospice as part of the model test, the use of in-network hospices increased in 2023, the first year that a majority of beneficiaries starting hospice (55.8%) chose to receive in-network care. By comparison, in 2022, 47.8% of beneficiaries in VBID-participating POs who started hospice used in-network hospices. Nonetheless, the utilization of Hospice Benefit component services in 2023 was low:

- In nine of 15 POs, fewer than 25% of decedents enrolled in plans that participated in the Hospice Benefit component used palliative care services, which was lower than the palliative care utilization that POs projected in their applications to CMS.
- Of the beneficiaries who started hospice care while enrolled in plans that participated in the Hospice Benefit component, only 156 used TCC. This represents 0.7% of all beneficiaries who entered hospice in a plan that participated in the Hospice Benefit component and 1.2% of beneficiaries who started care in in-network hospices.
- Approximately 7% of beneficiaries who started hospice care while enrolled in plans that participated in the Hospice Benefit component used a Hospice Supplemental Benefit.

We found few statistically significant associations between plans' participation in the Hospice Benefit component and beneficiary outcomes. The primary exception was a statistically significant 2.8 percentage point reduction in the proportion of beneficiaries receiving two or more visits from professional hospice staff in their final three days of life ($p < 0.01$, 95% CI [– 4.7 to –0.9] percentage points). However, this association was not consistent over time and did not hold in sensitivity analyses. Similarly, marginally significant associations with a Consumer Assessment of Healthcare Providers and Systems summary score in 2021, short hospice stays in 2022, and live discharges in 2022 were not robust over time or in sensitivity testing. As a result, we deem the evidence for these associations to be weaker than for other significant associations identified in this report.

Plan-Level Cost Outcomes

The Hospice Benefit component was associated with a $20 PMPM reduction in plan bids in 2021 ($p = 0.01$, 95% CI [–$36 to –$5]) and a $16 PMPM reduction in 2022 ($p = 0.04$, 95% CI [– $31 to –$1]); there was no statistically significant association in 2023. VBID was also associated with a statistically significant $4 decline in MAPD premiums in 2021 ($p = 0.04$, 95% CI [–$9 to –$0.12]) and a marginally significant increase in the number of MSBs offered in 2022. We found no statistically significant associations with these outcomes in other years or with costs to CMS in any year.

Evaluation Limitations and Strengths

Our analysis has several limitations that readers should consider when interpreting the results (see Table S.3). First, VBID participation was voluntary, and POs and plans that entered the model were different from those that chose not to participate. Although we addressed this issue with entropy-balancing and DD models, we cannot be sure that we eliminated all differences, which could bias the results. This issue is especially acute for the Hospice Benefit component, given limited plan participation in the model, low beneficiary uptake of Hospice Benefit component benefits, and the fact that a large share of participating plans was in Puerto Rico. Furthermore, our estimates reflect average associations between VBID and key outcomes among all participating plans in each year. Because participation in VBID General grew substantially over time, the majority of participants in most years were new entrants who may still have been fine-tuning their interventions. An additional limitation is that, for the VBID General beneficiary-level outcomes (for example, risk scores and inpatient use), we only analyzed data for 2020 and 2021, which may be unrepresentative years due to the effects of the COVID-19.

Table S.3. Summary of Limitations and Strengths of the Evaluation

Evaluation Limitations	Evaluation Strengths
• Evaluated a voluntary model that allowed participants wide latitude to design interventions • Could not fully rule out unmodeled differences between VBID and comparison groups • Assessed VBID General beneficiary-level data for only two years (2020 and 2021) • Model implementation coincided with COVID-19 pandemic • Lacked clinical data, such as lab results, that could help clarify results • Relatively few plans and beneficiaries participated in the Hospice Benefit component; most 2021 participants were in Puerto Rico	• Combined qualitative and quantitative data to understand model impacts • Analyzed many outcomes to gain a comprehensive assessment of VBID's effects • Addressed biases from observable and unobservable differences between VBID participants and comparison groups by – controlling for time trends common to VBID and comparison groups – using rigorous statistical methods (entropy-balancing and DD) to estimate effects

Regardless of these limitations, our evaluation relied on a rigorous mixed-methods approach that combined quantitative and qualitative methods to estimate how the VBID Model test is affecting key outcomes related to health care costs, utilization, and quality. We leveraged state-of-the-art statistical methods to address potential biases due to observed and unobserved differences between VBID and comparison groups. In addition, we contextualized our findings based on interviews with PO and hospice representatives to explain why the model led to certain outcomes. We also conducted many sensitivity and subgroup analyses to test the robustness of our findings; these additional analyses are described in the appendices.

Abbreviations

C-SNP	Chronic Condition Special Needs Plan
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CHF	congestive heart failure
CI	confidence interval
CMR	comprehensive medication review
CMS	Centers for Medicare & Medicaid Services
CON	Certificate of Need
COPD	chronic obstructive pulmonary disease
COVID-19	coronavirus disease 2019
DD	difference-in-differences
DSNP	Dual Eligible Special Needs Plan
ED	emergency department
EHR	electronic health record
EMR	electronic medical record
FAI	Financial Alignment Initiative
FFS	fee-for-service
HRA	health risk assessment
I-SNP	Institutional Special Needs Plan
LICS	low-income cost-sharing subsidy
LIS	low-income subsidy
LOS	length of stay
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAPD	Medicare Advantage Prescription Drug
MNP	minimum number of providers
MSB	mandatory supplemental benefit
MTM	Medication Therapy Management
NOE	notice of election
NP	nurse practitioner
NPHR	non-primarily health related
OACT	Office of the Actuary
OON	out-of-network
OOP	out-of-pocket
OTC	over-the-counter
PBP	plan benefit package

PCP	primary care provider
PHR	primarily health related
PMPM	per member, per month
PO	parent organization
PPO	preferred provider organization
RI	Rewards and Incentives
ROI	return on investment
SDOH	social determinants of health
SES	socioeconomic status
SNAP	Supplemental Nutrition Assistance Program
SNP	Special Needs Plan
SSBCI	Special Supplemental Benefits for the Chronically Ill
TCC	Transitional Concurrent Care
VBID	Value-Based Insurance Design
WHP	Wellness and Health Care Planning

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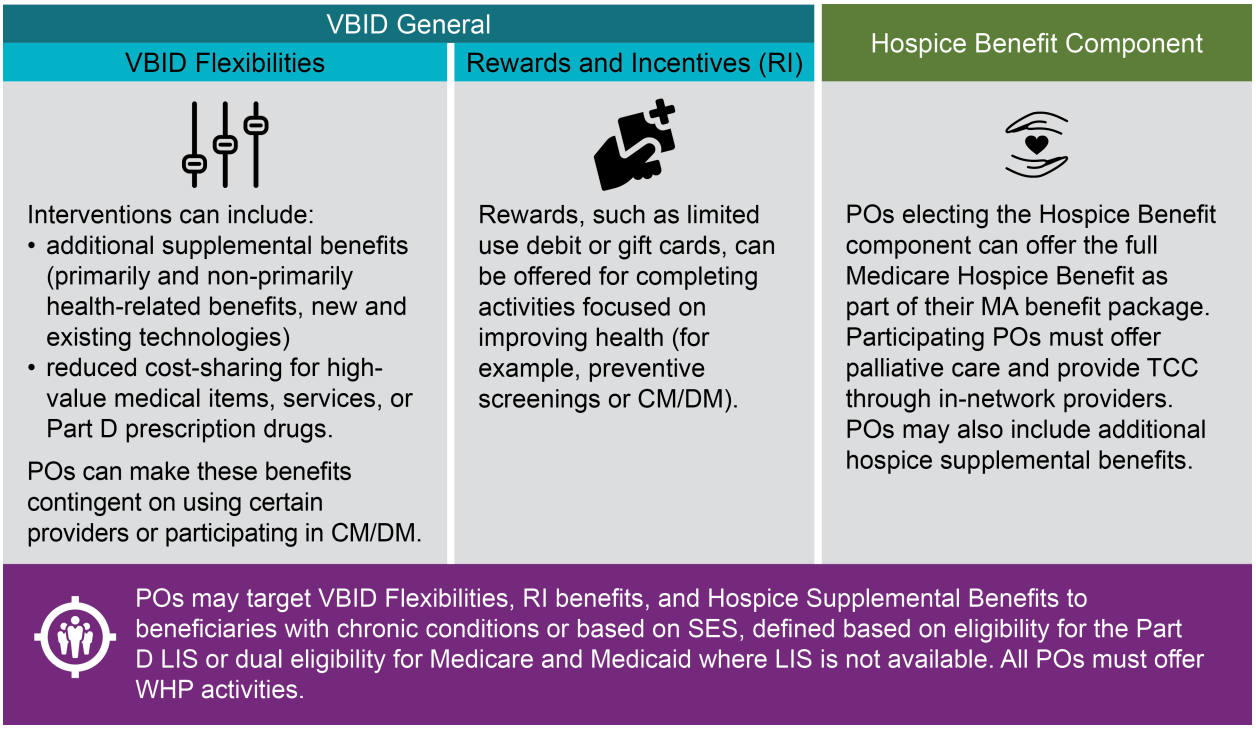
Chapter 1. Introduction

The Centers for Medicare & Medicaid Services' (CMS') Medicare Advantage (MA) Value-Based Insurance Design (VBID) model allows participating MA insurers, known as parent organizations (POs), to offer innovative benefit design options in eligible MA plans. The VBID Model allows plans to target benefits, such as reduced cost-sharing or supplemental benefits, to beneficiaries based on their chronic conditions and/or socioeconomic status (SES), with the goals of increasing beneficiaries' engagement in their care, encouraging the use of high-value care, and promoting healthy behavior. In turn, the model aims to improve care quality, enhance beneficiary health, and reduce health spending. Figure 1.1 shows the major components of the VBID Model available in 2023.

Figure 1.1. 2023 VBID Model Test Components



NOTE: CM/DM = care management or disease management; LIS = low-income subsidy; TCC = Transitional Concurrent Care; WHP = Wellness and Health Care Planning. From 2021 to 2022, POs were also permitted to offer Cash Rebates, to pass a portion of their MA rebates directly to their enrollees. Few POs used this option, and CMS discontinued it for 2023.

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 and hospices 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. VBID General and the Hospice Benefit component are being evaluated separately.

In this report, we present the results from the third annual evaluation of Phase II of the model test, focusing on outcomes for 2020 to 2023. (Phase I of the model test ran from 2017 through 2019 and involved a more limited variety of benefit design options, which were similar to the VBID Flexibilities options.) Because many aspects of the model and the evaluation have remained constant since 2020, passages of text found in this report may closely echo passages from prior evaluation reports (Eibner et al., 2023; Khodyakov et al., 2022).

Overview of the Model Test

VBID General

Benefits that POs may offer through the VBID General component of the model test fall into two subcomponents: VBID Flexibilities and Rewards and Incentives (RI). VBID Flexibilities include reduced cost-sharing for high-value Part C services, reduced cost-sharing for Part D drugs, and VBID-enabled supplemental benefits. These flexibilities can be targeted based on beneficiaries' chronic conditions or SES, and they can also be made contingent on beneficiaries' meeting participation requirements, such as using a designated high-value provider or meeting with a care manager.

RI interventions offer financial rewards, such as grocery cards, to beneficiaries who complete desired activities. Like VBID Flexibilities, RI can also be targeted based on SES or chronic conditions.

All participating POs must offer a Wellness and Health Care Planning (WHP) benefit focused on advance care planning to all enrollees in VBID-participating plans. Aside from this, POs can pick and choose the VBID benefits they wish to offer from the options shown in Figure 1.1. They also 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 whether to require beneficiaries to complete certain care management activities. 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. POs can also offer different interventions across their model-participating plans.

In 2021 and 2022, VBID General included a Cash Rebates option, through which participating plans could share their MA rebates with beneficiaries in the form of cash or monetary transfers. Unlike other VBID General benefits, Cash Rebates could not be targeted based on chronic conditions or SES. CMS discontinued the Cash Rebates option in 2023. Although our description of the VBID Model focuses on components that were in effect in 2023,

our data include plans that offered the now-discontinued Cash Rebates benefit because our analysis includes years 2020 through 2023.

The Hospice Benefit Component

In addition to "carving in" the current Medicare Hospice Benefit into MA-covered benefits, POs that participated in the Hospice Benefit component were required to provide access to palliative care services for seriously ill enrollees who were not eligible for, or preferred not to receive, hospice services. POs also had to make individualized Transitional Concurrent Care (TCC) services available to those who were eligible for hospice, met PO-developed TCC eligibility criteria, and wished 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 test.

POs could also offer Hospice Supplemental Benefits, which could include a variety 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 could be targeted based on SES or chronic conditions and could be limited to beneficiaries who choose in-network hospices. By including Palliative Care and TCC services, the Hospice Benefit component was designed to encourage smoother and timelier transitions to hospice when appropriate and preferred, thereby promoting the use of services that are aligned with beneficiary needs and preferences and reducing the use of avoidable acute care services. In March 2024, CMS announced that the Hospice Benefit component will be discontinued in 2025 (CMS, 2024).

As in VBID General, all plans participating in the Hospice Benefit component were required to offer WHP to all enrollees, regardless of hospice eligibility.

Participants

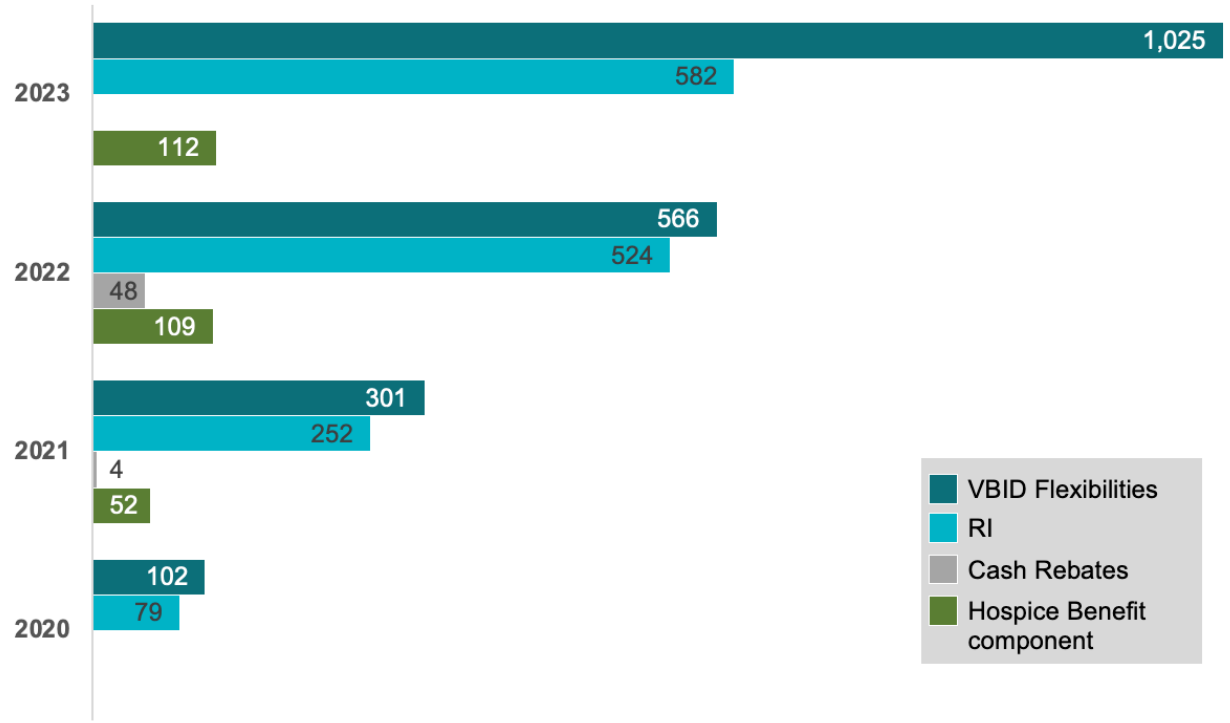
Participation in the MA VBID Model test continues to grow over time: the number of plans participating in VBID General increased from 144 in 2020 to 1,218 in 2023. Of those participating plans in 2023, 462 were new participants (37.9%). An increasing proportion of participating VBID General plans were Dual Eligible Special Needs Plans (DSNPs), a type of MA plan that offers coverage specifically to beneficiaries who are eligible for both Medicare and Medicaid (often referred to as *dual eligibles*). The share of VBID General plans that were DSNPs increased from 27.8% in 2020 to 49.7% in 2023. More than 80% of participating plans in each year were from POs that offered plans in nine or more states, with the average participating PO size increasing from 1,071,379 beneficiaries in 2020 to 3,732,206 beneficiaries in 2023.

The number of plans participating in the Hospice Benefit component also increased over time, from 52 in 2021 to 112 in 2023. Of those participating in 2023, 27 were new entrants (24.1%). The proportion of plans participating in the Hospice Benefit component that were DSNPs decreased from 28.8% in 2021 to 22.3% in 2023. In 2021, one-half (50.0%) of

participating plans were in Puerto Rico, but in 2022 and 2023 only about one-quarter of plans were located in Puerto Rico (27.7% in 2023). The percentage of participating POs that offered plans in nine or more states (a measure of geographic reach) grew from 19.3% in 2021 to 63.4% in 2023.

Figure 1.2 presents the number of VBID-participating plans each year by the type of intervention they offered. Participation in the VBID Flexibilities subcomponent continues to grow the fastest, with the number of participants in that subcomponent doubling from 566 in 2022 to 1,025 in 2023. The increase in the number of plans offering RI interventions has slowed; there was a large increase from 2021 to 2022 and a smaller increase of just over 50 plans between 2022 and 2023 (from 524 to 582). The net increase in the number of plans offering the Hospice Benefit component in 2023 was small (three plans), although the overall number more than doubled from the initial number of participants in 2021.

Figure 1.2. Summary of Interventions Offered by Plans, 2020–2023



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: RI plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. Plans with no enrollment were removed from all analyses.

Methods

This report uses a mixed-methods approach to examine the effect of VBID on a variety of outcomes. We use entropy-balanced DD regressions to quantify the impact of the VBID Model. In addition, we rely on the qualitative analysis of primary data we collected from POs and hospices to explain why and how the VBID Model might have affected key outcomes of interest and to describe POs' and hospices' implementation experiences in their own words. The quantitative approach provides numeric evidence of the VBID Model's impact by comparing VBID participants to nonparticipants, controlling for a variety of observable characteristics, fixed differences between VBID and comparison groups, and time trends. The qualitative approach provides depth and context to the quantitative findings by exploring participants' experiences with and perspectives on the model, often capturing the nuances and complexities that numbers alone cannot convey. This approach also helps uncover the underlying mechanisms, motivations, and contextual factors that influence how the VBID Model is implemented and the outcomes it was able to achieve. Compared with a standalone quantitative or qualitative analysis, a mixed-methods approach offers a more rigorous and comprehensive evaluation, which is recommended for assessing the impact of complex interventions that have multiple components and evolving designs (Farquhar, Ewing, and Booth, 2011; Skivington et al., 2021).

Outcomes Considered

We analyzed VBID's effect on a variety of outcomes, including POs' implementation experiences, plans' financial outcomes, beneficiaries' health and utilization outcomes, care quality, and more. Although our analysis covered 2020 through 2023, we did not assess each outcome with data from all four years. For outcomes that we assessed primarily through qualitative data, such as POs' implementation experiences, we focused on the data we collected in 2023. Our prior evaluation reports describe PO implementation experiences in earlier years (Eibner et al., 2023; Khodyakov et al., 2022). For other outcomes, such as inpatient utilization, relevant data streams have lengthy run-out periods, meaning that the final data for a given year may not be available for up to two years after the end of that year. In those cases, we assessed the data that were available when we conducted our analysis, which occurred in mid-2024 to late 2024. Table 1.1 shows the years that we considered for each outcome. We did not assess quality-related outcomes in 2020 due to coronavirus disease 2019 (COVID-19) pandemic-related changes in quality reporting in that year.

Table 1.1. Outcomes Addressed in This Report, by Chapter and Years Included

Outcome	Chapter	2020	2021	2022	2023
VBID General					
PO participation	2	—	—	—	✓
PO implementation experiences	3	—	—	—	✓
PO perspectives on utilization	4	—	—	—	✓
Plan enrollment, bid outcomes, premiums, and mandatory supplemental benefit offerings	5	✓	✓	✓	✓
Cost to CMS	5	✓	✓	✓	—
Beneficiary health and utilization outcomes	6	✓	✓	—	—
Beneficiary Part D OOP costs	6	✓	✓	—	—
Contract-level quality	7	—	✓	✓	—
Hospice Benefit component					
PO participation	8	—	—	—	✓
Hospice networks	9	—	✓	✓	✓
PO and hospice implementation experiences	10	—	—	—	✓
Hospice enrollment	11	—	✓	✓	—
Hospice care patterns and quality	11	—	✓	✓	—
Plan enrollment, bid outcomes, premiums, and mandatory supplemental benefit offerings	12	—	✓	✓	✓
Cost to CMS	12	—	✓	✓	—

NOTE: OOP = out-of-pocket. A dash (—) indicates that the outcome was not analyzed for that year in this report.

Quantitative Analysis of Secondary Data

To estimate the associations between VBID and outcomes, we compared VBID participants with entropy-balanced comparison groups using DD regression models. DD models compare trends in outcomes between the VBID group and a comparison group to assess whether the trends diverged after model implementation. For example, if bids among VBID plans declined after model implementation but bids among comparison plans held steady, we would have evidence that VBID was associated with a reduction in plan bids.

A key assumption of the DD methodology is that, in the absence of VBID, outcome trends for the VBID and comparison groups would have evolved in parallel. This assumption cannot be tested, because we cannot observe outcome data for the VBID group in a world in which VBID never occurred. To increase the plausibility of the assumption, we used entropy-balancing to ensure that pre-VBID outcome trends for VBID and comparison groups were similar. To model outcome trends, we used data from three years prior to model implementation (or exposure to the model, in the case of beneficiaries). We also used entropy balancing to ensure that VBID and comparison groups were balanced along other characteristics, such as plan type, beneficiary age,

and pre-VBID Star Rating levels. In cases in which data were missing, we imputed the missing values using the generalized efficient regression-based imputation with latent processes procedure (Robbins, 2024).

We considered a variety of outcomes that were defined at the plan level (such as bids), the beneficiary level (such as inpatient utilization), and the contract level (such as Star Ratings). Our entropy-balancing characteristics varied for each outcome, both because the units of analysis varied and because different outcomes required different covariates. In general, we avoided balancing on pre-VBID levels for the outcome in question because this approach could introduce bias due to reversion to the mean (Daw and Hatfield, 2018), but we did balance on pre-treatment outcome trends, as noted above.

VBID plans implemented the model in different years, and some discontinued participation over the course of the model test. To address this variation in the timing and duration of participation, we stratified the data and ran separate regressions for each possible participation pattern (for example, 2020 only, 2020 and 2021 only, 2020 to 2022, all four years, etc.) and combined the results using a weighted average, with the weights corresponding to the number of participating plans in the pattern. This approach is similar to the methods proposed by Callaway and Sant'Anna (2021) to address staggered adoption in DD analysis. For the beneficiary-level models, we implemented additional stratification to account for differences in whether beneficiaries' pre-VBID data came from fee-for-service (FFS) or MA. Our beneficiary-level analysis focused on the effects for VBID-targeted beneficiaries (that is, beneficiaries who were eligible to participate in their plans' VBID intervention), as opposed to all beneficiaries in participating plans. Further discussion of our methods can be found in Appendix A, and information on the variables used in the analyses can be found in Appendix B.

We conducted separate analyses for VBID General and the Hospice Benefit component. In cases in which the outcome was the same for VBID General and the Hospice Benefit component, such as plan bids, we used the same methods for each model component. However, some hospice-specific outcomes required alternative methods because beneficiaries who elect hospice are typically observed in the data only for a short period of time. To address this complication, most of our Hospice Benefit component analyses used a cross-sectional variation of the weighted DD analysis approach, in which we compared repeated cross sections of subsets of beneficiaries in VBID-participating and comparison plans. The specific subsets could include all health plan enrollees, all decedents, or all hospice enrollees, depending on the research question. More detail on the statistical methods for the hospice analysis can be found in Appendix C.

We report results for up to four years after the model was implemented (2020 through 2023). However, especially for VBID General, the number of participating plans increased substantially in each year, the composition of plans shifted to include more DSNPs, and the types of interventions that plans offered changed. We estimated separate regression models for each year that reflected the changing composition of plans and interventions over time. As a result, our findings show associations between VBID and key outcomes given the mix of participants and

interventions that existed in each year; they do not tell us how these associations changed as plans' interventions matured. In fact, because of the substantial increase in participation over time, our VBID General results for most years are driven by plans that were new to the model in that year. Although the composition of plans participating in the Hospice Benefit component was somewhat more stable, shifts in participation and intervention design still occurred (for example, greater participation among U.S. mainland plans starting from 2022); therefore, the same considerations apply when interpreting the results for the Hospice Benefit component.

For several outcomes jointly selected by RAND researchers and CMS, we conducted subgroup analyses to better understand the effects for subcomponents of VBID General, including VBID Flexibilities overall, interventions targeted based on SES, Part D cost-sharing reductions, Part C cost-sharing reductions, chronic conditions, and RI. These results are discussed, where applicable, in the main text and reported in full in Appendix D.

We report a large number of associations, with corresponding p-values and confidence intervals (CIs). We interpret each p-value and CI in isolation, using the conventional threshold of $p < 0.05$ to determine statistical significance, without correction for multiple testing (associations with $p > 0.05$ but < 0.10 are designated as marginally significant). We do not use a multiple testing correction because we are not making a single determination about VBID. For example, if the primary goal of this report was to determine if VBID worked, and we could conclude this if any of the tests were significant in the desired direction; then, correcting for the family wise error rate across all tests would be appropriate. In the absence of this single determination that would combine all tests, we evaluate the tests separately. However, we provide p-values so that interested readers may make any post hoc corrections they would like.

Primary Data Collection and Qualitative Analyses

To provide a more comprehensive analysis of the VBID Model's impact, we surveyed and conducted semistructured interviews with all POs that participated in the VBID Model test in 2023 and interviewed representatives of ten in-network hospices. We relied on these data not only to understand stakeholder thoughts and experiences with the model test but also to explain how and why VBID implementation may have affected key outcomes.

We have anonymized all data in this report. For POs and hospices, we use a de-identified name (for example, PO A, PO B, Hospice A, or Hospice B) to protect their confidentiality. We have also retained the labeling assignments for POs and hospices from previous VBID evaluation reports for continuity purposes. If relevant, we also noted whether a hospice we interviewed was in-network or out-of-network (OON) for a VBID-participating PO.

Between May and September 2023, we collected survey responses and conducted virtual or in-person interviews with representatives of POs that participated in the VBID Model test in 2023. We invited all 52 model-participating POs to complete the online survey; 51 POs completed it. Of the 42 POs we invited to participate in an interview, 37 did so. Representatives of six POs participated in the interview during an in-person site visit, and representatives of the

remaining 31 POs participated in a virtual interview. In total, we interviewed 225 PO representatives. The purpose of the survey and interviews was to explore how POs implemented the model test components, understand what implementation challenges they encountered, and elicit their perspectives on the impact of VBID on such outcomes as enrollment, care quality, and cost outcomes in 2023. During the interviews, we used each PO's survey responses to guide the discussion. Appendix E provides additional details on the PO questionnaires and interviews.

Between May and October 2023, we conducted semistructured interviews with 23 representatives of ten in-network hospices. Of the ten hospices, nine completed a pre-interview survey. We conducted interviews with the representatives of five hospices during in-person site visits; interviews with representatives of the remaining five hospices were conducted virtually. These interviews explored factors that hospices considered when deciding to participate in PO networks and their experiences negotiating contracts with POs, working with POs to coordinate care for VBID beneficiaries, and delivering Hospice Benefit component services. Appendix E provides additional details on hospice questionnaires and interviews.

We descriptively analyzed PO and hospice survey data to identify the most common responses and the variety of perspectives. Our approach to the analysis of all interview data was similar to previous VBID evaluation years and entailed a series of coding steps to process PO and hospice interview data, followed by a thematic analysis. Data-coding involved the development of a codebook from an initial set of interview transcripts and the codebooks used in prior years and then a systematic application of these codes to interview transcripts. We analyzed the coded transcripts using thematic analysis techniques to compare and contrast emerging themes, explore variation in implementation experiences by model components and participants, and identify responses to our key research questions (Guest, MacQueen, and Namey, 2012). Once all the data were analyzed, we compared our results with the findings reported in our previous reports 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 Appendix E.

Limitations

The VBID Model is voluntary, and, as such, POs can choose whether to participate and which plans to enter. If specific types of plans and/or POs selectively entered the model, our results could be biased. We have attempted to address this threat of bias through entropy balancing and DD analysis. However, it is possible that these approaches have not fully addressed all possible sources of bias. Most importantly, our methods cannot address the impact of time-varying, unobserved covariates that are correlated with outcomes and may differ for VBID and non-VBID plans and beneficiaries. For example, if VBID-participating plans adopted new utilization management practices (unrelated to VBID) alongside their VBID interventions, and non-VBID plans did not make similar changes, our approach could attribute the effects of these new practices to VBID. Similarly, if beneficiaries who intended to improve their health

purposefully enrolled in VBID plans, we might erroneously attribute these improvements to the model. By balancing on observable characteristics, we reduce the likelihood that VBID plans and beneficiaries would have behaved differently from comparators. However, we cannot rule out the possibility that time-varying, unobserved differences may have affected our results.

Self-selection into the model presented particular challenges for the hospice analyses because plans that participated in the Hospice Benefit component were disproportionately located in Puerto Rico, especially in 2021. This made it difficult to fully balance the observable characteristics of hospice-participating and nonparticipating plans. We faced a related challenge with DSNPs: By 2023, the majority of eligible DSNPs had joined the model test, leaving a smaller and possibly selected sample of nonparticipating DSNPs to serve as comparators. Because of the potential selection issues for both VBID General and the Hospice Benefit component, we describe our findings using associational rather than causal language throughout this report.

Another limitation is that VBID General encompasses a large variety of benefit design options that plans and POs can tailor in many ways. As a result, each VBID General intervention is different, and the mix of these interventions has changed substantially over time. We evaluated VBID General primarily as a whole, an approach that may miss effects that are limited to specific intervention types. Although we address this limitation to some degree by conducting subgroup analyses, the subgroups may encompass several interventions. Furthermore, some plans may have implemented similar interventions prior to joining VBID through other related CMS initiatives, such as Special Supplemental Benefits for the Chronically Ill (SSBCI). In these cases, our models are designed to pick up the incremental effects of joining the model test rather than the overall effect of the intervention that was continued from another initiative.

In addition, for beneficiary-level outcomes, we typically had only two years of data (2020 and 2021) available to analyze; it may take more time for results to materialize. More generally, because VBID participation increased substantially over time, the majority of VBID plans in most years are first year implementors. As a result, our results may not fully capture the long-term effects of VBID on outcomes. Relatedly, we did not have direct input from beneficiaries on their experiences with VBID benefits because we did not conduct interviews with beneficiaries for the current report.

Finally, we used insights gained from our qualitative findings from PO and hospice data collection to help interpret and contextualize the quantitative results. In most instances, our quantitative and qualitative results were consistent. However, we found cases in which POs' assessments of their own outcomes differed from our quantitative findings. These differences may have been driven by several factors. First, our quantitative analyses involved entropy-balanced regressions and a comparison group. In contrast, POs' own assessments of their outcomes were typically based on before-and-after comparisons or comparisons with their own plans that were not part of the VBID Model. Often, POs entered all of their eligible plans of a given type; therefore, they had no good comparisons. Second, our qualitative assessments were

based on self-reported data. It is possible that PO representatives may not have been completely accurate in their responses to our questions or may not have reviewed the underlying data on the outcomes before providing their responses to our survey questions about achieved outcomes. Third, our regressions were designed to reflect overall average outcomes among all VBID-participating POs; any given PO may have experienced an outcome that deviated from the average.

Report Structure

Our report has three parts. In Part I, we describe the results for VBID General, focusing on PO participants and their interventions (Chapter 2), implementation experiences (Chapter 3), benefit utilization and beneficiary experiences (Chapter 4), plan-level enrollment and financial outcomes (Chapter 5), beneficiary-level health and utilization outcomes (Chapter 6), and contract-level quality (Chapter 7). In Part II, we describe the results for the Hospice Benefit component, including PO participants and interventions (Chapter 8), hospice networks (Chapter 9), implementation experiences (Chapter 10), utilization and care quality (Chapter 11), and plan-level outcomes (Chapter 12). Part III includes the last two chapters, in which we focus on perspectives on model expansion for both VBID General and the Hospice Benefit component (Chapter 13) and our conclusions (Chapter 14). A separate appendix volume provides additional information on primary data collection and analysis, statistical approach, and other material.

Part I: VBID General

Chapter 2. VBID General Participants and Interventions

Key Findings

- Participation in VBID General grew steadily over time, with the number of plans offering VBID General interventions increasing from 144 in 2020 to 1,218 in 2023. The growth in participation was often driven by the desire of POs to address social determinants of health (SDOH) among their low-income beneficiaries.
- Plans participating in VBID General in 2023 were more likely to be DSNPs, have higher proportions of dual- and low-income subsidy– (LIS–) eligible enrollees, offer Part D benefits, have larger average enrollment, and be located in areas of higher MA penetration than nonparticipants. The participating plans were also less likely to be preferred provider organizations (PPOs) or have $0 premiums.
- DSNPs more commonly targeted beneficiaries with low SES, and non-DSNPs more commonly targeted beneficiaries with chronic conditions.
- Reduced cost-sharing for Part D and supplemental benefits dominated intervention offerings in 2023. The majority of plans offering at least one supplemental benefit intervention included both primarily and non-primarily health-related (NPHR) supplemental benefits. Grocery allowances, typically loaded on restricted-use debit cards, were the most-offered VBID General, NPHR supplemental benefit.
- RI interventions, most of which were offered primarily by one large PO, nearly always targeted beneficiaries with chronic conditions and focused on encouraging preventive health behaviors in all model test years.

In this chapter, we use **PO and plan characteristics** data to describe 2023 VBID General participants, focusing specifically on the difference between participating and nonparticipating POs and plans. Using model application materials, information from the model implementation and monitoring contractor, and data from the pre-interview survey and semistructured interviews with participating POs, we also describe the **change in model test participants' VBID General interventions and the beneficiary groups they targeted** between 2020 and 2023. (Appendix E provides details on the PO survey and interviews; Appendix F provides a summary of VBID participants' interventions.)

VBID General Participating Parent Organization and Plan Characteristics

Participation in VBID General grew from 2020 through 2023, with the number of participating plans increasing from 144 to 1,218 (Table 2.1). The proportion of participating plans that were DSNPs increased from 27.8% in 2020 to 38.0% in 2021 and continued to increase in 2022 and 2023, with DSNPs making up about one-half of participating plans in 2023 (49.7%). Likely due to the increase in DSNP participation, the proportion of enrollees in participating plans who were dual eligible for Medicare and Medicaid increased from 36.9% in 2020 to 57.0% in 2023. Finally, the average age of enrollees in participating plans declined over time, from 69.5 years old to 67.9 years old.

Table 2.1. VBID General Participating and Comparison Parent Organization and Plan Characteristics, 2020–2023

Characteristic	2020 Participants	2021 Participants	2022 Participants	2023 Participants	Eligible Nonparticipants (2023)
Number of POs	14	14	27	46	104
PO geographic reach (%)					
1–2 states	71.4	71.4	77.8	67.4	76.0
3–8 states	0.0	7.1	3.7	19.6*	22.1
9 or more states	28.6	21.4	18.5	13.0	1.9*
PO MA penetration	52.1 (14.1)	54.5 (13.3)	54.1 (9.4)	55.5 (7.8)	50.2** (10.3)
PO enrollment	515,246 (1,000,256)	737,014 (1,426,506)	562,715 (1,355,630)	443,603 (1,296,502)	25,202* (38,682)
Number of plans	144	376	859	1,218	3,093
PPO (%)	17.4	33.2***	29.5	30.5	36.9***
Offers Part D (%)	97.9	99.2	99.7	99.4	89.9***
DSNP (%)	27.8	38.0*	43.5	49.7**	4.3***
C-SNP (%)	0.7	1.1	2.8*	4.9*	5.6
I-SNP (%)	0.0	0.0	0.4	0.4	4.7***
Dual eligible enrollees (%)	36.9 (39.1)	46.8* (42.0)	52.1* (42.7)	57.0* (42.7)	19.5*** (26.0)
LIS-eligible enrollees (%)	39.6 (35.8)	50.6** (39.1)	54.7 (40.1)	60.8** (40.0)	25.8*** (26.8)
Offer $0 premium	45.1	33.8*	33.1	34.7	62.9***
Total premium	23.5 (39.3)	25.9 (32.9)	24.3 (26.0)	22.3 (23.1)	20.4 (39.2)*
Maximum OOP limit	5,288 (1,515)	5,603* (1,749)	5,333* (1,973)	5,932*** (2,271)	5,054 (1,928)
Enrollee age	69.5 (4.6)	68.5* (4.7)	68.4 (4.5)	67.9* (4.6)	71.5 (3.9)***
Plan enrollment	8,265 (10,692)	9,877 (14,691)	7,690* (12,773)	7,331 (12,919)	4,684*** (10,461)

SOURCES: Multiple sources of PO and plan characteristics data.
NOTE: C-SNP = Chronic Condition Special Needs Plan; I-SNP = Institutional Special Needs Plan. The mean values are shown with the standard deviation in parentheses, unless noted otherwise. Plan participation numbers exclude a small subset of plans in each year (one to four plans in each year) with no enrollment. Nonparticipants are those plans that were eligible but did not participate in either VBID General or the Hospice Benefit component in any year from 2020 through 2023. Please see Appendix A for additional information on VBID eligibility. Statistical significance is shown for the eligible comparison plans in 2023 compared with participating plans in 2023. Statistical significance for the participating plans is shown compared with the year prior. For example, the 2023 statistical significance for participating plans is compared with 2022 participating plans. ***, **, and * = statistical significance assessed using the unequal variances *t*-test at the 0.1%, 1%, and 5% levels, respectively.

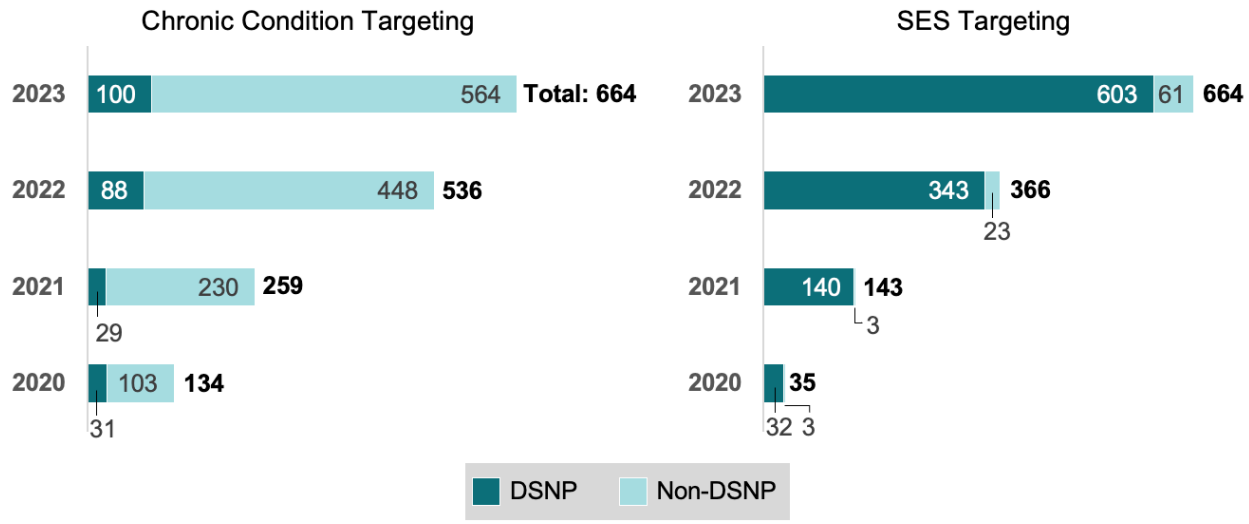
In 2023, most participating POs (67.4%) offered plans in one or two states, 19.6% offered plans in three to eight states, and 13.0% offered plans in nine or more states. Participating POs were located in areas of higher average MA penetration (55.5%) compared with nonparticipants (50.2%). Finally, participating POs had larger average enrollment compared with nonparticipating POs.

The 1,218 participating plans in 2023 were more likely to offer Part D benefits (99.4%) than the 3,093 eligible nonparticipating plans (89.9%). Nearly one-half (49.7%) of 2023 participating plans were DSNPs compared with 4.3% of eligible, nonparticipating plans. A similar proportion of participating and nonparticipating plans (4.9% and 5.6%, respectively) were Chronic Condition Special Needs Plans (C-SNPs), and fewer participating plans were Institutional Special Needs Plan (I-SNPs) (0.4% compared with 4.7%, respectively). Beneficiaries who are dual eligible for Medicare and Medicaid are automatically deemed eligible to receive LIS, but other Medicare beneficiaries who are not deemed eligible but who have low incomes and assets may also be deemed eligible or apply for and receive LIS. Only beneficiaries who are dual eligible may enroll in DSNPs. On average, VBID General plans had substantially higher proportions of dual and LIS-eligible enrollees than nonparticipating plans (57.0% and 60.8% compared with 19.5% and 25.8%, respectively), likely mostly due to the larger proportion of participating DSNPs. VBID General participants were less likely to have zero-dollar premiums than nonparticipants (34.7% and 62.9%, respectively), and VBID General participants had a slightly higher average of total premiums than nonparticipants ($22 compared with $20, respectively). Fewer VBID General participating plans were PPOs compared with nonparticipating plans (30.5% and 36.9%, respectively). Participating plans also had lower average ages for enrollees compared with nonparticipating plans (67.9 and 71.5, respectively). Finally, average total enrollment was higher for VBID General participating plans, with an average of 7,331 enrollees in participating plans compared with 4,684 enrollees in nonparticipating plans.

Targeted Groups

POs could offer VBID General benefits to beneficiaries based on one or more specific chronic conditions or based on SES, as defined by eligibility for both Medicare and Medicaid or Part D LIS. POs could also offer multiple interventions to the same group of beneficiaries in their VBID-participating plans. Figure 2.1 shows the number of plans implementing each targeting approach in at least one VBID General intervention, by year and plan type (DSNP and non-DSNP). A total of 664 plans targeted at least one of their interventions based on chronic conditions. Coincidentally, the same number (664 plans) targeted at least one of their interventions based on SES. However, the vast majority of participating DSNPs targeted interventions based on SES, and the vast majority of non-DSNPs targeted interventions based on chronic conditions.

Figure 2.1. Plans with at Least One Intervention Targeting Socioeconomic Status or Chronic Conditions, by Year and Plan Type



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses.

The number of plans with at least one VBID General intervention targeting chronic conditions grew from 134 in 2020 to 664 in 2023. The rate of growth in the number of plans targeting chronic conditions slowed in 2023, in which the number of POs choosing this approach to beneficiary targeting increased only by 23.9% or 128 plans. Chronic condition targeting was much less common in DSNPs than in non-DSNPs, because DSNPs often wanted to offer VBID General benefits to all their members as opposed to a group of beneficiaries with certain chronic conditions. PO-reported reasons for offering chronic condition–focused interventions in 2023 were similar to those reported in previous years and primarily included the desire to improve chronic condition management to delay the onset of more serious symptoms. For example, PO W decided to offer a diabetes-focused VBID General intervention, because diabetes "is a progressive condition that deteriorates with time and there are many, many risks."

Starting in 2020, the number of plans offering interventions that targeted beneficiaries based on SES grew at a fast pace, more than quadrupling in the first two years and more than doubling in the third year. Although the rate of increase slowed down in 2023, the number of plans still nearly doubled. In contrast with chronic condition targeting, most SES-based targeting occurred in DSNPs. POs provided four main reasons for the dramatic increase in SES-based targeting in VBID General. First, at least six VBID General participants reported moving to VBID benefits that were previously filed under the SSBCI program, which focuses exclusively on beneficiaries

with chronic disease.[2] Because VBID allows plans to target beneficiaries based on SES, some POs said that VBID allowed them to reach more people than with SSBCI. One PO AB representative said,

> What VBID allowed us to do for 2023 is convert our grocery card from an SSBCI, which really only got [sic] to somewhere probably less than 10% of the population for the plans they were filed in. The VBID program allowed us to expand the number of members that we could reach with that intervention significantly.

One PO L representative said that benefits filed under SSBCI were harder to explain to beneficiaries, because only some of them were eligible to receive these benefits:

> We can't just say to people, "When you enroll, we know you have diabetes. We're going to give you this food benefit." We have to say, "You may qualify," and then we have to individually qualify the members. So, it's a lot more administratively complex for us, and members don't like it. Like, "What do you mean you can't guarantee me I'm going to get it?" Like, "Well, how will you know?" And it's just very hard to answer those questions.

Second, SES-based targeting—particularly in DSNPs—is easy to implement because CMS identifies beneficiaries receiving LIS. Because all DSNP enrollees are, by definition, eligible for LIS, POs implementing SES-based targeting in DSNPs did not have to set up an eligibility screening algorithm or process. According to PO AF representatives, as a small organization with limited back-office support, they "were concerned about [their] ability to properly manage and implement the plan with a fluctuating qualification criterion, like a monthly assessment of who's in and who's out of the program. . . . [R]elying on the LIS screen or . . . DSNP . . . gives [them] a much more straightforward operational runway."

Third, POs wanted to help low-income beneficiaries address their health-related social needs. A representative of PO C explained, "It has been a primary need in our area to address food deserts to be able to really assist, from that social perspective, [with] those items that can impact a member's health and well-being." Another PO reported focusing on the low-income population because of the lack of social or economic supports: "They are typically the most difficult to manage in terms of health and wellness because of socioeconomic and other issues that they may have. So that is really the driver as to why we always focus on the DSNP population" (PO AL).

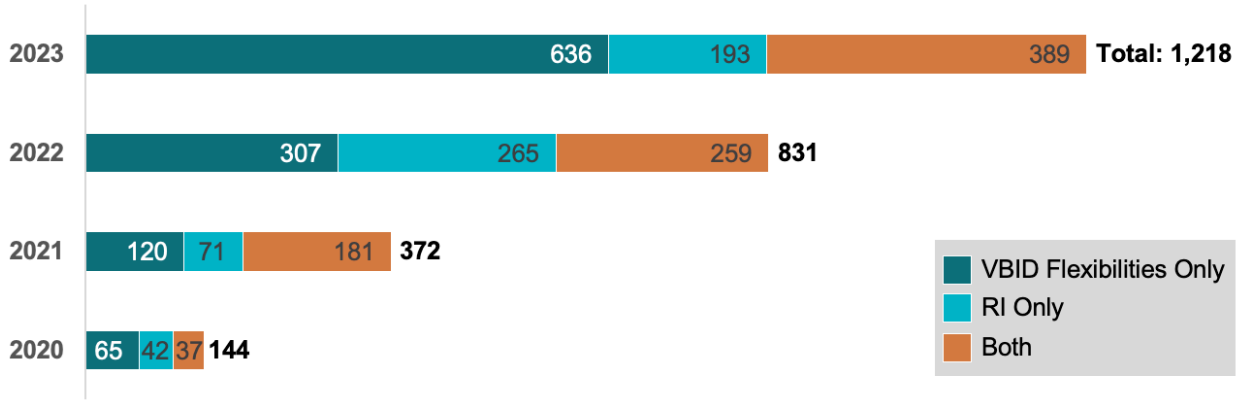
Finally, many POs wanted to offer lower cost-sharing for Part D drugs, specifically for low-income beneficiaries, as a way to maintain enrollment in a competitive market and to improve adherence (discussed in further detail below).

[2] SSBCI allowed plans to offer NPHR benefits outside the VBID Model test to beneficiaries with specific health conditions beginning in 2019.

VBID General Subcomponents Offered

VBID General includes two subcomponents: VBID Flexibilities and RI programs. (A third subcomponent, Cash Rebates, was offered only in 2021 and 2022, and, therefore, we do not discuss it further in this chapter.) As in previous years, more plans implemented VBID Flexibilities than RI interventions in 2023, making the former the most-implemented VBID General subcomponent (Figure 2.2). The number of plans with at least one VBID Flexibilities intervention doubled from 566 in 2022 to 1,025 in 2023. The number of plans with at least one RI intervention increased by 11.1% (524 to 582) between 2022 and 2023. The number of plans implementing both VBID Flexibilities and RI interventions also grew steadily over time, representing almost one-third of all 2023 VBID General plans.

Figure 2.2. Number of Plans Offering VBID General Subcomponents, by Year



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses. The count of plans implementing VBID Flexibilities in 2021 and 2022 does not include those implementing Cash Rebates.

VBID Flexibilities

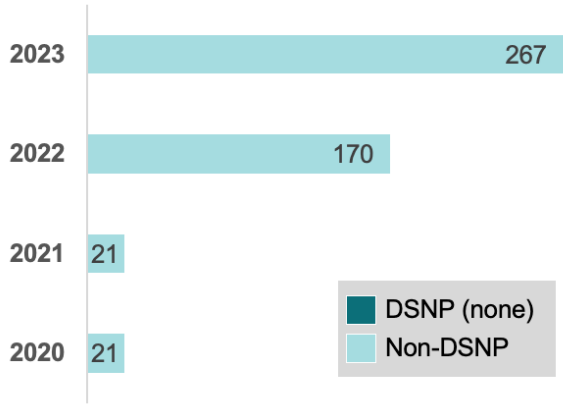
Participants offering VBID Flexibilities interventions could reduce Part C and Part D cost-sharing, offer VBID-enabled supplemental benefits, and make the receipt of these benefits conditional on meeting certain participation requirements, such as engagement with care management or seeking care from high-value providers.

Part C Reduced Cost-Sharing

The number of plans offering reduced cost-sharing for Part C interventions increased over time, rising from 21 plans in 2020 to 267 plans in 2023 (Figure 2.3). Although there was an eight-fold increase in participation in 2022, the number of plans offering a Part C intervention increased by less than 60% in 2023. Common intervention examples include reduced cost-

sharing for specialist visits and for specific durable medical equipment, such as an inhaler spacer. Part C cost-sharing interventions were mostly offered to beneficiaries with chronic conditions, although one PO offered an intervention to LIS-eligible beneficiaries to provide no cost-sharing for most medical services in exchange for using a certain high-value provider primary care clinic in 2023. Although the number of plans offering reduced Part C cost-sharing was on the rise in non-DSNPs in 2022 and 2023, DSNPs never offered this intervention. Several PO representatives we interviewed said that this was because these plans already charge no or low copays for physician services.

Figure 2.3. Number of Plans with at Least One Part C Reduced Cost-Sharing Intervention, by Year



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses.

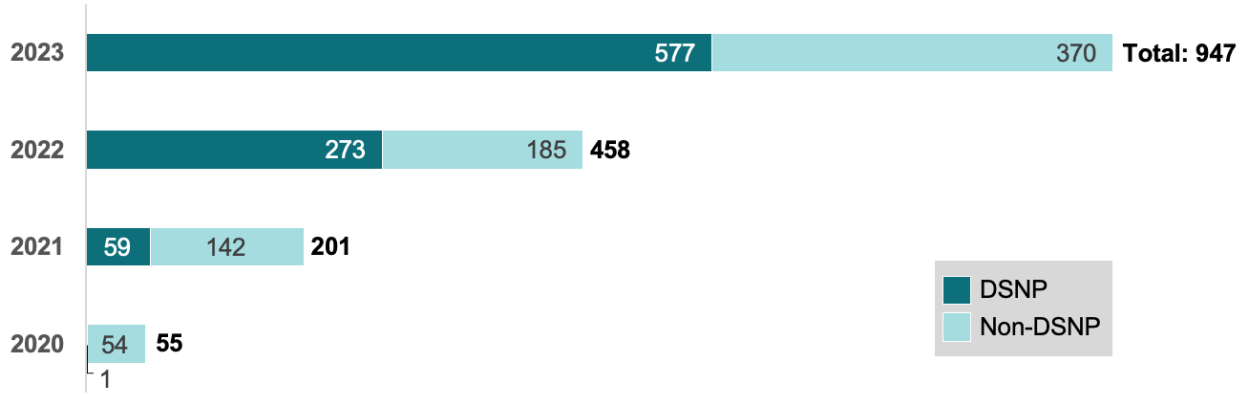
Part D Reduced Cost-Sharing

Offerings of reduced cost-sharing for Part D drugs have grown substantially over time, increasing from 55 plans in 2020 to 947 plans in 2023 (Figure 2.4). Part D reduced cost-sharing became the most-offered VBID Flexibilities intervention in 2023. More than 60% of plans offering Part D cost-sharing interventions in 2023 were DSNPs.

SES Targeting

The number of plans offering zero-dollar Part D cost-sharing for dual-eligible or LIS-eligible beneficiaries drove the increase in the number of plans offering reduced cost-sharing for Part D drugs in 2023. This intervention was mostly implemented in DSNPs, within which all beneficiaries could be targeted for the intervention (91% of plans targeting reduced cost-sharing for Part D drugs for dual-eligible or LIS-eligible beneficiaries were DSNPs; these data are not shown). POs reported offering this benefit as part of the model test because their competitors offered it and is now kind of a 'competitive must' in terms of our overall growth strategy,"

Figure 2.4. Number of Plans Offering Part D Reduced Cost-Sharing Interventions, by Year



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses.

said a representative of PO AK, which offered this VBID General benefit in a DSNP. Improving drug adherence was the other commonly mentioned reason for offering this intervention to low-income beneficiaries (this reason was also mentioned in previous years). PO S representatives explained that reducing cost-sharing for low-income members was a priority:

> It's not uncommon for us to have members out in the community who need six or eight or ten or even 12 medications every month. And you know, even if your cost is only $4 or $10 per prescription if you're on a fixed income, that adds up. That's maybe $100 every month. Trying to live on $500, that's one-fifth of your income just gone.

The increase in interventions offering reduced cost-sharing for Part D targeting dual-beneficiaries eligible for LIS, particularly for DSNPs, could be at least partially explained by a change in the VBID Model guidance. Beginning in 2022, the VBID Model test allowed defined standard benefit plans to continue receiving the low-income cost-sharing subsidy (LICS), which is the difference between the cost-sharing amount for a non–LIS-eligible beneficiary and the amount for an LIS-eligible beneficiary, as part of zero-dollar cost-sharing interventions.[3] Previously, plans could not receive LICS payments if they offered zero-dollar cost-sharing within a defined standard benefit plan. Several POs, including POs S, BE, and BK, noted that the change in LICS payments made VBID more attractive. A representative of PO S explained that, in VBID, "you can affect that copay while still retaining the value of the [LICS]

[3] CMS subsidizes drug cost-sharing for beneficiaries eligible for the Part D LIS. The LICS amount is calculated as the difference between the cost-sharing for a non–LIS-eligible beneficiary and an LIS-eligible beneficiary. Outside the VBID Model test, if a PO wanted to offer zero-dollar cost-sharing, it would have to apply this reduced cost-sharing prior to calculating the LICS, and, thus, there would be no LICS payment because there would be no difference between the non-LIS and LIS cost-sharing in this case.

subsidies. . . . so, it offered us an affordable way to be able to help our members bypass that financial barrier to get the care that they needed."

The discontinuation of the Financial Alignment Initiative (FAI) demonstration (CMS, undated) for Medicare-Medicaid plans was another reason for the increase in the number of plans offering reduced Part D cost-sharing for LIS-eligible beneficiaries in one state in 2023. FAI had enabled plans to offer zero-dollar cost-sharing for Part D drugs. PO K representatives noted that the model test allowed them to continue offering zero-dollar cost-sharing for Part D drugs after the FAI demonstration ended.

Chronic Condition Targeting

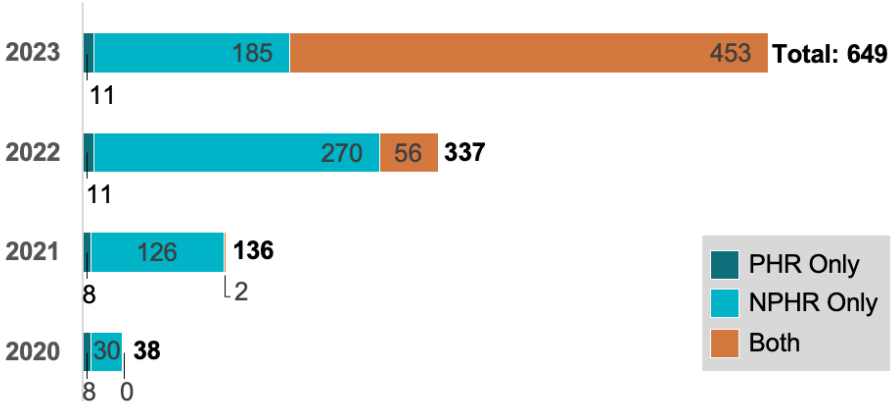
Reduced Part D cost-sharing for beneficiaries with certain chronic conditions was also a commonly offered intervention in 2023, primarily because one large PO (PO P) offered it in 308 plans. In 2023 PO P continued its reduced cost-sharing for inhalers to help treat chronic obstructive pulmonary disease (COPD) and added an intervention to reduce cost-sharing for direct oral anticoagulant drugs for beneficiaries with specific cardiovascular conditions. PO P also reduced cost-sharing for COPD inhalers in the coverage gap phase of the Part D benefit. "We did make this decision because we heard from our members and can see in our data that once these members started to enter the coverage gap, their adherence was going down," explained PO P representatives. Only three other POs offered this intervention to beneficiaries with chronic conditions, targeting reduced cost-sharing for specific drug classes to treat congestive heart failure (CHF) or diabetes (offered mostly in non-DSNPs) or reduced cost-sharing for all drugs for beneficiaries with any type of cancer (offered in DSNPs).

VBID Supplemental Benefits

The number of plans offering supplemental benefits as part of the model test increased from 38 in 2020 to 649 in 2023, almost doubling between 2022 and 2023 alone (Figure 2.5). VBID-enabled supplemental benefits were offered by more than one-half of participating plans in 2023. Supplemental benefits became the second most-offered VBID General intervention in 2023, moving up from the third most-offered intervention in previous years.

Supplemental benefits are categorized into primarily health-related (PHR) and NPHR benefits. PHR supplemental benefits include traditional supplemental benefits, such as vision, dental, and hearing services; additional days or visits of Medicare-covered services; and allowances for over-the-counter (OTC) items. NPHR supplemental benefits include grocery allowances, companion care, or general supports for living, such as utility bill or pest control service allowances. NPHR benefits could be offered to low-income individuals or beneficiaries with chronic conditions in the VBID Model test; outside the model test, they can only be offered to beneficiaries with chronic conditions via SSBCI.

Figure 2.5. Number of Plans Offering Primarily Health-Related and/or Non-Primarily Health-Related Supplemental Benefit Interventions, by Year



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: PHR = primarily health related. Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses.

The majority of plans (70%) offering at least one supplemental benefit intervention in 2023 included both PHR and NPHR in their VBID General offerings. The PO representatives we interviewed generally said that supplemental benefits, especially NPHR supplemental benefits, drive plan enrollment and retention and appeal to beneficiaries. A representative of PO AW said, "There are a couple of things that are really popular right now as supplemental benefits that you can offer through either the SSBCI or VBID. . . . Some of those things are healthy food items." That representative added that the DSNP market is "a very competitive landscape right now, as it relates to these VBID benefits. . . . Everybody is getting more competitive with how they structure these benefits."

Several POs, including POs AD and G, offered either a mix of PHR and NPHR or NPHR-only supplemental benefits as a wrap-around for Medicaid coverage for dual-eligible beneficiaries. As a representative of PO AD explained, "When we think about the Medicaid coverage in a lot of these areas for dental for Medicare beneficiaries, it is quite limited. Beneficiaries usually spend through their Medicaid dental benefit, and then they use ours alongside that to supplement." Because state Medicaid programs already cover the cost-sharing for Medicare Parts A and B medical services and CMS pays for the majority of drug costs for dual-eligible beneficiaries, these POs said that supplemental benefits would be more helpful to beneficiaries than any other VBID General benefit.

POs typically offered NPHR supplemental benefits that addressed social and economic barriers to better health. As a PO AB representative explained,

> What you're going to see is people trying to get creative to find ways to remove barriers where people are not focusing on their health today, because they're

> focusing on basic living needs. And we're all interested to see what the impact on these types of benefits can have on that population over time.

Grocery allowances, which are typically loaded on restricted-use debit cards, were the most-offered VBID General NPHR supplemental benefit in 2023 (635 plans offered at least one intervention with a grocery allowance; these data are not shown). A representative of PO C said, "Ironically, [our VBID intervention] all happened right when costs of groceries started skyrocketing, and we definitely heard a lot of feedback from our membership how much they appreciated the ability to be able to purchase healthy foods." One PO previously offering the Cash Rebate intervention (which could be offered as part of the model test for 2021 and 2022) converted their rebate into a healthy food benefit: "When we took a look at where our enrollees were actually spending their allowances, their cash equivalents, and what merchants they were using it for, and the particular items that they were using it for, we noticed that they were heavily utilizing it for grocery assistance," said a PO AP representative. Because the rebates were popular among low-income beneficiaries, POs did not want to lose their members by completely removing the benefit. As a PO AQ representative said, "Because if you put something and then you take it away, members will respond." This PO offered up to $2,520 a year in Cash Rebates in 2022 (the exact amounts varied by plan) and then offered a similar amount as part of its card-delivered benefits in 2023.

Card-Delivered Benefits

Relative to prior years, more POs gave their enrollees options for using card-delivered benefits in 2023. Many POs offered combined allowances for OTC and healthy food on a single reloadable debit card (also called a flex card), which allowed beneficiaries to spend their allocated funds on one or both benefits. PO AO representatives said that they combined food and OTC "purses" or "wallets" because enrollees like the shared funds: "People value that ability to choose what they spend on, so to have a bigger amount with more choice is more appealing than two smaller, let's call it, wallets with no choice." Dollar values varied widely across POs and even among plans from the same PO. For example, PO W offered the combined purse intervention with dollar values ranging from $30 to $325 per month across their plans.

Vendors usually distributed and operated these cards, established retail networks, and developed the lists of items eligible for purchase, with some exceptions. Some POs worked closely with vendors to develop rules for how beneficiaries can use these debit cards. Beneficiaries had to take time to understand when their allocated amounts expired, where they could use the cards, and what they could buy.

Accruals and Rollovers: The design of these card-delivered benefits, such as accrual times and fund rollover rules, affect POs' benefit utilization assumptions and overall cost projections. Allowing balances to roll over between longer periods increased costs to POs. Several POs, including POs L and AP, addressed this issue by offering monthly grocery allowances that did not roll over at the end of the month to encourage frequent use of the benefit. "I feel like if we're

really trying to drive member outcomes . . . members need to be utilizing it on a monthly basis, as opposed to just letting it aggregate and using it for something big," said a PO L representative.

In contrast, representatives of POs S and G used quarterly allocations without allowing benefits to roll over to give beneficiaries more time to spend their funds:

> We would love to do [monthly grocery benefits] more broadly, but it's very, very expensive to do from an actuarial perspective. So, moving to quarterly was trying to find that middle ground that we could afford, giving them more flexibility to spend more in a certain month or if they couldn't get out to the store for whatever reason in a certain month. (PO S)

Retail Networks: POs took either a very restrictive or expansive approach to retail networks that accepted their cards. PO S noted working with its vendors to expand retail networks to smaller grocery stores in their service area. In contrast, PO AK wanted to limit grocery stores, so that they could better track the items being purchased. As a representative of PO AK explained, "The one thing that we get a lot of feedback on is members can't use the card at any grocery store. . . . But of course, we have to make sure they're using it for what we say they can use it for."

Eligible Items: POs had different perspectives on what beneficiaries should be able to purchase with their cards. One PO G representative explained that they limited the foods that could be purchased using the food allowance: "For the healthy foods card, we really focus it and limit it to what we believe are healthy foods. Fruits, vegetables, meats, pantry staples, things like that." Representatives of two POs (Q and S) mentioned designing food allowances to wrap around existing Supplemental Nutrition Assistance Program (SNAP) benefits:

> We know that their SNAP food allowance is limited to roughly $175 a month and that as a result, it's the produce and meats . . . are things that go kind of by the wayside because they're perishable, they're more expensive overall. So, members on SNAP tend to prioritize the processed foods overall. So that was kind of a big driver behind us pushing the access to healthy foods. (PO S)

In contrast, PO AK took a more expansive approach to simply encourage the use of the benefit:

> We didn't want to find ourselves in a situation where members were struggling to use the benefit at the point of sale, because we didn't have visibility into regular pasta not being listed or a granola bar with chocolate chips, for example, not being considered on the list of healthy foods. . . . So, a lot of our communications really indicate, hey, use this for fruits and vegetables and meat and eggs because goodness knows, the price of eggs. But really, [we took] the member education approach for that while having the flexibility, so that we didn't inadvertently create member abrasion at the point of sale.

Supplemental Benefit Menus

For 2023, several POs, including POs W and AQ, offered a menu of supplemental benefits that included PHR supplemental benefits—such as dental, vision, and hearing services—along

with NPHR supplemental benefits—such as groceries, prepared food, pest control, utilities, pet grooming, gardening, home modifications, gas, or auto repair services. These POs required beneficiaries to select a few of the benefits on the menu, potentially trading between PHR and NPHR benefits. For example, PO W required beneficiaries to select their preferred supplemental benefits at the time of enrollment. Recognizing that beneficiary preferences and needs may change, the PO allowed their enrollees to change the benefit category once during the year. In contrast, PO AQ, which offered home-based assistance to their members, asked care managers conducting these visits to work with a beneficiary to help them determine how they want to spend their allocated amounts.

The desire to give beneficiaries flexibility, while limiting plan's supplemental benefit costs, was the main stated reason for offering the menu approach. One PO L representative said,

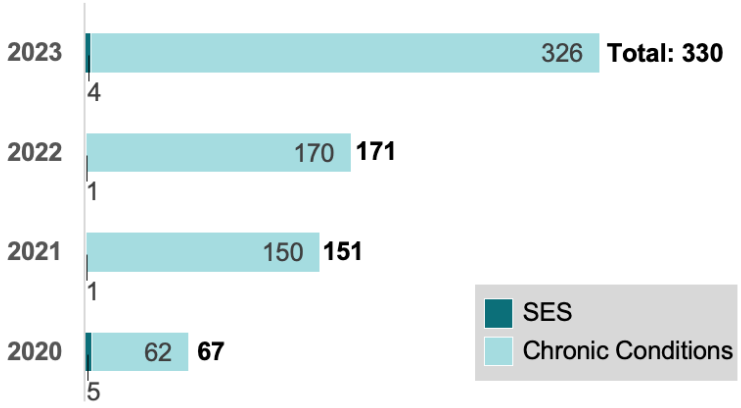
> If we filed a stand-alone home support services benefit, or if we filed a stand-alone home modification benefit and then filed a stand-alone pest control benefit, the challenge is it's harder to support all three benefits [because] it's more expensive. We would be able to offer lesser dollars [for each benefit]. By combining the three into one choice, members can choose what's most important, and they can focus the dollars on things that matter the most to them.

Participation Requirements

VBID General participating POs could condition the receipt of any VBID Flexibilities benefit on participation requirements, which could include beneficiaries' use of high-value providers or participation in care management. The number of plans with at least one intervention with a participation requirement grew from 67 in 2020 to 330 in 2023, or about one-quarter of participating plans (Figure 2.6).

Most plans with participation requirements targeted beneficiaries with chronic conditions. In 2023, one PO required beneficiaries to participate in a medication management program to receive reduced cost-sharing for direct oral anticoagulants (PO P). Another PO required beneficiaries with CHF to engage in a care management program to receive reduced cost-sharing for specialist visits and maintenance drugs (PO G). Two POs also took a less-common approach by requiring the use of one of the plan's specified high-value providers as a condition for receiving VBID-enabled supplemental benefits (POs P and Q) or lower medical service copays (PO Q).

Figure 2.6. Number of Plans with at Least One Intervention with a Participation Requirement, 2020–2023



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses.

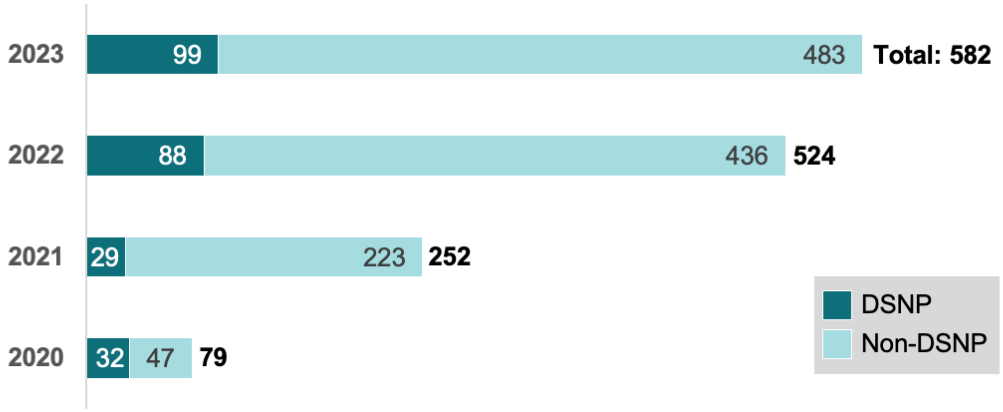
Rewards and Incentives

The number of plans offering RI as part of the model test increased from 79 in 2020 to 582 in 2023 (Figure 2.7). Although RI participation grew at a fast pace between 2020 and 2022, when it doubled or tripled each year and was the most-offered VBID General intervention, it slowed down substantially in 2023, when it only grew by 11% (58 plans), and became the third most-offered intervention. As in previous years, plans designed their RI interventions to target beneficiaries with chronic conditions and focused on encouraging preventive health behaviors. No plans offered RI interventions targeted to low-income beneficiaries in 2023, but some plans offered RI programs that targeted beneficiaries enrolled in DSNPs and those eligible for Medication Therapy Management (MTM). Less than one-fifth (17%) of RI interventions in 2023 were offered in a DSNP.

Common RI interventions offered rewards for completing different wellness activities, such as disease screenings, annual physician appointments, care management consultations, or annual wellness exams. Part D–related RI programs included rewards for completing a comprehensive medication review (CMR) and rewards for beneficiaries who fill their prescriptions, particularly for drug classes that contribute to the Star Ratings drug adherence measures, such as hypertension, high cholesterol, and non-insulin diabetes medications.

A wide variety of incentive amounts were offered, depending on the intervention and plan. Some incentives were as low as $5 for completing an appointment with an endocrinologist (PO AH). Others were as high as $50 for completing a CMR (PO U). Many POs offered multiple

Figure 2.7. Number of Plans with at Least One Rewards and Incentives Intervention, by Dual Eligible Special Needs Plan Status, 2020–2023



SOURCE: Authors' analysis of VBID Model test intervention and application data.
NOTE: Plans could implement more than one intervention for more than one targeted group in a plan, so the number of plans does not equal the total number of plans participating in the given year. VBID plans with no enrollment were removed from analyses.

interventions, for which rewards could accrue to a larger amount if a beneficiary completed all required activities, such as an annual maximum of $120 for filling 30-day supplies of hypertension medications 12 times (PO AG). PO AE implemented a $25 incentive for completing six to eight sessions of a diabetes management program. Its representatives, however, said that the reward amount may not be high enough to change behavior: "Our duals seem to like it. It's kind of like the icing on the cake. And, so, I do think it helps, but I don't know if it would be a dealbreaker."

Some POs noted that RI components were becoming less attractive because the rewards are typically loaded onto cards, which may be confusing for members if they receive several cards from their insurance company. A representative of PO AX said,

> It's already complicated for members to have an OTC card, sometimes a separate card for the rewards. Sometimes it's just a separate balance. And so, by having, you know, another layer of that reward program, it gets to be a little bit too many different balances, wallets, purses, or cards that the member is dealing with.

Summary

Overall participation in VBID General continues to grow, with 1,218 plans participating in 2023, an increase of 441 (56%) from 2022. Most POs used VBID General benefits to address SDOH among their beneficiaries. Nearly one-half of participants were DSNPs, and participating plans had much higher proportions of dual- and LIS-eligible beneficiaries than comparison plans.

Roughly equal numbers of plans had at least one intervention targeting low-income beneficiaries or beneficiaries with chronic conditions, a split that has been similar each year from

2020 to 2023. Part C reduced cost-sharing was offered in about one-fifth of plans participating in VBID General, and the most-common types of services offered with reduced cost-sharing were specialist visits or specific durable medical equipment. Reduced cost-sharing for Part D became the most-frequently offered VBID General intervention in 2023. Most POs targeted this intervention to low-income beneficiaries in DSNPs. One large PO also offered this intervention for specific chronic conditions in several hundred plans.

Just over one-half of VBID General plans offered at least one intervention with VBID-enabled supplemental benefits. They were the second-most frequently offered VBID General intervention in 2023. NPHR items, such as grocery allowances, were increasingly popular among model participants, and many plans were shifting to delivering these benefits through a single flex card. Sometimes plans combined OTC, grocery, utility, and even RI benefits onto the same flex card.

In 2023, RI programs became the third-most frequently offered VBID General intervention; previously, it had been the most-offered intervention since 2020. Most POs used RI to target beneficiaries with chronic conditions and provide rewards for chronic condition management.

Finally, about one-quarter of plans overlaid participation requirements on their VBID General interventions, mostly to require chronic condition management activities or visits to certain providers deemed high-value.

Chapter 3. Implementation Experiences

Key Findings

- POs continued to report that VBID General implementation was a relatively small lift. All POs implementing Part D interventions and almost all POs that entered DSNPs in the model test reported that implementation was not too burdensome.
- One-quarter of POs reported that implementation varied by intervention type and noted that Part D interventions were much easier to implement than card-delivered supplemental benefits, including healthy food items and utilities.
- POs considered model-specific data-reporting, working with vendors or subcontracts, communicating information about VBID benefits to beneficiaries, and administering multiple sets of benefits within a plan to be either moderately or slightly challenging.

In this chapter, we use data from the survey and interviews with representatives of participating POs to describe their **VBID General implementation experiences**. The survey questions asked representatives to rate the level of challenge their PO experienced with certain aspects of implementation. The interviews explored POs' general implementation experience and asked additional questions about the implementation challenges POs experienced.

VBID General Implementation Experiences

As in previous years (Eibner et al., 2023; Khodyakov et al., 2022), most representatives of POs implementing VBID General interventions reported that implementation was a relatively small lift in 2023. Of the 29 POs that completed our interview in 2023 and answered the question about perceived implementation lift, 86% (N = 25) reported that the implementation of at least one VBID General intervention was a relatively small lift. All of these POs reported that they offered a Part D intervention as part of the model test; 92% (N = 23) implemented VBID General in a DSNP; 72% (N = 18) offered at least one VBID-enabled supplemental benefit; 68% (N = 17) continued their model test participation from 2022; and 60% (N = 15) changed their VBID General interventions in 2023, mostly by adding card-delivered supplemental benefits, such as food or utilities.

The remaining four POs considered VBID General implementation to be either a large or a medium lift. Both of the POs that considered implementation to be a medium lift were continuing model test participants that changed their VBID interventions in 2023 and implemented both a Part D intervention and at least one VBID-enabled supplemental benefit in DSNPs. The two other POs that considered VBID General implementation to be a large lift offered the same types of VBID General interventions; one of these POs was a new model test participant, and the other PO was a continuing participant that changed its VBID General intervention design in 2023.

It is worth noting that roughly one-quarter of POs (N = 7) reported that their implementation experiences varied by the type of intervention they implemented. In general, PO representatives said that, although Part D intervention implementation was generally a small lift, the implementation of card-delivered benefits, including food and utilities, was a much larger lift because it often required creating new workflows and working with new vendors. As a PO C representative put it,

> [VBID General implementation has] been a pretty significant lift for our organization because we didn't have a debit card of this nature in place before. It involved us getting involved with a new vendor and then developing some additional digital and phone-oriented tools that the members could use to check their balance, help them understand locations where they could use the card, things that were eligible for purchase on the card. And then also, it's been a significant lift from our customer service team, as people have had various questions about the benefit, calling in and trying to understand the different pieces, both as they were getting ready to start using it at the beginning of the year but then as they have been going through various experiences throughout the year.

Implementation Challenges

Although the majority of POs continued reporting that VBID General implementation was not a major lift in 2023, the results of our survey completed by 45 POs (Table 3.1) suggest that four aspects of model test participation posed moderate or slight challenges: model-specific data-reporting to CMS (with a median rating of moderately challenging) and working with vendors or subcontracts, communicating information about VBID benefits to beneficiaries, and administering multiple sets of benefits within a plan (with a median rating of slightly challenging). The remaining aspects of implementation were deemed not challenging at all (median scores). These 2023 survey results seem to be more similar to those from 2021 than 2022: No aspect of VBID General implementation received a moderate median rating in 2022, whereas both data-reporting and working with vendors were considered to be moderate challenges in 2021.

Model-Specific Data Reporting

As part of the VBID Model test, participating POs have to comply with model-specific monitoring and data collection requirements, including WHP completion and the number of eligible beneficiaries who have received or used various VBID Flexibilities benefits (CMS, 2022b). Forty-four percent of POs (N = 20) in 2023 rated the level model-specific data-reporting as moderately, considerably, or a great deal challenging, typically because they considered it to be a labor-intensive and manual process. One-half of these 20 POs were continuing model test participants, and the other one-half were either new or rejoining POs. PO AE representatives

Table 3.1 Survey Ratings of VBID General Implementation Challenges, 2023

Implementation Challenge	Not at All	Slightly	Moderately	Considerably	A Great Deal	Not Applicable	Median
Reporting data as part of model participation activities (*N* = 45)	10	14	10	6	4	1	Moderately
Communicating VBID benefits information to beneficiaries (*N* = 45)	20	15	7	0	3	0	Slightly
Working with vendors or subcontractors that help implement your VBID intervention(s) (*N* = 44)	12	12	12	3	2	4	Slightly
Administering multiple sets of benefits within one PBP (*N* = 45)	22	4	6	2	1	9	Slightly
CMS reviews of marketing materials (*N* = 45)	24	9	6	3	1	2	Not at all
Tracking beneficiary VBID eligibility over time (*N* = 45)	32	6	3	0	1	3	Not at all
Implementing annual wellness health care planning services to all beneficiaries in a PBP (*N* = 45)	23	12	6	3	0	1	Not at all
Identifying VBID-eligible beneficiaries (*N* = 45)	34	6	2	1	0	2	Not at all
Communicating VBID benefits information to providers (*N* = 44)	24	9	8	1	0	2	Not at all

SOURCE: Authors' analysis of 2023 MA VBID PO questionnaire data. Not every PO answered each question.
NOTE: PBP = plan benefit package.

summarized their data-reporting challenges by saying,

> [Data reporting] requires quite a bit of resources and time. Time for interpreting the new requirements every year, as well as defining what those requirements are, identifying where the data will come from or the source of the data, and then of course validating the data. . . . A couple of the things that we had challenges with is accumulating data from multiple sources. And what I mean by that is there's one data pull that we need to pull just the enrollment data from the enrollment system, we need to pull claims data from our claims system, and then we need to pull in our [VBID] spreadsheet that's being used to tell us when members complete the program. And so just lots of multiple sources and pulling that together . . . [using] manual processes.

Moreover, representatives of the nine POs we interviewed considered data-reporting for WHP to be particularly challenging because they have to include data on all beneficiaries in their VBID-participating plans (regardless of whether the beneficiaries are actually eligible to receive VBID benefits). This requires pulling data from multiple sources, which may include outreach to providers. As PO Q representatives put it,

> The cadence of reporting requirements [is a challenge], and then . . . we don't have information available [about] tracking of wellness and health care planning. It is easier for the VBID beneficiaries than it is for the broader beneficiary book that we have, but that does become very burdensome for us to go through, track, and then aggregate alternate kinds of venues of information. It is not all claims-based. Some of it is health risk assessment. Some of it is supplemental data. It would be much more streamlined if we added that into the VBID reporting that we already had, but because it's across our entire population, it is very difficult for us to pull together.

During the interviews, representatives of six POs also raised concerns about data-reporting timelines, frequency, clarity, and modifications over time, all of which added to their perceived participation burden. One PO AK representative said,

> [Data-reporting requirements for the following plan year] have not been released until October, and that's hard to start to prioritize the work for teams that may need to make adjustments to the reporting element. Understanding the requirements and what has changed ahead of time or earlier [would have allowed] us to prioritize the work on our end. So, that was a challenge, especially for Year Two when we had stood up the reporting and are following the particular format and then identified where there have been changes that needed to be made for 2023. Second, I feel like the timelines, too, with the reporting, it's really obviously challenging when we're in the midst of bid development. There was an opportunity to do some test reporting for the beneficiary-level data in the May time frame, right when we're trying to race toward the finish line to get bids in.

Finally, representatives of five POs mentioned data-reporting challenges together with challenges related to working with vendors. These challenges typically related to reporting about the use of VBID-enabled supplemental benefits that do not come from medical claims. Some POs noted that distinguishing between the utilization of food and OTC benefits charged to the same card was particularly difficult for reporting purposes. According to PO L representatives,

> Transportation, we can track it, but the vendors have to track where the ride went to in a different way than they're used to doing. . . . Food and OTC has been very challenging because the vendor is reliant on what the stores send them. When a member goes to a store, and say they buy $200 worth of stuff and they run their card through, and maybe $43 of it is qualified food, another $20 of it is OTC, and the rest of it is just other stuff they bought, we don't always get the data. We're not always getting the data back from the stores so we can tell the difference. So, they might send us everything the member bought on that transaction. . . . [The vendor has been] trying to get the stores to clean up their data.

According to the representatives of three POs, one large retail chain in particular was difficult to work with to get the right type of data reported: "In terms of the data, one of the large chains we work with is not able to report the basket-specific data for us to segregate food from other OTC and health-related items," said a PO AG representative. PO AW representatives considered this situation to be so pressing that CMS should ask this store chain to help plans with

data-reporting, because this store accounted for 75% of the dollars spent on both OTC and food for this PO.

Working with Vendors or Contractors

In general, POs considered working with vendors and contractors to be a slight challenge. However, the same proportion of POs (27%) reported that vendor relationships were either moderately, slightly, or not at all challenging (Table 3.1). It is possible that the types of vendors the POs worked with as part of VBID may have affected their responses to our question about whether working with vendors and subcontractors was an implementation challenge. The PO representatives we interviewed said that working with vendors involved in the delivery of VBID-enabled supplemental benefits was rather challenging, whereas working with Pharmacy Benefit Managers—vendors involved in the delivery of Part D benefits—was not challenging at all.

Working with vendors or contractors that issue the debit cards beneficiaries use to pay for healthy food, OTC items, utilities, and internet services or that process mail orders for healthy food was challenging for many model test participants in 2023. At least two POs (Q and S) specifically stated that vendor-related challenges led to "some level of [member] abrasion and disruption, whether it's just from pure confusion or because somebody didn't receive their card, or they took the wrong card to the pharmacy" (PO Q).

Some POs, such as PO AL, reported that their newly eligible beneficiaries wanted to use the food benefit right away and did not want to wait seven business days to receive their cards. Others, such as PO BF, reported challenges with food vendors not being able to handle a large volume of calls from beneficiaries ordering items over the phone. Several POs, including POs C, G, Y, and K, described the back-and-forth they needed to have with new vendors to establish all back-end procedures required for offering card-delivered VBID benefits. Identifying eligible OTC and food items was a challenge described by representatives of several POs, including POs B, S, and AF. PO S representatives cited a challenge with

> identifying restricted SKUs [stock-keeping units or unique codes assigned to a product to track inventory], where [the system] passes the data for OTC or for food to say "this is an apple and not a candy bar." That information is passing up to some checkpoint to say, yes, an apple is an eligible item, but a candy bar is not and would reject it.

A new theme related to working with vendors emerged in our 2023 discussions about creating processes to allow beneficiaries to use their cards to pay for utilities, including cell phone, gas, electrical, and water bills. For example, PO S and AW representatives encountered challenges with ensuring that all relevant utility companies were added to the list of approved merchants. A PO AW representative reported that, after a beneficiary complaint of a card not being accepted, the PO would have to ask the card vendor "to add this merchant to their accepted provider list." PO B representatives similarly reported they had to add prepaid cell phone carriers to the list of eligible utility service providers after the start of this model year, and PO S had to

troubleshoot delays in processing utility payments because some beneficiaries did not see payments posted to their utility company bills for several days after making payments on the PO's bill payment portal.

Communication with Beneficiaries

Although our 2022 analysis showed that communication with providers was among the top implementation challenges, the 2023 results suggest that this has shifted to communication with beneficiaries. Two aspects of beneficiary communication were particularly challenging: explaining to beneficiaries how to use card-delivered supplemental benefits and explaining to beneficiaries the details of benefit eligibility more generally.

Forty-two percent of the POs that participated in our interviews (N =13) said that explaining to beneficiaries how cards work, what food and OTC items are eligible, and what stores accept the cards was rather challenging. Some POs that started using reloadable cards had to remind their members about the switch to new cards and instructed members not to throw away their cards once the loaded benefits are depleted because more funds may be on the way (POs AG and AP). To address at least some of these challenges, POs had to invest in educating beneficiaries, providers, and their own customer service representatives and in building technological solutions to these problems. PO C representatives noted that they have

> noticed that there is a significant number of members within this population that may have different definitions that fall outside of the scope of "healthy [foods]." To address that, we've had to come up with various strategies, whether that be addressing our member materials, helping have talking points for our customer service team, and then also incorporating a barcode scanner into our app that allows members to actually scan food items or OTC items when they're at the store to see if they're eligible for purchase or not.

The second type of beneficiary communication challenge is related to explaining who is eligible for VBID benefits, while remaining compliant with the marketing guidance for the VBID Model (CMS, 2022c). Although the majority of POs that offered VBID General benefits to their low-income beneficiaries did so in DSNPs, which simplifies the identification of eligible beneficiaries, some POs clarified that there is a very small number of LIS-eligible beneficiaries in DSNPs who do not have dual-eligible status (Level 4 LIS) or who may lose their eligibility throughout the year. POs are required to state that members may lose benefit eligibility in Annual Notices of Change (ANOCs) but doing so has been confusing to their members. According to a representative of PO AK, which offered a Part D benefit in a DSNP,

> There is a very small percentage of members that may actually have Medicaid and meet the requirements to enroll in a DSNP, but they . . . lose low-income subsidy [throughout the year]. It requires us to have additional disclaimers in all of our materials. For example, we list the zero-dollar deductible, zero dollars for Tiers 1 through 5. But we have to add in disclaimers across the board that it's dependent upon your eligibility for Extra Help. And if you lose Extra Help, you'll be subject to the deductible and 25% coinsurance.

Although PO AK representatives said that this was yet another thing to keep in mind in developing their communication and marketing materials, PO Q representatives noted that the requirement to add the text about the possibility of losing LIS eligibility "created some level of abrasion in those edge cases." Moreover, PO Q representatives said that listing information about VBID benefits and potential eligibility criteria in ANOCs that are distributed to all beneficiaries in their VBID-participating plan, when only 1,000 of 44,000 beneficiaries were eligible to receive VBID benefits, caused a lot of confusion and frustration among ineligible beneficiaries. Being able to have a different ANOC for beneficiaries who are not eligible for VBID benefits would have eliminated a lot of problems. In addition, representatives of five POs (POs Q, AE, AF, AK, and BE) noted that they have to constantly remember that VBID-participating plans have to comply with additional marketing restrictions that go above and beyond those spelled out in Medicare Marketing Guidelines (CMS, 2009):

> Sometimes I'll say, "Oh, we have VBID marketing that's different from our [Medicare Marketing Guidelines] that apply to all MA plans that we have to pull out." So, we have to pull both of those marketing guidelines and work in sync to make sure that we're crossing all of our Ts and dotting our Is. (PO AE)

Finally, several POs, including POs N and AG, reported issues related to the need to process claims and receive data from other sources, including self-attestations of activity completion, before issuing rewards for completing RI programs. This increased the number of calls to their customer service. As a PO N representative put it,

> We have members who go get their mammogram today and call us tomorrow to say, "Where's my reward?" Well, you say, "We have to wait until your provider gets the claim," and so there was a little bit of a kind of re-education piece for the members who were used to those rewards and how to earn them.

Administering Multiple Sets of Benefits Within One Plan

The final aspect of VBID General implementation that was deemed slightly challenging by the POs that completed our survey was the administration of different benefits within the same plan. This challenge is not new, and it was frequently reported as an implementation challenge during the early years of the model test; yet, this aspect of model implementation gained new meaning in 2023. Previously, this challenge was associated with offering additional benefits to the members who qualify for VBID benefits based on having certain chronic conditions. For 2023, several POs reported experiencing difficulties with using combined purses on debit cards that allow beneficiaries to spend their allowances on either food or utilities. According to PO S representatives, it was challenging for them and their vendor to use this single-purse approach for multiple VBID-enabled supplemental benefits:

> You've got food where [some items are on] the restricted item level, versus we want to use that same benefit value towards utilities. From a technology perspective and capability of the vendor, it would be easier if we said, oh, it's $100 for food and it's $100 for utilities. That would be a lot cleaner for them. It's

> this kind of component of trying to do both with one purse [that was challenging].

PO N representatives reported experiencing similar implementation challenges when they tried combining VBID and non-VBID supplemental benefits on a single card:

> We had some lift this year because we also offer a dental benefit, which used to be on a separate physical card, and we combined those so that OTC, the healthy foods, the rewards and incentive, and the dental are all on a single, physical card now.

Providers and their office staff also likely find it difficult to navigate a wide variety of VBID-enabled supplemental benefits offered by the same plan, different plans offered by the same PO, and non–VBID-enabled supplemental benefits available to everyone in a plan. Several PO representatives, including those from POs N, P, R, S, W, AW, BE, and BF, reported that they started investing additional resources in provider education to raise awareness about the different types of NPHR supplemental benefits that their patients might benefit from and to keep providers updated on the changes in the benefits offered every year. Such efforts may help beneficiaries better understand and actually use the benefits available to them.

Summary

Using PO survey and interview data, this chapter provided insights into POs' implementation experiences with the VBID General component of the model test. Most POs reported that implementing VBID General interventions in 2023 was a relatively small lift, with 86% of POs reporting only minimal or no challenges. All of these POs offered zero-dollar Part D drugs to LIS-eligible beneficiaries as part of the model test or implemented VBID General interventions in DSNPs. These intervention designs made it easier for participating plans to identify eligible beneficiaries and eliminated the need to administer multiple sets of benefits within the same plan because every beneficiary in a participating plan is eligible to receive VBID General benefits. The remaining POs found VBID General implementation to be a medium or large lift. These POs either joined the model in 2023 or introduced new VBID General interventions that year.

In general, POs' implementation experiences varied by the types of VBID General interventions they offered. Part D intervention implementation was generally considered much less burdensome than card-delivered benefit implementation, including food and utilities, because the latter often required creating new workflows and working with new types of vendors that may not have had much prior experience in the health care industry.

Although VBID General implementation was relatively smooth in 2023, POs identified four aspects of the model test participation that posed either moderate or slight challenges, including model-specific data-reporting, working with vendors, communicating information about VBID benefits to beneficiaries, and administering multiple sets of benefits within a plan. Although model-specific data-reporting was the only aspect of VBID General implementation that received a median rating of moderately challenging in 2023, it was considered only a slight

implementation challenge in 2022 (Eibner et al., 2023). This difference in perceived data-reporting burden could be attributed to changes in model-specific monitoring and data collection requirements and additional data-reporting required of POs.

Chapter 4. Participating Organization Perspectives on Benefit Utilization and Beneficiary Experiences

Key Findings

- Part D benefit utilization met POs' expectations and was almost universal because all eligible beneficiaries received the benefit when they filled their prescriptions. However, utilization of RI programs was not universal because of participation requirements, such as participation in an MTM program, before receiving a reward.
- POs were generally satisfied with the utilization of card-delivered benefits: 50% to 95% of targeted beneficiaries used those benefits, and healthy food was the most used card-delivered benefit.
- Beneficiaries liked the simplicity of zero-dollar Part D drugs and appreciated the immediate financial relief they provided.
- Although beneficiaries viewed card-delivered benefits as an attractive feature that increased their satisfaction with their plan, they were often confused about how to use the cards and complained about card use rules.
- Beneficiaries liked RI programs, and PO representatives cited the effectiveness of their financial incentives in driving participation in such health-focused activities as CMR.

In this chapter, we use PO survey and interview results to describe the **utilization of VBID General benefits** and **beneficiary experiences with these benefits**. VBID-participating POs will be required to report individual-level data on benefit use among their targeted beneficiaries, starting with calendar year 2024. We used data on benefit utilization gathered through PO interviews, focusing specifically on the three most-offered VBID General interventions: Part D benefits, VBID-enabled supplemental benefits (we discuss card-delivered benefits because it was the most frequently offered NPHR supplemental benefit), and RI programs. We use PO survey and interview data to describe what PO representatives think about beneficiaries' experiences with their VBID General benefits.

Utilization

During the interviews, PO representatives described their perspectives on the utilization of Part D cost-sharing reductions, card-delivered benefits, and RI. Generally, they were pleased with the utilization of card-delivered benefits and RI programs, stating that the use of these benefits either met or exceeded their expectations. PO representatives often described the use of Part D benefits by their targeted beneficiaries as universal, noting that anyone who goes to the pharmacy to fill a prescription uses the benefit. We could not independently verify the accuracy of these PO-reported utilization results because mandatory reporting of VBID General benefit utilization will not be available until 2025.

Reduced Cost-Sharing for Part D

The utilization of Part D reduced cost-sharing interventions generally met PO expectations. PO representatives reported almost universal utilization of this VBID General benefit, which they attributed to the fact that everyone who fills a prescription pays a lower copay or receives the medication free of charge. One PO AX representative said that this benefit "doesn't require the member to do anything different than fill their prescription. So, in our case, there's not really a cohort of utilizers and non-utilizers. It's just whether or not they're eligible and they're actually picking up their prescriptions."

PO E representatives added that beneficiaries do not need to be aware of this Part D benefit in order to benefit from it:

> Whether the member even knew about it or not, they benefited from it. So just by being in the plan and meeting the eligibility criteria by default . . . 100% of people in the plan . . . as long as they use the drug, they benefited. . . . I think that's exactly what we expected. We expected it to apply to 100% of people who use drugs, and that's what it did.

Card-Delivered Benefits

POs reported that 50% to 95% of targeted beneficiaries used their card-delivered benefits. Most beneficiaries, according to our interviewees, used the majority of the funds loaded onto their cards. Some POs issued one card with multiple purses that beneficiaries could use on healthy food and grocery items, OTC, utilities, and gas. Actual benefit use varied by purse type. For most POs, food benefits were the most utilized benefit type on the multi-purse cards. One PO N representative said, "Food utilization is, by far and away, our biggest utilization compared to over-the-counter stuff. . . . Food purchase is 71% of the OTC/healthy foods cards. The over-the-counter items are 29%." However, representatives of POs S and AG said that OTC was their largest spend category. None of the POs that also included utilities as one of the card purses reported that this benefit was their highest spend category.

Utilization of card-delivered benefits either met or exceeded POs' expectations and average industry-wide utilization rates. In some cases, POs attributed high utilization to their communication with members. One PO AK representative said,

> We have about 89% activation rate with our cards and our members . . . which is pretty good. Most companies have between 74% and 76% at any time. Our actual engagement rate . . . which means a member has used their card at least one time in that month, is at 85%. Industry is normally 72%. And so, we accredit that to the multiple communications that we send out saying make sure you spend this month. It won't roll over. Don't lose out on your benefit.

Expansions of the types of items beneficiaries could purchase using the card and increasing benefit generosity may have also contributed to increases in the utilization of card-delivered benefits. A representative of PO AP said,

> Utilization has increased year over year. And I think that is partly due to offering another benefit, i.e., the utility benefit, as well as expanding upon the grocery allowance benefit, but also when we moved to the [redacted] card, we also opened it up to retail locations. That was something that was obviously needed for our healthy grocery card, but also it increased the OTC spending. If someone is going to a retailer to spend X amount of dollars for their OTC benefit, chances are they will also be picking up a few grocery items and using the card there, as well.

Similarly, a representative of PO C noted that combining several benefits into one purse increased the utilization of these benefits:

> The [food and OTC] benefit is extremely popular, so about 93% of our population has used the card at some point this year. . . . When we were initially looking at pricing the benefit, we tried to base it on a previous, separate OTC benefit and separate healthy food card benefit. We increased utilization on that card when putting it forward. The actual [20]23 experience has come in even over that expectation.

According to representatives of PO L, which has a combined purse for healthy food and utilities, when faced with the need to choose how to spend their allowances, beneficiaries typically picked food:

> If we're talking about any of these VBID benefits that's used the most, it would be the healthy food/utilities. Because they're combined, I think of them as one as far as utilization because members are making an active choice. They're going to say: "You know what? I'd rather pay for the food." Utilities maybe subsidized somewhere else.

It is worth noting that the mode of benefit delivery can substantially affect utilization rates. Although healthy food was among the most utilized card-delivered benefits, produce boxes delivered via mail order were not as frequently used. PO BF representatives described their experiences with this benefit in a DSNP by saying that the uptake

> was a little slow. We started out the first of the year, not seeing as many orders as we thought. But by the time we were into second quarter, we were seeing much higher utilization. So, I think it's kind of about where we thought it would be now. . . . Utilization ranges by quarter. And so, we're seeing a range anywhere from probably around 44% up to 53%. In most cases, more than half of our members on the dual SNP [Special Needs Plan] plans are utilizing the benefit.

Rewards and Incentives Programs

POs indicated that RI interventions were well received by beneficiaries, and their uptake generally met POs' expectations. According to a PO U representative,

> The incentive on the MTM is well-received as well. It's for members that, you know, we can tell them: "Hey, we appreciate what you're doing, and we really want you to get this done." Also, it does help to potentially incentivize folks that might not have done that before to say: "Well, let me check this out or let me

> give this a shot," and see how it works for them from an MTM perspective. I do think there is a positive reception for that.

All RI programs, by design, required beneficiaries to complete requirements before they could receive a VBID benefit. Some POs, such as PO P, offered Part D–focused RI programs, which required eligible beneficiaries to complete an interactive CMR to receive a gift card. Such programs had lower uptake than reduced cost-sharing benefits for Part D drugs, even if offered by the same POs. This might be because beneficiaries must first take a proactive step and enroll in an RI program before they can receive additional benefits and not every eligible beneficiary enrolls into these programs. As a PO P representative put it,

> Members must enroll with our pharmacy clinical programs team. . . . Our challenge there is just reaching people. We outreach with different communications and phone calls to get them on the phone and offer the program. Because of the way that we have our test set up, sometimes, many times, the first time they hear about it is from our outreach. When we do get them on the phone though, we have a very high enrollment rate that we've seen pretty consistently over the years. Typically, if we have them on the phone and offer this, 60% of the people are saying: "Yeah, sign me up," and will go on to use this benefit if they have a prescription—an active prescription on file. So, it's sort of a two-parter for us, where we have to reach people first to tell them about the program. And then when they learn about it, the majority of them will convert and enroll.

To increase drug-focused RI program completion rates, PO AO offered a $15 reward for completing an annual CMR and an additional $10 in rewards for each 30-day fill of cholesterol, oral diabetes, or hypertension medications (up to $120 per year). Representatives of PO AO described these financial rewards as a "driving force behind the annual uptake of the CMR."

Beneficiary Experiences

PO representatives generally reported that VBID General had a positive impact on care experiences and satisfaction among their targeted beneficiaries. Of the 43 POs that responded to a survey question about how VBID General has affected care experiences or satisfaction among targeted beneficiaries, 70% (N = 30) reported an increased positive impact due to VBID; the remaining 30% (N = 13) reported no impact. Below, we describe POs' perspectives on beneficiary experiences with various types of VBID General benefits. We describe experiences with card-delivered benefits first, because this is what POs spent more time discussing during the interviews.

Card-Delivered Benefits

According to many PO representatives we interviewed, beneficiaries viewed card-delivered benefits as an attractive feature that increased their satisfaction with their plan. One PO C representative indicated that, when they introduced their healthy food and OTC card to eligible beneficiaries, they were surprised by "the initial popularity of the benefit. We expected members

to like and appreciate the benefit, but from day one, it was an extremely popular benefit. [However], the intensity of that reaction was a little bit surprising." PO AW representatives described the positive feedback they received from their members about the healthy food, OTC, and utility benefits delivered on one card by saying that beneficiaries "appreciate the help with their healthy food and their utilities. I think OTC, they appreciate, too. The healthy food and the utilities are specific things that they call out to us." Moreover, PO B representatives noted that their healthy food card was a driver behind several outcomes, including member satisfaction:

> So I would say that the food card is going to be tied to medical trends. It's going to be tied to member satisfaction, which should start to show through our CAHPS [Consumer Assessment of Healthcare Providers and Systems] scores. And it might have some impacts on Star [Ratings] as well, because I think there's a couple customer satisfaction metrics in there.

Nonetheless, PO representatives also indicated that card-delivered benefits were a major source of member complaints and grievances due to confusion about how to use the cards or the desire to change the rules associated with these benefits. The same POs that described beneficiaries' love for their card-delivered benefits often reported challenges with those benefits. Those challenges were especially apparent at the beginning of the calendar year and negatively affected beneficiary experiences:

> When members have issues using their cards, especially in the first quarter, that's obviously a challenge, not only for us as a health plan but for our members. And so, it's really hard to influence outcomes if members can't use their card to purchase those items they need. . . . So, if members are calling in complaining about not being able to use their card or not being able to purchase the items that they need or filing grievances about those things, I think those are definitely indicators of a negative experience. (PO AW)

PO AF representatives also reported that some beneficiaries did not receive their cards and, therefore, could not use the benefit early on:

> We have received different feedback from members; in some cases, it's been not receiving the actual card. So having to work with the vendor to have it re-sent or figure out what was wrong with the address or any variation in between.

Some POs noted that not all beneficiaries were happy with how the card-delivered benefits work. For example, PO AD representatives indicated that beneficiaries want their unspent funds to roll over from month to month to give them more time to use the benefit and that beneficiaries reached out to customer service to express their preferences:

> I think where we heard the most feedback was around rollovers and the frequency of their benefits. So, for example, their gas and utilities and their groceries benefit this year are offered on a monthly cadence with no rollover in order to expand that for them. Next year, we're looking at moving that to a quarterly cadence. It still will not roll over next year, but it does allow our members more time to use their benefits. So, if they're out of town, out of the country—their cards aren't working out of the country but will work anywhere in the U.S.—in those situations, they're not losing out on their benefits.

PO AK representatives noted that their beneficiaries wanted more stores to accept their cards: "The one thing that we get a lot of feedback on is members can't use the card at any grocery store." Representatives of PO AG, whose benefit cards initially worked only for online purchases, said that their members prefer retail or brick and mortar stores because this dual-eligible population "[doesn't] shop online. They shop in mom-and-pop stores and pharmacies and grocery stores in their neighborhood."

Other member complaints were related to utility cards and utility bill payments. PO B representatives stated that, although their monthly grievance rate is very low, many of the complaints concerned utility payments because a vendor's bill pay system did not initially include all prepaid cell phone providers:

> We've had roughly 500 cases of grievances out of the 500,000-ish transactions. And a lot of those early on grievances that we saw were related to that early upfront issue that we had with the utility bill pay issue. Positive thing now we could say is we see through working with your vendor and working through those implementation challenges, we've already lowered that number dramatically which is starting to taper off to where you're seeing probably between 40 to 50 grievances per month.

Similarly, PO S representatives reported that their card vendor experienced payment processing delays when members tried to use the card to pay their utility bills, which had a negative impact on beneficiary experiences.

Finally, some PO representatives raised concerns about the possibility that they would have to change the monetary value of their card-delivered benefits from year to year, which could cause financial challenges for beneficiaries. For example, PO N representatives increased quarterly card-related benefits significantly in 2021 as a mid-year benefit enhancement to correct reductions in their Medicare Loss Ratio caused by low health care utilization during COVID-19 pandemic lockdowns. The following year, they had a hard time explaining to their beneficiaries why the monetary value of their card-delivered benefits went down.

Determining the optimal dollar value of the benefit was particularly challenging for plans that experienced changes in their Star Ratings. A PO N representative said,

> It's a little bit difficult, particularly when a plan does well in Stars and gets additional bonus money to spend on benefits. You can afford to increase that card [benefit amount], and then that becomes part of their lifestyle. And then if your Stars drop or something else happens to your revenue, you can't give them that card anymore. It's really devastating to members to lose that. . . . There's this really fine line you walk . . . when you're addressing those social health needs as a health plan . . . they become so much more reliant on you to provide that benefit. When we're financially not able to anymore, it's really devastating.

Other VBID General Benefits

POs reported that beneficiaries also have positive experiences with other VBID General benefits, especially those that are focused on Part D benefits. Several POs noted the simplicity of

their Part D–focused intervention designs. PO E representatives said that their LIS-eligible beneficiaries appreciate their zero-dollar cost-sharing for Part D drugs:

> If they are taking medications, they just think it's part of the benefit. It's not overly complicated. They don't have to do anything to benefit from it. And so, I think that if we pointed out the fact that this is something extra, then they would be happy about it, but I don't even know that they think it's something extra. They just think it's part of the program.

PO C representatives described a similar sentiment with respect to their Part D reduced cost-sharing intervention, noting the invisibility of changes for their members this VBID General intervention brought to their benefit design:

> I think that one [benefit] might be [that it is] just invisible. The member goes [to the pharmacy], they do not owe anything at the point of sale, [and] it's a win. It's probably not something they're going to call in about because it's just great news, and they're happy. . . . It's a win all around, and we see [that] everyone who is in the DSNP plan qualifies for that no–cost-sharing.

Moreover, PO AE representatives reported that their beneficiaries like the Part D RI program, which rewards members with diabetes $25 for participating in six to eight sessions of CM:

> They love the reward. . . . I think they like the multidisciplinary team approach. They like having a pharmacist that helps them as well, right, that talks to their provider. We do a lot of advocating with their provider, right, to get them on a continuous blood glucose monitor, just to get them in—you know what I mean—to see their providers, and I think they like that we just are like a trusted steward, besides just a form of a resource for education.

Summary

In this chapter, we explored POs' perspectives on the utilization of and their beneficiaries' experiences with the three most-offered VBID General benefits. Because data-reporting on benefit use is not mandatory until the 2024 plan year, this chapter relied on self-reported data from PO surveys and interviews.

PO representatives were generally satisfied with the utilization of card-delivered benefits and RI programs, noting that the utilization rates either met or exceeded their expectations. They reported that 50% to 95% of targeted beneficiaries used their card-delivered benefits, with healthy food benefits being the most utilized category. PO representatives often attributed the high utilization rates of card-delivered benefits to effective PO communication strategies and the expansion of benefit types and amounts. RI programs were also well-received by beneficiaries, and their uptake generally met POs' expectations. PO representatives thought that the financial incentives offered by RI programs have generally been effective in driving participation in various health-focused activities, such as CMR. POs perceived Part D cost-sharing reductions to

be almost universally utilized, because beneficiaries automatically received lower copays or free medications when filling prescriptions.

PO representatives generally reported that their enrollees were pleased with the card-delivered benefits and that these benefits positively affected care experiences and satisfaction among beneficiaries. However, in some instances, the very popular card-delivered benefits were also a source of beneficiary complaints due to issues with card use, delivery delays, and the desire for more flexible benefit rules. According to POs, beneficiaries liked the simplicity of zero-dollar Part D drugs and appreciated the immediate financial relief they provided. Although RI programs required beneficiaries to complete participation requirements, POs reported that beneficiaries valued the financial rewards and the support from their insurers.

Chapter 5. Plan-Level Enrollment and Financial Outcomes

Key Findings

- VBID General implementation was associated with a statistically significant increase of 27% in plan enrollment in 2023 ($p < 0.01$, 95% CI [8% to 51%]).
- VBID General implementation was associated with a statistically significant decrease of $11 per member, per month (PMPM) in Medicare Advantage Prescription Drug (MAPD) bids in 2023 ($p = 0.02$, 95% CI [–$19 to – $2]).
- Despite lower bids in some years, VBID General was associated with a statistically significant increase of $25 PMPM in costs to CMS in 2022 ($p = 0.01$, 95% CI [$6 to $44]). The data for 2023 were not complete as of this writing. Increases in costs to CMS were driven by higher MA rebates and higher risk scores.
- Although we found no statistically significant association between VBID General and changes in beneficiary premiums in 2022 or 2023, VBID was associated with a statistically significant $2.14 PMPM increase in 2021 ($p = 0.04$, 95% CI [$0.16 to $4.36]).
- Despite decreases in the number of mandatory supplemental benefits (MSBs) offered, VBID General was associated with increases in the PMPM cost of MSBs, which may reflect the cost of providing supplemental benefits in plans' VBID interventions.

To determine if VBID General implementation was associated with changes in plan enrollment, financial outcomes, and MSBs, we conducted a series of analyses at the plan level. We looked at changes in **total plan enrollment** associated with VBID General implementation, because beneficiaries might change plans (or move into or out of FFS) in response to VBID General interventions. Although VBID interventions require resources to implement, they may decrease costs in the long run by reducing health care complications that require expensive medical treatment. We therefore also analyzed changes in **plan bids** (POs' projected costs of providing benefits for a standardized population), **costs to CMS** (actual payments made by CMS to POs for providing coverage), and **premiums** paid by beneficiaries. Finally, we analyzed the number of **MSBs** offered to all beneficiaries, which could change if POs reduce spending on these benefits to make a larger investment in VBID.

The financial outcomes analyzed in this chapter (plan bids, costs to CMS, and premiums) are measured on a PMPM basis. Where possible, we analyzed the results for 2020 through 2023, the four years of the current VBID Model test. However, for costs to CMS, complete 2023 data were not yet available when we conducted analyses for this report. Because we reported results for earlier years in previous reports, we focus our discussion on the results for the latest year available, generally 2023. Results for all years are shown in the figures. Tables providing additional detail on our estimates for all years are available in Appendix G.

To conduct the analyses presented in this chapter, we used entropy-balanced DD models that compare outcome trends among VBID plans with outcome trends among nonparticipating plans that are weighted to resemble the VBID group. Appendix A describes these methods in detail. The results presented in this chapter are not weighted by plan enrollment. For some purposes,

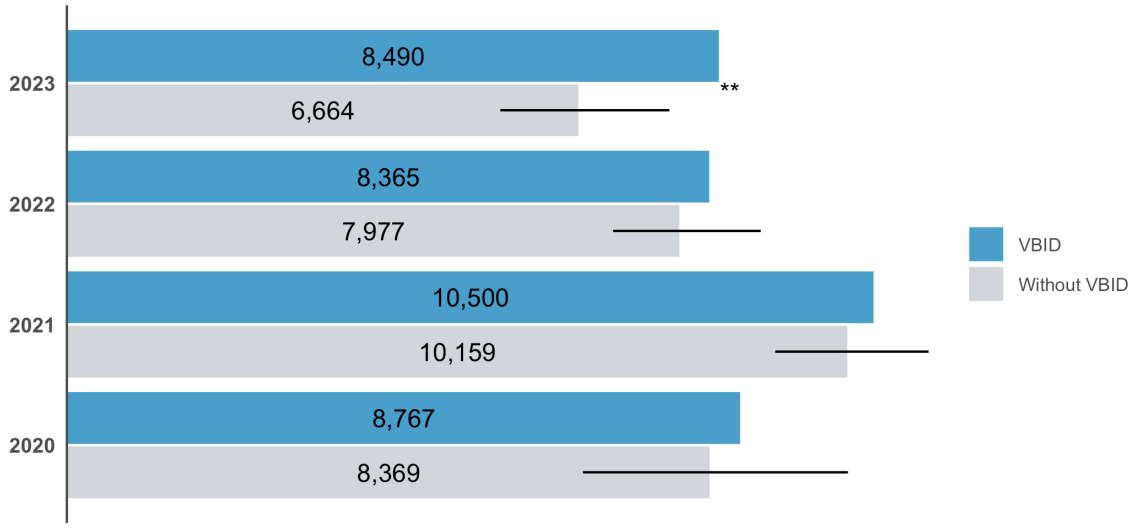
such as assessing the average impact of plan-level outcome changes on beneficiaries or evaluating the overall financial impact of changes in costs to CMS, readers may prefer to examine estimates in which VBID plans are weighted by enrollment. We report enrollment-weighted results as sensitivity analyses in Appendix G.

To contextualize our quantitative findings, we also use the results of our PO surveys and interviews. In particular, we use these data to explain how and why VBID General interventions might have affected enrollment and financial outcomes.

Enrollment

We analyzed total plan enrollment, measured as the number of beneficiaries enrolled in a plan as of July 1 of each year. VBID was associated with a statistically significant 27.4% increase in enrollment in 2023 ($p < 0.01$, 95% CI [8.4% to 50.7%]). Estimated associations between VBID General and enrollment in 2020, 2021, and 2022 were also positive but were not statistically significant and much smaller than the estimate for 2023: a 4.8% increase in 2020 ($p = 0.75$, 95% CI [–13.7% to 30.7%]), a 3.4% increase in 2021 ($p = 0.49$, 95% CI [–6.3% to 14.0%]), and a 4.9% increase in 2022 ($p = 0.39$, 95% CI [–7.3% to 17.8%]). Figure 5.1 shows the estimated changes in enrollment after converting the estimated percentage changes to total enrollment levels.

Figure 5.1. Estimated Association Between VBID General Interventions and Plan Enrollment



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with estimated changes in average total plan enrollment given the percentage changes reported in the text, with slight variations due to rounding.

The results of our 2023 PO surveys and interviews support the finding that VBID General was associated with greater enrollment. Of the 43 POs that answered a survey question about the impact of VBID General interventions on plan enrollment and retention, slightly more than two-thirds (N = 29) reported an increase, 30% (N = 13) reported no impact, and one reported a decrease in beneficiary enrollment and retention.

The data from our PO interviews provided additional insights into how VBID General participation could help plans increase enrollment. Our interviewees cited offering zero-dollar cost-sharing for Part D drugs to LIS-eligible beneficiaries and having rich VBID supplemental benefits as key features for increasing plan enrollment and retention. A representative of PO AX said, "Members like [zero-dollar Part D drugs], and we have high retention rates on these products. We attribute that to the VBID interventions. . . . [M]embers are seeing the value of the zero-dollar Part D, and so they want to stick with it."

Nonetheless, POs viewed this VBID General intervention as a necessary but not sufficient condition of market success: "You don't get a competitive advantage [by offering zero-dollar Part D drugs], but by not offering it, you have a competitive disadvantage. It's just keeping up with the market. . . . We'd be an outlier in the market in we didn't do this," said a PO E representative.

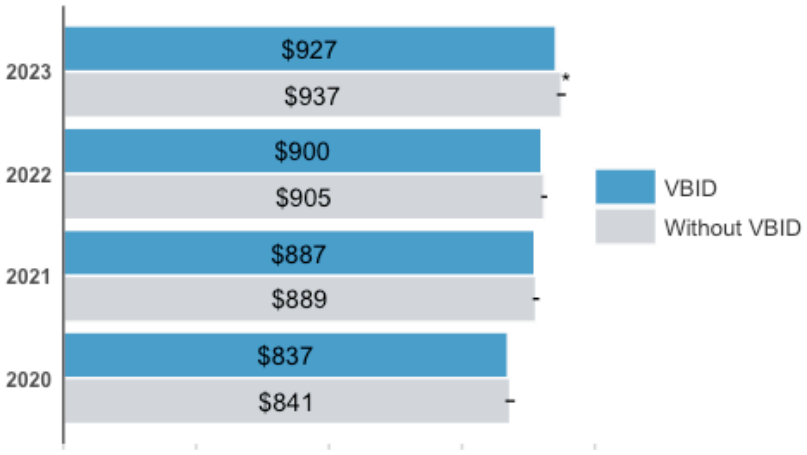
Although POs viewed zero-dollar Part D drugs as a required benefit for staying in business, they considered VBID supplemental benefits to be a market differentiator. According to PO AQ representatives, "[T]he VBID benefits have definitely become the main element for enrollment movements in the market. When you say the debit card, the food benefit, when you say home assistance, these things have become differentiators."

The representatives of POs reporting no impact of VBID General on enrollment and retention generally said that they could not attribute changes solely or directly to their VBID interventions. One PO BF representative said, "It takes a lot to move the actual percentage of those people. . . . I wouldn't say it's just a complete nonfactor. How much of an influence it has, I don't know." Finally, the only PO reporting reduced enrollment and retention was a new model test participant.

Plan Bids

We analyzed the total MAPD bids: the sum of the standardized MA and Part D plan bids submitted to the CMS Office of the Actuary (OACT). These bids are the POs' projected PMPM cost of providing statutorily required Medicare Parts A, B, and D benefits. The standardized bid reflects the projected PMPM cost for a beneficiary with a risk score of 1.0. (The risk score is a diagnosis-based measure that reflects beneficiaries' anticipated health spending.) The results are reported in Figure 5.2.

Figure 5.2. Estimated Association Between VBID General Interventions and Medicare Advantage Prescription Drug Bids



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

In 2023, VBID General was associated with a statistically significant decrease of $11 in MAPD bids ($p$ = 0.02, 95% CI [–$19 to –$2]). In comparison with the MAPD bid that would have been expected in the absence of VBID, this estimated effect represents a decrease of 1.1%. VBID General was also associated with a marginally significant decrease of $4.76 in MAPD bids in 2022 (p = 0.09, 95% CI [–$10.58 to $0.83]). Although estimated associations between VBID General and MAPD bids in 2020 and 2021 were not statistically significant, they were negative in both years (2020 effect: –$4.38, p = 0.32, 95% CI [–$13.14 to $4.71]; 2022 effect: – $2.61, p = 0.36, 95% CI [–$8.89 to $3.38]).

The MAPD bid is the sum of the MA bid and the Part D bid. To understand how each of these components contributed to the reduction in MAPD bids observed in 2023, we analyzed MA and Part D bids separately. We found that the estimated $11 reduction in the total MAPD bid in 2023 was driven by a $12 reduction in the MA bid (p = 0.01, 95% CI [–$21 to –$4]). In comparison with the MA bid that would have been expected in the absence of VBID, this represents a decrease of 1.4%. The association between VBID General and the Part D bid was positive ($1.48) but not statistically significant (p = 0.21, 95% CI [–0.86 to 3.79]).

The finding that MA bids decreased is consistent with the data collected from PO representatives during the primary data collection. Most POs (39%) completing our survey in 2023 reported that VBID General implementation led to decreases in their MA bids; the remaining POs reported no impact (32%) or an increase (29%) in MA bids.

Representatives of POs that associated VBID with decreases in their MA bids generally attributed the decreases to one of two factors: strategic reductions in profit margins to finance

VBID benefits and the expectation that beneficiaries who use VBID benefits would have a lower utilization of avoidable care. Regarding the first factor, CMS calculates the difference between each plan's bid and a regional benchmark, and—if the bid is below the benchmark—plans may retain a portion of the difference as their MA rebate.[4] These MA rebates can be used finance additional benefits, including VBID benefits. POs sought to generate more rebate dollars to pay for a variety of VBID General benefits, including VBID supplemental benefits and Part D benefits. Some did this by reducing their profit margin, which could, in turn, lower their bid. One PO BK representative said,

> We did reduce the Part C bid, the margin on it to create the savings for the rebate, to create more savings and rebates so we can buy down the Part D premium to target the LIS amount. So, the Part C bid did go down, but the Part D cost did go up, and so that was the interaction.

Regarding the possibility that VBID reduced the utilization of avoidable health care, some insurers offered additional benefits, such as an MTM program, as part of the VBID Model. According to a representative of PO U, their MA bids went down because they were

> looking at utilization [and] . . . cost associated with the members. We were able to identify a certain amount of savings with the MTM showing . . . what the members' expected costs would be traditionally and what the same members' cost would be if they went through the MTM process completely. We're able to identify savings in the cost associated with those members and we're able to input that information into our bids to decrease the costs.

POs that reported increased MA bids on the questionnaire said that they had to account for the additional cost of some of their VBID General benefits, such as RI programs and WHP, and file those costs as administrative costs in their MA bid. One PO AF representative noted that their MA bid also incorporated other administrative costs, including "additional program components that did not otherwise exist from an oversight standpoint, a reporting standpoint, expansion of our provider agreements or new provider agreements, vendor agreements."

Nearly three-quarters (73%) of surveyed POs reported an increase in plan administrative costs that they attributed to VBID General; 25% reported no impact. One PO C representative explained that some of their VBID General benefits were costly to administer:

> There's a charge for having the vendor and for them to maintain our card, so that's going to be an administrative expense. And then I just think any additional staffing needed to fill out VBID applications, to monitor the membership, to report member services, to address the needs of the members if they call in with questions about VBID, that would all fall under administrative expense.

POs were split in their perspectives on the impact of VBID General on their Part D bids, with 43% of POs that completed our questionnaire reporting no impact and 43% reporting an

[4] More precisely, the MA rebate is calculated as the difference between the benchmark and the bid, multiplied by a quality adjustment factor based on the plan's Star Ratings and the Medicare Payment Advisory Commission's Medicare Advantage Program Payment System (2023).

increase. Among POs reporting an increase, some indicated that they raised their Part D bids to offset the impact of reduced beneficiary cost-sharing for Part D drugs. A representative of PO BK explained as follows:

> Part D cost did increase . . . mainly from shifting the cost-sharing from the member to the plan. And then there was an assumption that there would be a little bit of an increased utilization to the brand [name drugs] because now there's no copay.

In addition to asking POs about their perspectives on how VBID General affected their bids, we also asked about their perspectives on the return on investment (ROI) from participation in the model test. As in previous years, very few POs reported seeing an ROI from their VBID General interventions. Most POs stated that they did not yet have enough data to determine an ROI or that the COVID-19 pandemic's effect on utilization was making it difficult to develop a baseline for developing an ROI. Moreover, a representative of PO AB noted that it may take a long time to be able to see ROI-related results: "Everybody needs to understand, these people, 70-, 80-years-old, they've had a lifetime of this behavior. We're not going to change it in three months or six months or even a year."

Costs to Centers for Medicare & Medicaid Services

We calculated total costs to CMS as the sum of MA and Part D payments made by CMS to MAPDs for the cost of MA and Part D coverage.

MA costs to Medicare are equal to the plan bid multiplied by beneficiaries' MA risk score, plus any MA rebate payments to the plan (see the previous section on "Plan Bids" for a definition of the MA rebate). MA costs were constructed using MA bid data provided by OACT and data from the Integrated Data Repository on final MA risk scores for plan enrollees.

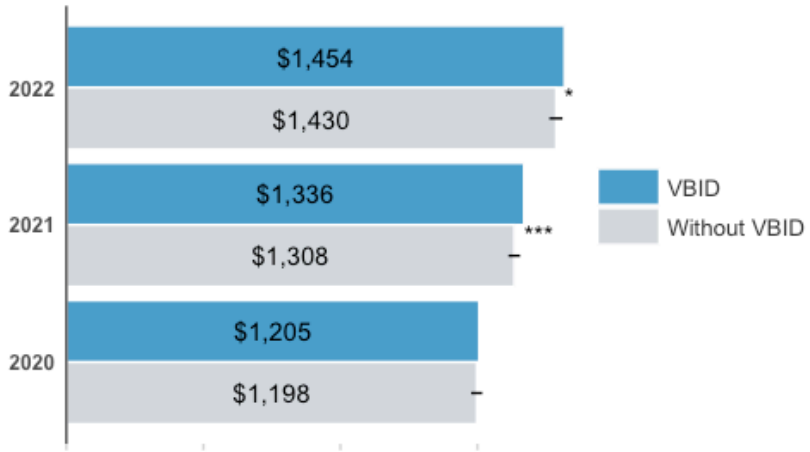
Part D costs to Medicare comprise the national average monthly bid amount multiplied by the beneficiary's Part D risk score, plus low-income premium and cost-sharing subsidy payments and reinsurance costs (the government's portion of costs in the catastrophic phase). Part D costs were calculated using a combination of several CMS data sources, described in more detail in Appendix G.

We analyzed total costs to CMS for 2017 to 2022 (Figure 5.3). Costs to CMS for 2023 were not available at the time of this writing in 2024 because of data lags associated with some components of Part D costs. We also note that Part D costs to CMS do not account for direct and indirect remuneration received by plans (such as manufacturer rebates) nor do they account for risk corridor payments calculated after final payment reconciliation is completed, because these data were not available to the research team.

In 2022, VBID General implementation was associated with a statistically significant increase of $25 PMPM in costs to CMS ($p = 0.01$, 95% CI [$6 to $44]). In comparison with the cost to CMS that would have been expected in the absence of VBID, this estimated effect

represents an increase in the total cost to CMS of 1.7%. VBID General implementation was also associated with higher costs to CMS in 2021 ($29, $p < 0.01$, 95% CI [$11 to $45]). We found no statistically significant association between VBID General implementation and costs to CMS in 2020 ($7, $p = 0.45$, 95% CI [–$10 to $23]).

Figure 5.3. Estimated Association Between VBID General Interventions and Total (Medicare Advantage + Part D) Per Member Per Month Costs to Centers for Medicare & Medicaid Services

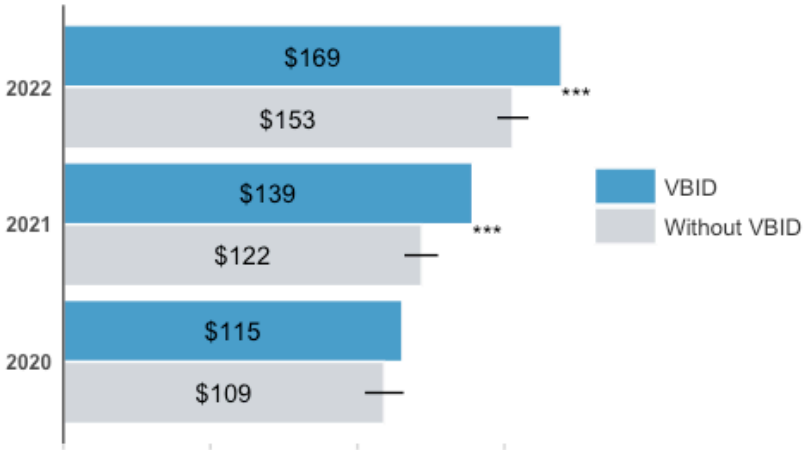


SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

When we examined MA and Part D costs to CMS separately for 2022, we found that MA costs to CMS accounted for most of the increase in total costs to CMS. In 2022, VBID General was associated with a statistically significant increase of $20 ($p = 0.02$, 95% CI [$3 to $36]) in MA costs to CMS, an estimated effect that represents an increase of 1.6%. Part D costs to CMS did not have a statistically significant association with VBID General implementation in 2022 ($5.10, $p = 0.14$, 95% CI [–$1.58 to $11.86]).

MA costs to CMS are determined by the MA bid, the risk score, and the MA rebate. As we previously discussed, VBID General was associated with a decline in MA bids in 2022, suggesting that increases in MA costs were likely driven by changes in the MA rebate, changes in the risk score, or both. We found that both of these factors likely contributed to the increase in MA costs to CMS. In 2022, VBID General was associated with a statistically significant increase of $17 ($p < 0.01$, 95% CI [$11 to $22]) in the MA rebate (Figure 5.4). In comparison with the MA rebate that would have been expected in the absence of VBID General implementation, this estimated association represents an increase in the MA rebate of 10.8%.

Figure 5.4. Estimated Association Between VBID General Interventions and Medicare Advantage Rebate



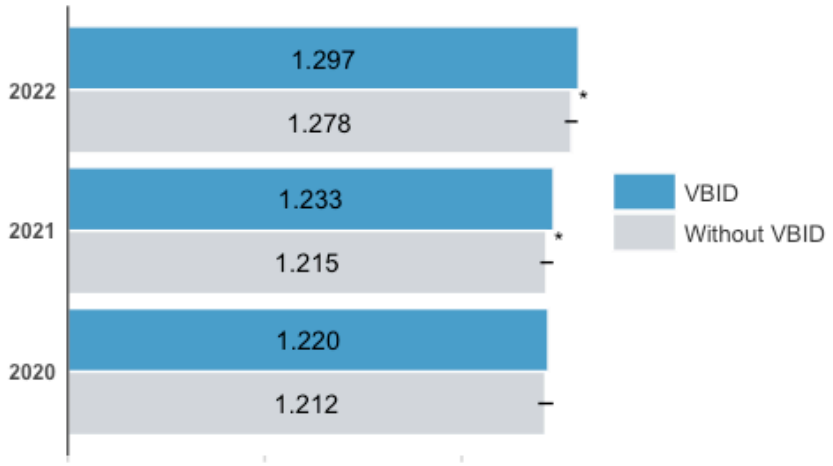
SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

In 2022, VBID General was also associated with a statistically significant, 0.02 point increase in the MA risk score ($p = 0.02$, 95% CI [0.00 to 0.04]) (Figure 5.5). In comparison with the MA risk score that would have been expected in the absence of VBID General implementation, this estimated association represents an increase of 1.5%. In calculating costs to CMS, the risk score is multiplied by the MA bid. Given that the average standardized MA bid was about $850 in 2022, an 0.02 point increase in risk score would be associated with an increase in MA costs to CMS of about $17, roughly the same magnitude as the increase in MA rebates.

Figures 5.4 and 5.5 do not show MA rebate and risk score results for 2023, because we did not have all the data needed to estimate total costs to CMS for that year (mainly due to missing data on Part D costs to CMS). In Appendix G, we report that VBID General was associated with a statistically significant $23 increase in the MA rebate in 2023 ($p < 0.01$, 95% CI [$14 to $31]).

Although our DD analyses suggest that VBID General was associated with increased risk scores in 2022, the majority of POs (90%, $N = 38$) did not report any impact of model test participation on risk scores on the questionnaire. The remaining four POs were split in their perceptions: Although two POs (5%) reported seeing decreases in risk scores that they attributed to VBID General participation, the other two POs reported seeing increases in risk scores. In discussing questionnaire responses during the interviews, PO representatives generally said that they did not design VBID General interventions with the goal of affecting their risk scores. One PO C representative said that their VBID benefits were not meant to "push members to get more services from the hospitals or increasing coding opportunities."

Figure 5.5. Estimated Association Between VBID General Interventions and Medicare Advantage Risk Score



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

Representatives of the two POs that reported an increase did identify two mechanisms of increasing risk scores. The first mechanism was the WHP program, which is a model test requirement that must be offered to all beneficiaries in a VBID-participating plan. According to a PO AX representative, WHP can help reflect more accurate risk through improved coding: "The wellness and health care planning allows us uptick there, certainly similar to the programs that we have, but with the clinical team having a little bit stronger focus because of doing things slightly differently. We think that that might have helped to contribute to better coding for these members."

The second mechanism was the RI programs that provide financial rewards to beneficiaries who complete an annual health risk assessment (HRA). For example, PO AL offered a Part C RI program that has "a wellness reward that is $100 per quarter, four quarters, $400 a year." It starts with an HRA and continues with tailored care management engagement and the completion of quarterly wellness activities, such as receiving recommended vaccinations, attending nutrition classes, and having specific health measures and screenings performed (such as blood pressure and colonoscopies). This PO designed the RI program "to help us drive a higher risk adjustment score, so to speak."

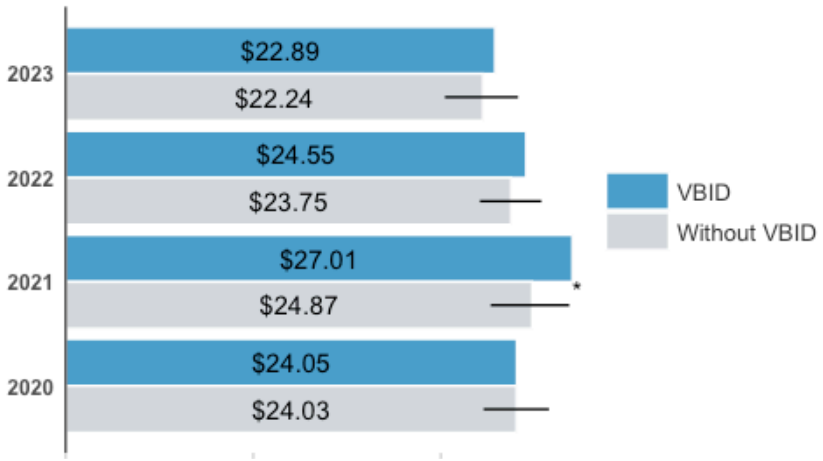
It is worth noting that the representatives of PO AE had a different perspective on risk scores. That PO used diagnosis coding as a tool to determine the impact of VBID General on beneficiaries' risk scores and saw a risk score decrease among beneficiaries participating in their RI diabetes management program. The risk score reduction could be a sign of a positive impact on beneficiaries' health.

Beneficiary Premiums

We analyzed the association of VBID General implementation with total monthly premiums for MA and Part D coverage, which are one component of beneficiary costs. Plan-level premiums were drawn from the approved plan data within the Health Plan Management System and reflect the final amount that plan enrollees would pay before the application of any Part D LIS premium subsidies.

Although estimated associations were positive, they were not statistically significant in most years (Figure 5.6). The exception was 2021, for which we estimated a statistically significant $2.14 increase ($p = 0.04$, 95% CI [$0.16 to $4.36]). The estimated increase in 2021 was driven by a statistically significant $3.05 increase ($p < 0.01$, 95% CI [$1.93 to $4.18]) in Part D premiums, which was partially offset by a statistically significant $1.86 decrease ($p < 0.01$, 95% CI [–$3.18 to –$0.58]) in MA premiums. (We note that LIS-eligible beneficiaries were likely shielded from these Part D premium increases; the plan-level premium variable examined here does not account for LIS; estimates of changes in Part D out-of-pocket (OOP) costs associated with VBID can be found in Chapter 6.) The non-statistically significant associations with MAPD premiums that we estimated for other years were as follows: $0.65 in 2023 ($p = 0.51$, 95% CI [– $1.23 to $2.68]), $0.80 in 2022 ($p = 0.33$, 95% CI [–$0.81 to $2.47]), and $0.02 in 2020 ($p = 0.96$, 95% CI [–$1.72 to $1.77]).

Figure 5.6. Estimated Association Between VBID General Interventions and Medicare Advantage Prescription Drug Premiums



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

Similar to the quantitative findings, nearly all (98%) surveyed POs reported no impact from VBID participation on MA premiums, and 76% reported no impact on Part D premiums (20% reported increases in Part D premiums).

As we described in the "Plan Bids" section, PO representatives reported trying to buy down VBID-related costs with rebate dollars rather than passing those costs to beneficiaries in the form of higher premiums. In some cases, POs reduced their margin to increase the size of their rebates. A representative of PO AZ elaborated on the goal of keeping premiums low for beneficiaries:

> We're trying to target [our Part D bid] at the premium that it would be covered by . . . the low-income subsidy, and then we are targeting zero-dollar member [MA and Part D] premium because we can still. So really, that's why there are no increases [in premiums], but the bid obviously is going to be increasing because of additional cost. . . . At the same time, benchmark is increasing. And so when we do the bids, we balance all of the different components and ultimately get back to the zero-dollar premium.

Plans that implemented reduced Part D cost-sharing in DSNPs were required to include the cost of this VBID benefit as administrative costs, which would increase Part D bids and premiums. However, several POs offering this intervention in DSNPs explained that, because CMS covers some or all of LIS-eligible beneficiaries' premiums, their enrollees did not see any increases in plan premiums. As a PO L representative put it, "The way we are doing it on these plans does not impact premium because these are all DSNPs. . . . We're not increasing premium to members by having VBID. It's covered for them by their Extra Help."

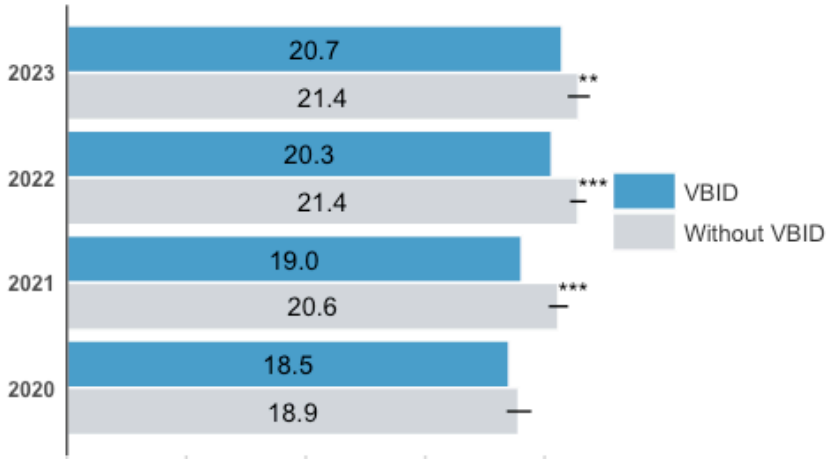
Mandatory Supplemental Benefit Offerings

MA plans can choose to offer MSBs, such as vision, hearing, and dental coverage, and can determine the number and type of such benefits that they provide. (The term *mandatory* means that these benefits are included in the benefit package that is offered to all beneficiaries who choose to enroll in the plan and is distinguished from *optional* supplemental benefits, which beneficiaries may choose to purchase in addition to their plan's established benefit package.) We counted the number of unique MSBs offered each year as reported in the publicly available plan benefit package (PBP) data.

We found that VBID General was associated with a statistically significant decrease in the number of MSBs offered in 2021, 2022, and 2023 (Figure 5.7). Specifically, VBID General was associated with a statistically significant decrease of 1.54 MSBs in 2021 ($p < 0.01$, 95% CI [– 1.95 to –1.13]), 1.10 MSBs in 2022 ($p < 0.01$, 95% CI [–1.45 to –0.77]), and 0.68 MSBs in 2023 ($p < 0.01$, 95% CI [–1.16 to –0.24]). In comparison with the number of MSBs that would have been expected in the absence of VBID General implementation, these estimated effects represent a decrease of 7.5%, 5.1%, and 3.2% in each year, respectively. We found no evidence

of a relationship between VBID and the number of MSBs offered in 2020 (–0.40, $p = 0.13$, 95% CI [– 0.93 to 0.10]).

Figure 5.7. Estimated Association Between VBID General Interventions and Number of Mandatory Supplemental Benefits Offered



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

The measure of the number of MSBs that we analyzed included only those benefits that were available to all plan enrollees. Many plans also offered VBID-enabled supplemental benefits, which are available only to beneficiaries who are targeted by their plans' VBID interventions. The cost of MSBs reported by plans in the bid pricing tool reflects both VBID-related supplemental benefits and other MSBs. We found that MSB costs increased in 2021, 2022, and 2023. For example, in 2023, VBID General was associated with a $24 PMPM increase in MSB costs ($p < 0.01$, 95% CI [$17 to $30]). The results for other years can be found in Appendix G.

Consistent with our quantitative findings about the cost of MSBs, 60% of POs completing our questionnaire reported an increase in MSB costs associated with VBID General; the remaining 40% reported no impact. Some POs mentioned specifically that they reduced the number or limited the generosity of their non-VBID MSBs to pay for VBID supplemental benefits. As a representative of PO AP explained, "We offered [VBID] benefits like the healthy food and utilities, but we may have had to adjust elsewhere to make sure those premiums are still pretty low for our beneficiaries." The menu approach to offering supplemental benefits, in which beneficiaries could pick and choose a few benefits from a larger group of options, also helped constrain the costs of offering VBID supplemental benefits because beneficiaries could select only a subset of benefits.

Comparison with Findings of 2023 Evaluation Report

With the exception of the number of MSBs offered, our 2023 evaluation report analyzed the outcomes examined here for 2022 and earlier years. The results presented in the current report are slightly different from those shown in the prior report due to methodological changes, including the enforcement of tighter balance on pre-period outcome trends, a more conservative approach to statistical inference, and changes to crosswalking plans across years. However, these differences were small and did not change the tenor of the overall findings.

We found only one instance in which a statistically significant result from the prior report is no longer statistically significant: In the 2023 report, we estimated that VBID General implementation was associated with a statistically significant $1.33 increase in total beneficiary premiums in 2022 ($p < 0.01$, 95% CI [$0.39 to $2.27]). Although the estimate presented here ($0.80) is also positive and falls within the 95% CI of the previously published estimate, the association is no longer statistically significant ($p = 0.33$, 95% CI [–$0.81 to $2.47]). In addition, for MAPD bids in 2022 and MA rebates in 2020, the results shifted from not statistically significant in the prior report to marginally significant here.

Some differences from the results published in our 2023 evaluation report are also apparent in the estimated association between VBID General and plan-level MA risk scores. These differences reflect, in part, the fact that the 2023 evaluation report analyzed the impact on the projected MA risk score reported with plan bids, whereas the results shown here used data on the final MA risk scores aggregated from beneficiary-level data. In our 2023 evaluation report, we estimated that VBID General implementation was associated with a statistically significant increase of 0.02 risk score points ($p = 0.04$, 95% CI [0.00 to 0.04]) in the projected MA risk score for 2020. Here, we found that VBID General was associated with a statistically insignificant increase of 0.01 risk score points ($p = 0.43$, 95% CI [–0.01 to 0.03]) in the final MA risk score for 2020.

Summary

We found a statistically significant association between VBID General and higher plan enrollment in 2023. Many POs said that zero-dollar cost-sharing for Part D drugs and VBID supplemental benefits, such as flex cards, helped them with beneficiary enrollment and retention.

Our analysis of plan-level financial outcomes for 2023 showed that VBID General implementation was associated with lower standardized MAPD bids, reflecting lower standardized MA bids. Several POs mentioned that they intentionally lowered their bids—for example, by decreasing their margins—to recoup higher rebate dollars they used to fund VBID benefits. Despite the evidence suggesting that VBID was associated with lower bids in some years, we found that VBID was associated with increases in total costs to CMS in 2021 and 2022. (We could not examine total costs to CMS in 2023 due to a lack of complete data.) The

increases in cost to CMS in 2021 and 2022 reflected increases in both the MA rebate and the MA risk score.

Quantitative analyses in this report and our 2023 report found that VBID was associated with an increase in risk scores, both at the plan and the beneficiary levels (Chapter 6). Although POs in general did not report a link between VBID and risk scores, one PO mentioned that WHP requirements might lead to higher risk scores, and another PO highlighted a link between their RI intervention and increased coding intensity.

We found limited evidence to suggest that VBID was associated with changes in MAPD premiums. Although associations were positive in most years, the association was statistically significant only in 2021. POs reported that they aimed to avoid VBID-related premium increases, in some cases reducing their margin to keep premiums from going up. However, some DSNPs reported that they increased Part D premiums to fund Part D cost-sharing reductions, an approach that they found palatable because CMS covers the Part D premium for beneficiaries who receive the Part D LIS.

Finally, we found that VBID General implementation was associated with reductions in the number of MSBs that plans offered to all enrollees and an increase in the PMPM cost of MSBs. Because the costs of some VBID benefits must be priced as MSB costs, the reduction in the number of MSBs offered to all plan enrollees combined with the increase in PMPM MSB costs suggests that plans cut back on the MSBs offered to all plan enrollees to fund their VBID benefits. This hypothesis is further supported by our qualitative findings. MSBs are financed through a combination of beneficiary premiums and the MA rebate, so benefit design choices that limit increases in the cost of MSBs can limit the growth of premiums and potentially attract more enrollees to a plan.

Chapter 6. Beneficiary-Level Health and Utilization-Related Outcomes

Key Findings

- VBID General was associated with increases in targeted beneficiaries' average risk scores of 0.055 points in 2020 (95% CI [0.029 to 0.080]) and 0.070 points in 2021 (95% CI [0.041 to 0.100]). These changes represent increases of 3.5% and 4.4%, respectively.
- For 2021, VBID was associated with an additional 3,923 beneficiaries adhering to cholesterol medications and an additional 9,027 women receiving breast cancer screenings. VBID also increased adherence in 2020, but fewer people were affected because fewer plans participated in the model. PO representatives also reported that their interventions had beneficial impacts on adherence.
- VBID was associated with a 3.5% increase in non–COVID-related inpatient stays in 2020 (95% CI [1.8% to 5.1%]) and a 3.6% increase in 2021 (95% CI [1.8 to 5.3]).
- VBID was associated with a $24.59 reduction in annual Part D OOP costs in 2021 (95% CI [–$33.99 to – $16.20]). This represents a 24.0% reduction in beneficiaries' Part D OOP spending and is consistent with POs' expectations about the model's effects.

VBID General is designed to improve beneficiaries' engagement in their health care, promote healthier choices, and improve adherence to recommended care. In turn, the model has the potential to affect beneficiary-level outcomes related to adherence, utilization, and spending. In this chapter, we analyze whether VBID General was associated with changes in beneficiaries' **risk scores; adherence to non-insulin diabetes drugs, statins, and hypertension medication; adherence to breast cancer screening recommendations; the utilization of inpatient services; and Part D OOP costs.**

We focus our analysis on beneficiaries who were targeted by their plans' VBID interventions and estimate associations using entropy-weighted DD regression models. These models compare outcome trends among VBID-targeted beneficiaries to comparison beneficiaries who are weighted to resemble the VBID group. Most beneficiary-level outcomes rely on encounter data, which have a two-year run-out period. As a result, our analysis focuses mostly on estimates for 2020 and 2021.

We use an "intent to treat" approach, meaning that we analyzed all targeted beneficiaries, regardless of whether they became eligible for or used VBID benefits. As a result, not all targeted beneficiaries included in our analysis engaged with their plans' VBID interventions. In 2020, 66% of targeted beneficiaries were in plans that required beneficiaries to fulfill participation requirements to receive VBID benefits, and the share of beneficiaries who met these requirements was low (10% to 13%, depending on intervention type). However, the share of beneficiaries with participation requirements declined the following year, with fewer than 12% of eligible beneficiaries facing such requirements in 2021. Regardless of whether they faced participation requirements, all VBID-targeted beneficiaries were exposed to WHP. See Khodyakov et al. (2022) for additional discussion.

Unlike the beneficiary analysis in our 2023 VBID evaluation report, which restricted the sample to a stable cohort of targeted beneficiaries who had been enrolled in their VBID plan for at least one year prior to the intervention, we now include all VBID-targeted beneficiaries in our analysis, except those who were new to Medicare at the time they enrolled in a VBID plan.

As part of these changes, we now include people who moved from FFS to a VBID plan in our analyses. People who transitioned from FFS to MA could experience changes in health care utilization due to this transition, and data for some outcomes, such as risk scores, may not be fully comparable for MA and FFS beneficiaries. We addressed this concern by stratifying our analysis, so that beneficiaries who moved from FFS to a VBID plan are compared only with entropy-balanced beneficiaries who moved from FFS to a non-VBID MA plan. This approach controls for any general changes in outcomes that could occur due to the transition to FFS, so long as they are similar for VBID and non-VBID beneficiaries. We also stratified analyses based on the amount of pre-period data we had for each beneficiary, so that our analyses compared people with a similar amount of data.

Including a larger share of VBID-targeted beneficiaries in our model improves the representativeness of our findings relative to the prior report. However, our DD models are more complicated to estimate due to the stratifications we mentioned above. Appendix A describes how we adapted our methodology to address these challenges in more detail.

Beneficiary Risk Scores

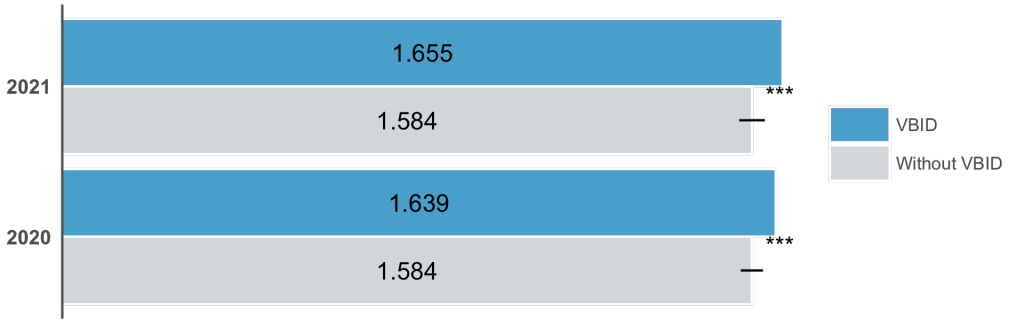
Conceptually, the relationship between VBID and beneficiary risk scores is ambiguous. On the one hand, because VBID encourages beneficiaries to interact with the health system (for example, by lowering cost-sharing for high-value services), it is possible that the model test could lead to more conditions being diagnosed and coded. Among plans that targeted their interventions based on chronic conditions, it is also possible that the process of identifying eligible beneficiaries could result in new diagnoses. For example, plans might conduct HRAs to ensure that all eligible beneficiaries are identified and offered VBID benefits. On the other hand, VBID could prevent conditions from developing or worsening by encouraging healthy behaviors, preventive treatment, and chronic care management, an effect that could lower risk scores or reduce their growth over time.

We analyzed the relationship between VBID and beneficiaries' risk scores based on the year in which diagnoses were identified. For example, what we refer to as the 2020 risk score captures risk scores based on 2020 diagnoses and is used for payment in 2021. Although the conceptual relationship between VBID and risk scores could be either positive or negative, in our prior evaluation report, we found a positive association between VBID implementation and targeted beneficiaries' 2020 risk scores.

For 2021, we continued to find a positive association between VBID and targeted beneficiaries' risk scores. VBID was associated with an 0.055 point ($p < 0.001$, 95% CI [0.029,

0.080]) increase in risk scores in 2020, which represents a 3.5% increase over what would have been expected without VBID (Figure 6.1). For 2021, we estimated that VBID was associated with an 0.071 point increase in risk scores ($p < 0.001$, 95% CI [0.041 to 0.100]), which represents a 4.4% increase over what would have been expected otherwise.

Figure 6.1. Estimated Association Between VBID General Interventions and Targeted Beneficiaries' Risk Scores



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

Medication Adherence

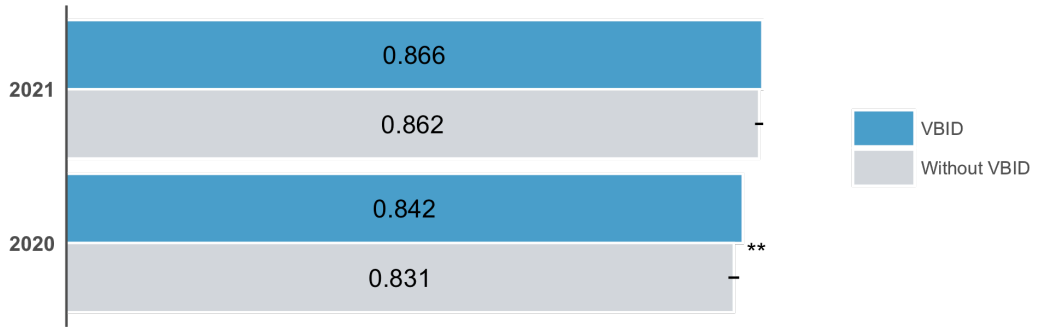
Many VBID General interventions reduced Part D cost-sharing, which could increase medication adherence among targeted beneficiaries. Interventions that promoted care management or increased contact with primary care providers (PCPs) could have also affected beneficiaries' medication use. We considered three medication-related outcomes that are included in the CMS Part D Star Ratings: adherence to non-insulin diabetes drugs, adherence to statins, and adherence to hypertension medication. In all cases, we limited the analysis to VBID-targeted beneficiaries with conditions for which the drug would be part of recommended care (based on being in the denominator for the relevant Star Ratings measure). Beneficiaries are considered to be adherent if their Part D events indicate that they have filled their medication for at least 80% of days in the calendar year.

Non-Insulin Diabetes Drugs

As shown in Figure 6.2, we found that VBID General was associated with a 1.1 percentage point increase in the probability that targeted beneficiaries were adherent to non-insulin diabetes medication in 2020 ($p < 0.01$, 95% CI [0.4 to 1.8] percentage points). This implies that VBID was associated with approximately 674 additional beneficiaries becoming adherent in 2020. The association remained positive in 2021 but was substantially smaller than in 2020 (0.4 percentage

point increase) and no longer statistically significant ($p = 0.12$, 95% CI [–0.1 to 0.9 percentage point]).

Figure 6.2. Estimated Association Between VBID General Interventions and the Probability That Targeted Beneficiaries Were Adherent to Non-Insulin Diabetes Medication



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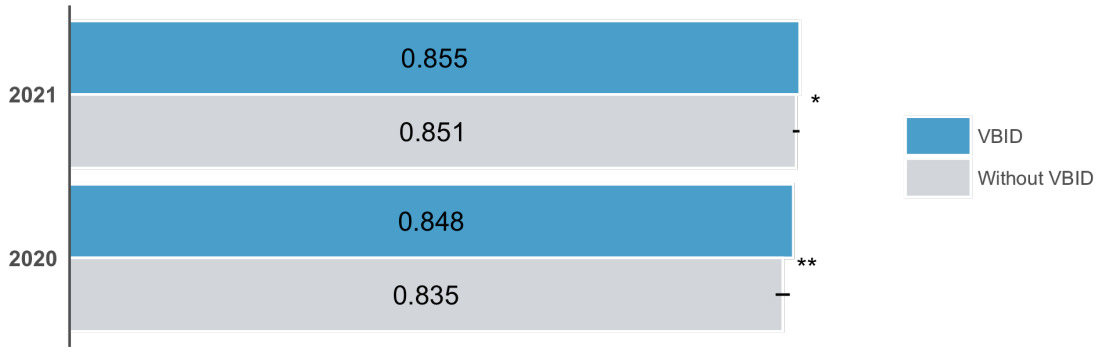
Cholesterol Medication (Statins)

VBID General was associated with a 1.2 percentage point increase in the probability that a beneficiary was adherent to cholesterol medication in 2020 ($p < 0.01$, 95% CI [0.4 to 2.1] percentage points) and an 0.4 percentage point increase in the probability that a beneficiary was adherent to cholesterol medication in 2021 ($p = 0.04$, 95% CI [0.0 to 0.8 percentage point]) (Figure 6.3). This suggests that VBID was associated with an additional 2,092 beneficiaries in 2020 and 3,923 beneficiaries in 2021 who were adherent to cholesterol medication. The estimated number of beneficiaries affected in 2021 was larger than the number affected in 2020, even though the percentage-point effect was larger in 2020 (1.2 percentage points versus 0.4 percentage point). Plan participation in VBID grew substantially between 2020 and 2021, hence many more beneficiaries were included in the denominator when calculating the number affected in 2021.

Hypertension Medication

We found no statistically significant association between VBID General and beneficiaries' adherence to hypertension medication in either year (see Appendix H for details).

Figure 6.3. Estimated Association Between VBID General Interventions and the Probability That Targeted Beneficiaries Were Adherent to Cholesterol Medications



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Parent Organization Perspectives on the Impact of VBID General on Medication Adherence

The results of our PO interviews generally support the above-described quantitative findings: Representatives of all but two POs (POs AA and BF) we interviewed noted that they either already saw or expect to see improvements in medication utilization and adherence. In some cases, however, POs' perceptions about which drugs were most affected differed from our quantitative estimates. For example, a representative of PO AK said that, for their PO, "[h]ypertension metrics seem to be the ones with a bit higher [levels] of adherence. And then statins, which I'm surprised to say as a second, and then the diabetes metric. Diabetes metric being sort of the last in line."

Positive impacts on medication adherence are not surprising, given that many VBID General participants offered zero-dollar cost-sharing for Part D drugs to LIS-eligible beneficiaries. One PO AL representative said,

> I can definitely say that we have improved, especially on the Part D side, because of that zero cost share. There may have been a time where folks weren't picking up their refills timely or there were delays in picking up their medications. Maybe, they didn't have [money to pay] their copays. We've seen a definite improvement.

One PO BE representative agreed, saying that their

> members [are] adhering to their medications because it [sic] is $0. [VBID General benefits] removed those financial barriers on Part D side . . . [especially when] this population is on multiple meds. So even though low-income subsidy drug co-payments were relatively affordable, if all members take seven to ten

> drugs easily, especially in this population, it adds up. [Without this intervention] members would start by choosing between whether to get groceries versus medications.

Nonetheless, representatives of several POs, including those from POs AA and BF, reported that the impact of their zero-dollar cost-sharing for Part D drugs on medication adherence was lower than expected. They attributed this result to "to the fact that most of [their] members . . . receive a low-income subsidy and their copays are lower to begin with" (PO AA). Representatives of PO BF also noted that, although it is important to address cost as a barrier to medication noncompliance and their members appreciated having no copays for medications, "the cost may not have really been . . . the [main] barrier for medication adherence." Another PO BF representative agreed, adding that

> oftentimes, members may have more than one barrier to their adherence. While finance may certainly be a barrier, and we're eliminating that through the benefit, they may still have other needs, such as the transportation to get to the pharmacy or to have the level of health literacy and comfort to actually take their medication and understand how to take it as prescribed. Or, it could just be in terms of their personal beliefs, if they experience side effects and it worries them or if they distrust medications or don't feel that it's appropriate to take. We see quite a range of those and, oftentimes, they do layer on top of each other.

Adherence to Breast Cancer Screening Recommendations

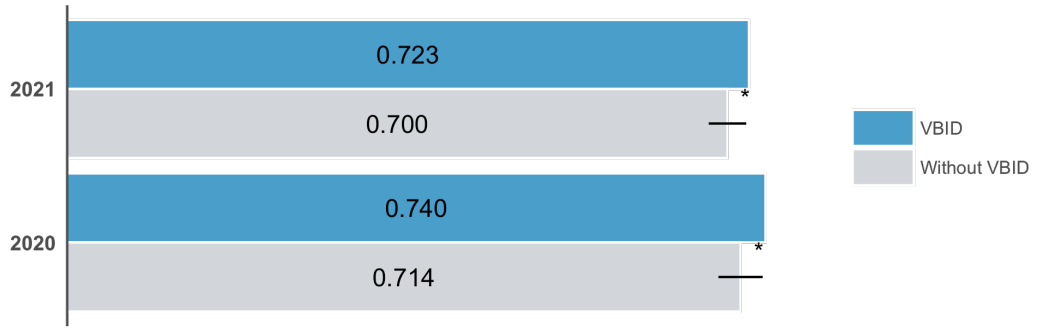
VBID interventions often aim to increase the use of recommended preventive care, for example, by encouraging beneficiaries to interact with care managers or by promoting the use of primary care through zero-dollar PCP visits or the WHP requirement. We focused on breast cancer screenings because they are recommended on a biennial basis for all women between the ages of 52 and 74, a subset of which includes a large share of the Medicare population.[5] Studies have found an association between increased primary care utilization and adherence to breast cancer screening recommendations (Onega et al., 2018; Sutradhar et al., 2016). Furthermore, at least one PO (PO N) directly incentivized mammography through its RI program.

We found that VBID was associated with a 2.6 percentage point increase in adherence to breast cancer screening recommendations in 2020 ($p = 0.03$, 95% CI [0.3 to 5.0] percentage points) and a 2.3 percentage point increase in 2021 ($p = 0.03$, 95% CI [0.3 to 4.3] percentage points). This translates into 1,373 additional women getting screened in 2020 and 9,027 additional women getting screened in 2021. Substantially more women were affected in 2021 because many more plans participated in VBID that year, and, therefore, more women were targeted by their plans' VBID interventions.

[5] Other screenings, such as colon cancer screenings, are recommended on a less frequent basis (five or ten years, depending on an individual's health history); hence, fewer beneficiaries are due for this service in any given year.

During the interview, PO N representatives noted that they "have seen improvement in the clinical measures that [they] offer rewards for [as part of their RI program, including] colorectal cancer screening and breast cancer screening." Representatives of other POs did not call out improvements in breast cancer screening as an outcome they achieved, most likely because their VBID General interventions did not specifically target cancer screening rates.

Figure 6.4. Estimated Association Between VBID General Interventions and the Probability That Targeted Beneficiaries Were Adherent to Breast Cancer Screening Recommendations



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Utilization

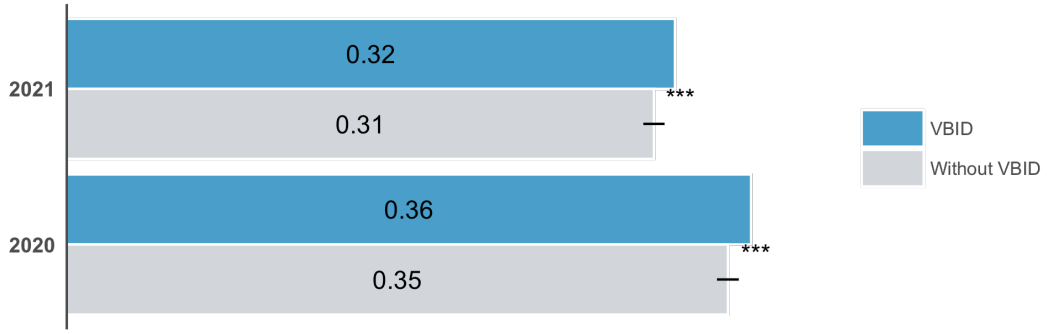
One of the goals of VBID is to reduce the utilization of costly downstream services that may result from poorly managed chronic disease, a lack of adherence to medication regimes, and barriers to receiving recommended care. We initially considered two outcomes to represent costly and potentially avoidable utilization: inpatient stays unrelated to the COVID-19 pandemic and emergency department (ED) visits. However, in analysis described in our 2023 report, we found that ED encounter data-reporting changed in VBID-participating plans around the time that VBID was implemented (as measured based on the consistency of reports in encounter data compared with bids). Because of concerns about the validity of the ED data, we report quantitative findings describing the impact of VBID General on ED visits in Appendix H. In this section, we present the results of our quantitative and qualitative analysis of the impact of VBID General on non–COVID-19 inpatient hospital stays and qualitative analysis of the impact of VBID General on ED visits.[6] We excluded COVID-19–related inpatient use because this could not plausibly be related to VBID, and we wanted to avoid picking up any spurious correlations

[6] To eliminate hospitalizations related to COVID-19, we excluded inpatient stays with diagnoses codes U07.1 or B97.29 occurring on any claim line.

due to differences in the impact of the pandemic between VBID participants and comparators. Our regressions also adjust for COVID-19 case rates as a balancing characteristic.

We found that VBID was associated with a 3.5% increase in non-COVID inpatient stays among targeted beneficiaries in 2020 ($p < 0.01$, 95% CI [1.8% to 5.1%]) and a 3.6% increase in 2021 ($p < 0.01$, 95% CI [1.8% to 5.3%]). The results are shown in Figure 6.5. Associations between VBID and ED visits were positive and statistically significant in 2020 but in not 2021. However, these associations are presented in the appendices because we are not confident in the data.

Figure 6.5. Estimated Association Between VBID General Interventions and Targeted Beneficiaries' Inpatient Stays



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

PO representatives did not perceive that VBID General was associated with increases in inpatient hospital stays or ED visits. Indeed, more than three-quarters of POs reported that VBID General did not impact inpatient hospital stays ($N = 32$) or ED visits ($N = 33$); all remaining POs reported a decrease in these metrics. During the interviews, PO representatives often said that inpatient admissions and ED visits may be trending lower. However, they were not comfortable describing this as an overall decrease because either the results were very preliminary or it may have been hard to attribute changes in high-intensity service use specifically to certain VBID General interventions, such as pest control or gas benefits.

However, several PO representatives reported that VBID-related improvements in medication adherence were leading to reductions in inpatient stays and ED visits. According to PO AO representatives, "[I]npatient utilization [and ED visits] for those [with high cholesterol, diabetes, and hypertension] have decreased, and we'd like to think that some of that is due to the increase in medication adherence." Moreover, PO AL representatives said that "length of stay has shortened considerably [because beneficiaries] are taking their medications and are going to

their primary care physicians now. I feel that that is one of the ones that I can honestly say is a direct attribution." A representative of PO P also agreed that they have already "seen a very clear improvement in medication adherence, [which they view as] a leading indicator of medical savings [attributable to a] decrease in inpatient [hospital stays]."

Part D Out-of-Pocket Costs

Over time, an increasing share of VBID General interventions reduced Part D cost-sharing, with the goal of increasing medication adherence among targeted beneficiaries. Lower Part D cost-sharing may also reduce Part D OOP spending, although the effect will depend on whether the cost-sharing reductions are large enough to outweigh any increased Part D utilization. In practice, most VBID plans with Part D cost-sharing reductions reduced cost-sharing for selected drugs to zero, which should reduce beneficiaries' expenditure regardless of changes in utilization.

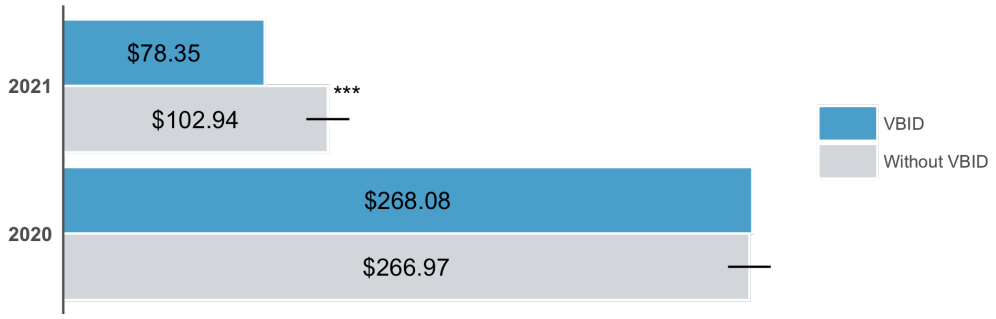
Figure 6.6 shows the results of our analysis. In 2021, we found that VBID was associated with a $24.59 reduction in annual OOP spending ($p < 0.01$, 95% CI [–33.99 to –16.20]). The 2021 result reflects a decrease in OOP spending of 23.9% relative to what would have been expected without VBID. By contrast, the association between VBID and Part D OOP spending in 2020 was positive ($1.11) and not statistically significant ($p = 0.79$, 95% CI [–$7.21 to $9.43]). Compared with 2020, the stronger effect in 2021 may reflect that a larger share of plans offered cost-sharing reductions in that year or that the composition of participating plans and the nature of their interventions changed over time. We note that there are large differences in average OOP spending across the years, indicating substantial compositional changes in VBID-participating plans and their targeted beneficiaries. The relatively low OOP spending in 2021 is likely driven by an influx of DSNPs into the model, whose enrollees are typically eligible for the Part D LIS and, therefore, have little cost-sharing.

The majority of surveyed POs (70%) reported a decrease in beneficiary OOP costs, with the rest reporting no impact. A higher proportion of new model test participants than continuing POs expected decreases in beneficiaries' OOP costs (78% versus 64%).

POs offering the reduced cost-sharing for Part D interventions anticipated lower OOP costs for beneficiaries for prescription drugs. Representatives of POs E, AG, and BF noted that they hoped reductions in cost-sharing would indirectly allow beneficiaries to spend more dollars elsewhere:

> We are able to help members get medications that they may not have been otherwise able to afford. It allows them to use that money in other ways to support gaps in their social determinants—so, to support nutrition, support for food insecurities, transportation, you know, other utility costs. So, just being able to use that financial money somewhere else instead of using it to pay for medication is probably the biggest benefit (PO E).

Figure 6.6. Estimated Association Between VBID General Interventions and Targeted Beneficiaries' Part D Out-of-Pocket Costs



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

Differences from the 2023 Evaluation Report

Our prior evaluation report focused specifically on targeted beneficiaries who were enrolled in the same VBID plan for at least one year prior to the start of the model test. However, restricting the analysis to beneficiaries who were continuously enrolled in their plan required us to discard data from nearly 30% of VBID-targeted beneficiaries in 2020 and continuing this approach for the current report would have required us to discard roughly one-half of all targeted beneficiaries in 2021. In the current analysis, we included all targeted beneficiaries with at least some pre-period data from either MA or FFS, regardless of whether they were continuously enrolled in the same plan. This change enabled us to retain more than 98% of VBID-targeted beneficiaries in the analysis.[7] To define the pre-period, we focus on the beneficiary's first exposure to the model test, as opposed to the plan's first exposure.

Despite the large change in the sample, our findings are very consistent with those presented in our 2023 evaluation report, with similar effect sizes and statistical significance levels for risk scores, non-insulin diabetes drugs, and statins. The only three differences are as follows:

- Our prior report found a small, positive, and statistically significant association between VBID and adherence to hypertension medication in 2020 (a 0.7 percentage point increase, $p < 0.01$, 95% CI [0.3 to 1.0] percentage points). With the updated methods, this result is no longer statistically significant, and the point estimate is close to zero (a –0.1 percentage point reduction, $p = 0.79$, 95% CI [–1.0 to 0.7] percentage points).

[7] The denominator for this calculation reflects VBID-targeted beneficiaries who were enrolled in a VBID plan as of January 1 of each year.

- Our prior report found no statistically significant relationship between VBID and adherence to breast cancer screening recommendations, and the current report finds a positive association. However, our previous result was also positive and only narrowly missed the conventional threshold for being considered statistically significant (a 1.0 percentage point increase, $p = 0.10$, 95% CI [–0.2 to 2.3] percentage points in the prior report; a 2.6 percentage point increase, $p = 0.03$, 95% CI [0.3 to 5.0] percentage points in the current report).
- Our prior report found a larger association between VBID and non–COVID-19 inpatient hospitalizations than we have reported here (a 12.9% increase, $p < 0.01$, 95% CI [11.0% to 14.9%] in the prior report; a 3.5% increase, $p < 0.01$, 95% CI [1.8% to 5.1%] in the current report).

Overall, our results are highly similar to those presented in the 2023 report, despite significant methodological changes to increase the representativeness of the sample.

Summary

In this chapter, we analyzed several outcomes related to VBID-targeted beneficiaries' health, utilization, and OOP spending. To analyze the impact on health outcomes, we looked at beneficiaries' risk scores, which we assessed using risk scores measured in the years in which beneficiaries received diagnoses (2020 and/or 2021) and used by CMS to adjust plans' payments in the subsequent year. Risk scores reflect diagnoses that are estimated to affect health care spending. Conceptually, the relationship between VBID and beneficiaries' risk scores is unclear. On the one hand, if VBID improves beneficiaries' health, then targeted beneficiaries may receive fewer diagnoses over time relative to comparison beneficiaries, ultimately leading to lower risk scores. On the other hand, VBID may also increase the number of interactions that beneficiaries have with providers, leading to more diagnoses and higher risk scores. Consistent with the latter hypothesis, we found that VBID was associated with a roughly 4% increase in beneficiaries' risk scores in both 2020 and 2021. This finding is consistent with the plan-level increase in risk score estimated in Chapter 5 and with the results of our prior evaluation. Although higher risk scores may be desirable if they more accurately reflect beneficiaries' diagnoses and health care needs, higher risk scores also increase payments to MA plans, potentially increasing costs to CMS.

Moreover, consistent with the goals of the model, we found associations between VBID General and beneficiaries' adherence to cholesterol medication and breast cancer screening recommendations in 2020 and 2021 and to non-insulin diabetes medication in 2020. For 2020, these associations suggested that an additional 674 beneficiaries adhered to diabetes medication regimes, an additional 2,092 beneficiaries adhered to statin regimes, and an additional 1,373 women received breast cancer screenings. For 2021, the associations imply that 3,923 additional people adhered to cholesterol medication and 9,027 additional women received breast cancer screenings. The number of additional people adhering to their medications, as implied by these

associations, grew over time as more plans participated and more beneficiaries were exposed to the model test. The relationship between VBID and diabetes adherence was not statistically significant in 2021, and there was no statistically significant relationship between VBID and adherence to hypertension medications in either 2020 or 2021.

In contrast with what POs reported in our qualitative interviews, our data analysis found that VBID was associated with increases in non–COVID-19 hospital inpatient stays in both 2020 and 2021. Theoretically, we expected a decrease in inpatient stays, reflecting VBID's goal of increasing beneficiaries' use of wellness-oriented services, such as primary care, care management, and preventive care. The use of such services might reduce downstream complications that lead to hospitalization. However, prior literature has found that reductions in the OOP cost of outpatient care can lead to increases in both inpatient and outpatient utilization, suggesting that these two types of services are complements (Kaestner and Lo Sasso, 2015). Related work has found that increased use of high-value services is associated with greater use of low-value services (Cliff, Hirth, and Fendrick, 2019). Given this evidence, it is possible that beneficiaries who obtained more primary and preventive care through VBID also obtained more hospital-based care, perhaps though increased referrals or the identification of unmet need for inpatient services.

Finally, we estimated that VBID led to a 23.9% reduction in targeted beneficiaries' Part D OOP costs in 2021 but not 2020. This result could reflect that, compared with 2020, a greater proportion of VBID-participating plans offered Part D cost-sharing reductions as part of their interventions in 2021.

Chapter 7. Quality of Care and Patient Experiences

Key Findings

- VBID General was associated with a statistically significant increase of 0.20 points in overall Star Ratings in 2021 (p = 0.02, 95% CI [0.04 to 0.35]) and 0.19 points in 2022 (p < 0.01, 95% CI [0.06 to 0.32]). Most POs we surveyed, however, reported anticipating no changes to their Star Ratings from their VBID interventions.
- In both 2021 and 2022, VBID General was associated with statistically significant increases in the domain-level Star Ratings measure for managing chronic conditions. In 2021, VBID was associated with a 0.20 point increase (p = 0.01, 95% CI [0.05 to 0.36]) and in 2022 VBID was associated with a 0.21 point increase (p = 0.01, 95% CI [0.06 to 0.37]).
- We found no statistically significant association between VBID General implementation and changes in the domain-level Stars Ratings for drug adherence. Although some POs representatives expected VBID to increase drug adherence, others thought that improving drug adherence for low-income populations may need additional interventions beyond reduced cost-sharing for Part D drugs.

In this chapter, we analyze the association between VBID General implementation and health care quality using Star Ratings data, PO questionnaires, and PO interviews. Star Ratings are a measure of health care quality intended to help consumers make informed health insurance enrollment decisions. Star Ratings also affect payment because better performance can result in larger MA rebates. Star Ratings are assessed at the contract level (a *contract* is a group of plans offered by the same PO subject to the same agreement with CMS) and measure quality along several domains. We analyzed the **overall Star Ratings**, all **five domain-specific ratings for MA**, and the **Part D drug safety and accuracy of drug pricing domain** (Table 7.1). The scale of each star ranges from 1 to 5.

Our unit of analysis for this chapter is the contract. We count a contract as "VBID participating" if any plan within the contract was a VBID plan. Star Ratings for a specific calendar or display year are released to the public for use in the Medicare Plan Finder prior to the annual election period for that calendar year. (In other words, the Star Ratings for the 2024 display year were released in fall 2023.) Generally, the Star Ratings for a particular display year reflect data from two years prior, so the 2024 Star Ratings display year reflects data collected in 2022 (the measurement year).[8] Throughout the text, we refer to the Star Ratings based on the relevant measurement year. We analyzed the Star Ratings for the 2021 and 2022 measurement years. We did not include data from measurement years 2019 or 2020 in our analyses due to the variety of methodologic adjustments CMS made to the Star Ratings during the COVID-19 pandemic (details on the changes can be found in Appendix I).

[8] Star Ratings measures are derived from several data sources that use measurement year data from two years prior for the current display year. The call center data and CAHPS survey are the exceptions because they reflect the data from the prior year (so, the 2023 Star Ratings display year contains CAHPS data from 2022).

Table 7.1. Summary of Star Ratings Domains Analyzed

Domain Number	Domain Title	Abridged Description of Contributing Measures
Part C, Domain 1	Staying Healthy: Screenings, Tests and Vaccines	Breast and colorectal cancer screenings, flu vaccine, monitoring physical activity
Part C, Domain 2	Managing Chronic (Long Term) Conditions	Care management activities in SNPs, diabetes care, medication reconciliation post-discharge, reducing fall risks, statin therapy
Part C, Domain 3	Member Experience with Health Plan	Getting care, plan customer service, overall health care and plan quality
Part C, Domain 4	Member Complaints and Changes in the Health Plan's Performance	Complaints about health plan, members choosing to leave plan (disenrollment), quality improvement
Part C, Domain 5	Health Plan Customer Service	Appeals processes, call center foreign language and teletypewriter services
Part D, Domain 4	Drug Safety and Accuracy of Drug Pricing	Medicare Plan Finder accuracy, medication adherence measures, MTM program completion

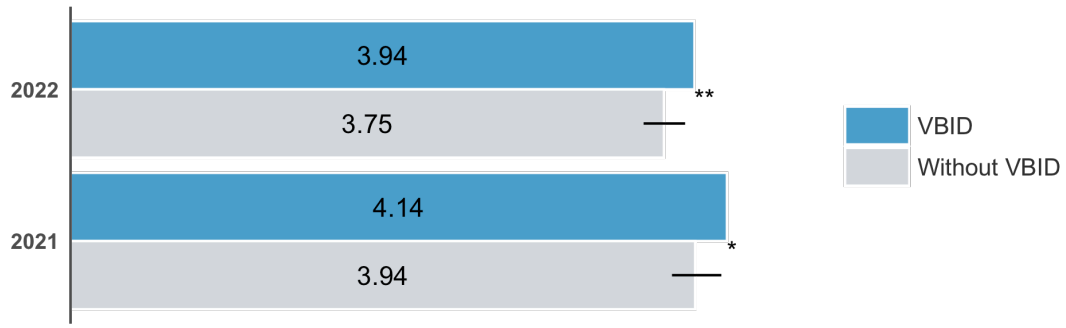
POs' interview comments and survey results reflect the 2021 Star Ratings measurement year. Post–COVID-19 pandemic, CMS reversed changes it made during the pandemic and implemented additional changes in measurement years 2021 and 2022. Because these changes were the same in participating and nonparticipating contracts, they do not affect the interpretation of our DD analyses. However, these changes contributed to some uncertainty regarding POs' assessment of whether participation in the model test led to changes in their overall or domain-level Star Ratings that we discuss below. More information on these methodologic changes for Star Ratings can be found in Appendix I.

Overall Star Ratings

We found a positive and statistically significant association between participation in VBID General and contracts' overall Star Ratings (Figure 7.1). VBID General participation was associated with a 0.20 point increase in overall Star Ratings for 2021 ($p = 0.02$, 95% CI [0.04 to 0.35]) and a 0.19 point increase in 2022 ($p < 0.01$, 95% CI [0.06 to 0.32]), roughly a 5% increase in the overall Star Ratings each year.

In contrast with the quantitative findings, however, the results of our PO surveys suggest that only about one-fifth of POs reported that VBID was associated with an increase in their overall Star Ratings. The remaining POs reported no impact. The interviewed PO representatives generally thought that their VBID interventions would not have a direct link to changes in their overall Star Ratings because many common interventions that included supplemental benefits were not designed to improve care quality directly; instead, their impact on health is likely to be indirect. Some also thought that, although the overall Star Ratings may not be affected, some

Figure 7.1. Estimated Association Between VBID General Interventions and Overall Star Ratings, Measurement Years 2021 and 2022



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

In contrast with the quantitative findings, however, the results of our PO surveys suggest that only about one-fifth of POs reported that VBID was associated with an increase in their overall Star Ratings. The remaining POs reported no impact. The interviewed PO representatives generally thought that their VBID interventions would not have a direct link to changes in their overall Star Ratings because many common interventions that included supplemental benefits were not designed to improve care quality directly; instead, their impact on health is likely to be indirect. Some also thought that, although the overall Star Ratings may not be affected, some domains might. For example, PO C representatives, whose VBID-participating DSNPs offered zero-dollar Part D drugs and a flex card that covered OTC items and healthy food, explained that, although they didn't anticipate an immediate link with care quality, they noted that these benefits may help beneficiaries seek care they need: "This is improving probably their life at home and addressing—you know, you always hear people say, 'Someone's not going to worry about going to get a mammogram if they're worried about where their next meal is coming from.'" Increases in preventive screening, such as mammograms, could improve the staying healthy domain of the Star Ratings.

POs may also have reported no impact on Star Ratings because there are other factors besides VBID that affected this outcome. During the interviews, several PO representatives noted that VBID participation per se may not be driving any changes in Star Ratings. A representative of PO S stated that recent methodological changes in how the Star Ratings are calculated contributed to their uncertainty on VBID's impact: "We did go down from four stars to 3.5 stars on that for [20]23. And it was right on the cusp, and it was driven by the extra weighting on CAHPS." PO AX representatives said that it would be difficult to disentangle the effects of their VBID intervention from other co-occurring interventions:

> It's pretty difficult to tie clinical outcomes to a specific intervention. These products that we're offering the VBID on are DSNP products, where we already have the SNP model of care on top of the VBID interventions. So, it becomes difficult to say: "Okay, which care management tactic, which clinical outcomes program has made the difference?"

Finally, Star Ratings are a contract-level measure, and many POs did not enter all their plans in a given contract into the model test. POs W and AX stated that their VBID targeted groups were too small to "move the needle" on the overall Star Ratings (PO W). "The Star Ratings are calculated at the contract level, so we've got 11,000 or 12,000 members combined in a pool of 73,000 to 74,000 members. So, this VBID intervention alone isn't going to be enough to boost the Stars on the entire contract," explained a representative of PO AX.

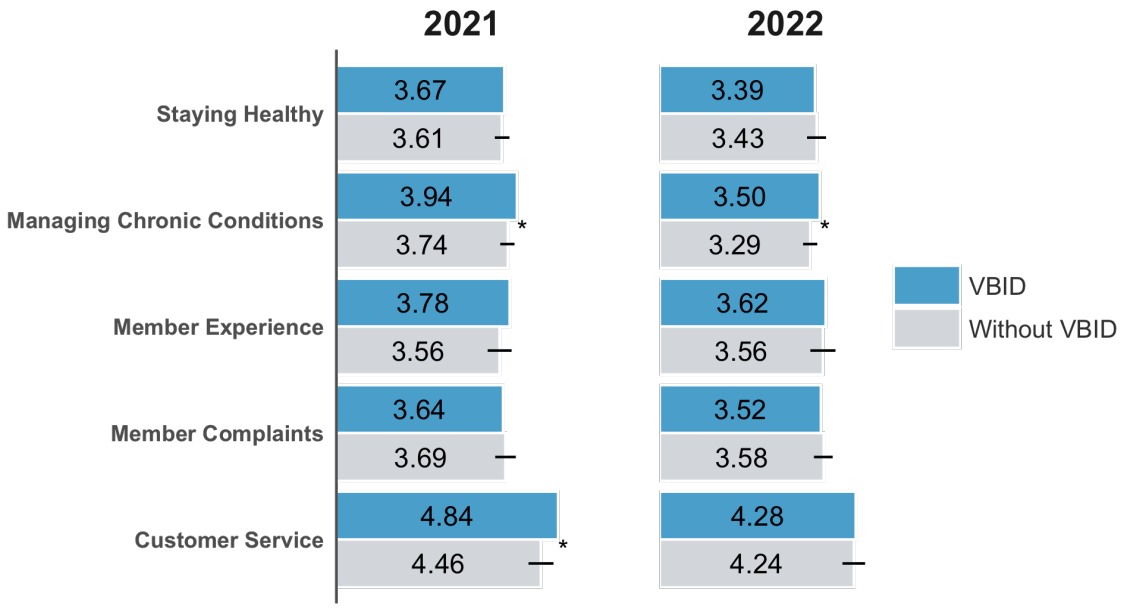
Because VBID-participating contracts may contain nonparticipating plans or nontargeted beneficiaries, we conducted a sensitivity analysis for contracts with varying levels of VBID exposure (25%, 50%, and 75% of beneficiaries in a VBID-participating plan) in Appendix I. The overall Star Ratings estimates for 2022 were similar in magnitude and significance to the main finding in Figure 7.1. The 2021 effects were also positive but not statistically significant. Similar to our 2023 report (Eibner et al., 2023), we found no evidence of a dose-response effect, although in 2022, the effect was largest among contracts in which at least 75% of beneficiaries were in a VBID plan. These findings should be interpreted with caution because dose was measured as the number of beneficiaries in a VBID-participating plan in the contract and not all of these beneficiaries may have been eligible for their plan's VBID intervention.

Domain-Level Star Ratings

Part C Domain

VBID General participation was positively and statistically significantly associated with an increase in the domain-level Star Ratings for managing chronic conditions at 0.20 points for 2021 ($p = 0.01$, 95% CI [0.05 to 0.36]) and 0.21 points for 2022 ($p = 0.01$, 95% CI [0.06 to 0.37]). Measures in this domain include diabetes preventive care utilization, controlling blood pressure, reducing fall risk, and several measures related to hospitalizations, such as having medication reconciliation after a hospital discharge. There were no statistically significant associations of VBID General participation and most of the other domain-level Star Ratings. The one exception was a 0.38 point increase ($p = 0.01$, 95% CI [0.10 to 0.65]) in the customer service domain in 2021, which includes measures for appeals processes and call center foreign language and teletypewriter availability for beneficiaries with hearing loss. Beneficiary appeals are tracked as part of VBID monitoring activities (CMS, 2020), which could have led participating plans to increase attention to this domain as part of the model test. However, given that the association was only seen in one year, we interpret this finding with caution.

Figure 7.2. Estimated Association Between VBID General Interventions and Part C Domains 1 to 5, Measurement Years 2021–2022



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented VBID General, holding other factors constant. The black lines indicate a 95% confidence interval for the level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

The majority of POs (60%) completing our survey reported that VBID General had no impact on individual measures that contributed to Star Ratings in 2023; 37% of surveyed POs reported an increase in individual measures. When asked about the impact of VBID General on domain-level Star Ratings for Part C measures, most interviewees flagged the disenrollment measures as the ones most likely to be positively affected by their VBID interventions rather than the chronic condition measures. (Chapter 5 provides more detail on POs' perspectives on the impact of VBID General on beneficiary retention.) The interviewed PO representatives did not think that VBID General interventions would affect Star Ratings scores for the management of chronic conditions domain. On the survey, however, POs were split about whether overall care quality for targeted beneficiaries would improve as a result of VBID: 50% indicated no change and 50% indicated an increase.

Part D Domain

As described in Chapter 2, many plans implemented either reduced cost-sharing for Part D drugs or RI programs for drug adherence or MTM completion, of which both have the potential

to affect measures in the Part D domain. However, we found no statistically significant association between VBID participation and the Part D domain measure capturing drug adherence and MTM completion rates (a 0.04 increase in the Star Ratings in 2021, $p = 0.74$, 95% CI [–0.15 to 0.22]; a 0.03 increase in the Star Ratings in 2022, $p = 0.77$, 95% CI [–0.14 to 0.19]). In Chapter 5, we estimated that VBID was associated with increases in adherence to certain drugs. However, these changes may not have been enough to affect the Part D Star Ratings domain, which combines adherence measures with additional outcomes related to pricing and the use of MTM.

POs had mixed perceptions regarding the impact of their VBID General interventions on drug adherence metrics. For example, similar to the results of our quantitative analyses, representatives of POs AA and BF reported that their intervention to reduce cost-sharing for Part D drugs for low-income beneficiaries was not as effective as they had anticipated and did not improve drug adherence measures. "I think we were a little bit surprised that we didn't see a greater increase in medication adherence across our general population that qualified for the VBID program," said a representative of PO AA. The same representative continued, "I do think some of that is attributed to the fact that most of our members receive a low-income subsidy, and their copays are lower to begin with." A PO BF representative also noted the lack of impact of this intervention on drug adherence and suggested that "the barrier for medication adherence may not have been cost" for their low-income members.

Similarly, PO N representatives noted that any improvement in medication adherence requires a multipronged approach, combining copay elimination with financial incentives for participation in disease management programs. (This PO implemented a variety of interventions that included zero-dollar cost-sharing for Part D drugs, a healthy food allowance, and several Part D–focused RI programs.)

> Our members are more willing to sit down with a pharmacist for a 30-minute to 45-minute phone call when there is payment involved with that. For our adherence program, we have seen an increase in our adherence rates. When I compare members who are VBID-eligible and they participated, there is like a 1% to 2% increase in adherence rates between those two populations. And, so, I do think that offering incentives and then also having a pharmacist involved in their treatment to include coaching and reminders helps with our rates. (PO N)

Other PO representatives, however, reported seeing small improvements in drug adherence that they attributed to their VBID General interventions:

> We did see a slight uptick, probably about 1% or so. We are attributing some of that increase to the additional rewards that we are giving members so that they more frequently pick up their medications and have a better outcome with their maintenance medications for those three chronic conditions. (PO AO)

Although the representatives of some POs, such as PO E, reported that their Star Ratings went up as a result of improved drug adherence, others reported that the gains would diminish over time:

> We've done really well as a plan on our adherence Stars measures. I think we did see a point of improvement in our diabetes and statins measures going from [20]21 to [20]22, but we are finding as we get bigger, it's getting harder. We've got some pretty intensive clinical programs that we're figuring out how to scale as we grow, but it's getting harder, for sure. (PO AK)

Summary

VBID General participation was associated with a statistically significant increase in the overall Star Ratings, consistent with our findings from the last report. Improvements in the domain-level Star Ratings for chronic condition management and member experience seemed to drive the improvement in the overall Star Ratings, which suggests improved quality of care for beneficiaries. PO representatives generally thought that reduced disenrollment associated with VBID General interventions would be the most likely mechanism for improving Star Ratings. However, our quantitative analyses showed no statistically significant associations with the member experience Star Ratings domain, which captures disenrollment.

Similar to our 2023 report, we found no statistically significant associations in the domain for drug adherence. This finding was surprising because so many plans offered the zero-dollar cost-sharing for Part D drugs for LIS-eligible beneficiaries, RI programs for MTM completion, or other adherence-focused interventions. Many of the Part D interventions targeted reduced cost-sharing to beneficiaries with LIS status, who already had low cost-sharing. Some interviewees noted that improvements in drug adherence for this population may require additional interventions. However, our beneficiary-level analysis in Chapter 6 showed that VBID was associated with improvements in targeted beneficiaries' adherence for certain drugs. The lack of concordance between the beneficiary- and contract-level results could reflect that the relatively modest changes for a small group of beneficiaries did not move the needle on the contract-level Star Ratings domain.

Part II: The Hospice Benefit Component

Chapter 8. Participants and Interventions

Key Findings

- Fifteen POs participated in the Hospice Benefit component in 2023, up from nine POs in 2021 and 13 POs in 2022. Four POs did not reapply for the model in 2024, citing administrative burdens.
- As in prior years, participating POs had larger average plan enrollment and wider geographic reach than nonparticipants. Participating plans were more likely to be DSNPs and were about equally likely to be C-SNPs and I-SNPs as nonparticipants.
- Eight of 15 participating POs capped their TCC benefit at one month; the remaining seven did not limit the number of TCC days. Two POs extended the maximum number of days in TCC for 2023 to allow beneficiaries and their families more time to elect hospice.
- Nine POs offered a Hospice Supplemental Benefit that eliminated cost-sharing for hospice drugs and biologicals and inpatient respite care. Another nine POs expanded access to in-home respite care and allowances for beneficiaries to use for a variety of different needs.
- To identify beneficiaries who are eligible for Palliative Care, all POs relied on provider referrals. Nine POs also used electronic health record- (EHR-) or claims-based algorithms, and some refined algorithms over time to identify a broader set of eligible beneficiaries.
- POs had to establish a hospice network as part of their Hospice Benefit component participation. To operate as in-network providers, hospices invested in processes to communicate and coordinate care with POs, bill for services provided, resubmit denied claims, and report requested data to POs. Hospices' level of investment varied across POs.

In this chapter, we provide an overview of the Hospice Benefit component of the VBID Model test, describe **2023 Hospice Benefit component participants**, and compare participants with model-eligible nonparticipants. We also summarize **2023 Hospice Benefit component interventions**, integrating information from the model application materials, data from PO and in-network hospice interviews, and PO survey results. Appendix E provides details on how we conducted PO and hospice interviews and pre-interview PO surveys. Finally, in this chapter, we describe the **investments that in-network hospices made** to be able to deliver care to patients from Hospice-participating plans.

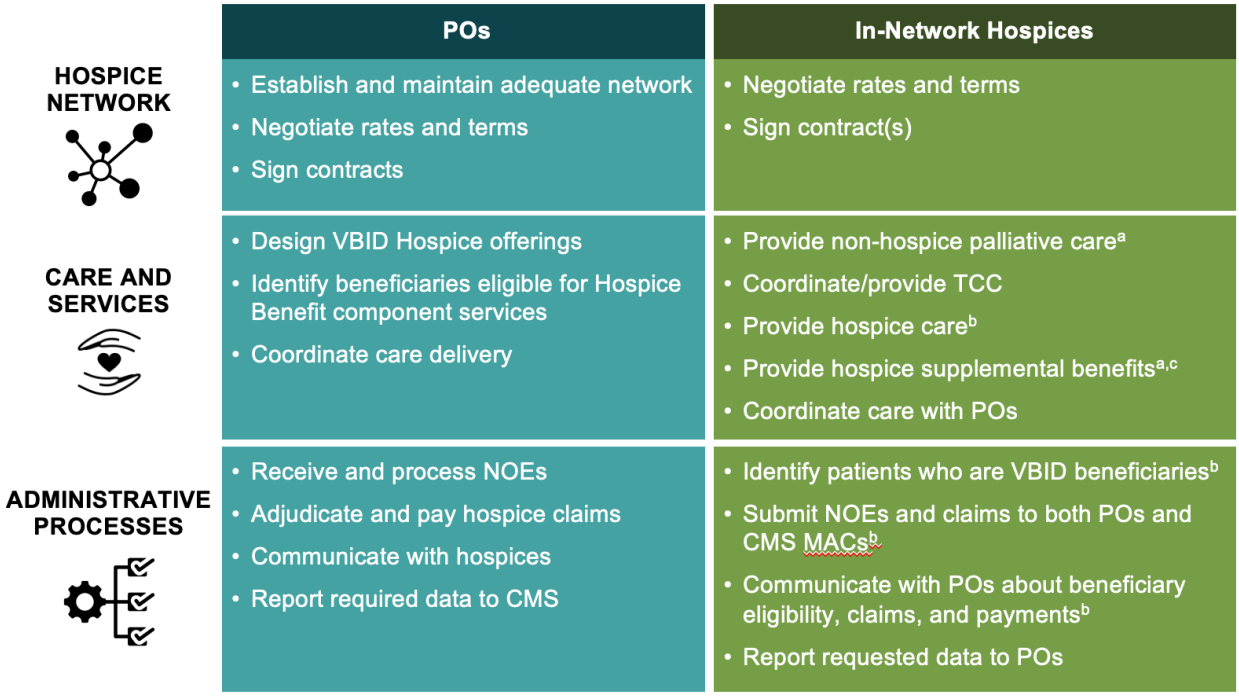
Overview of the Hospice Benefit Component

The Hospice Benefit component allows POs to offer a number of benefits and services that require collaboration with hospices. Figure 8.1 summarizes the activities that POs and in-network hospices undertook to implement the Hospice Benefit component, including establishing and maintaining hospice networks (described in detail in Chapter 9), designing and delivering Hospice Benefit component services (including all Medicare Hospice Benefit services), and conducting administrative processes. Although both POs and hospices performed these functions, the nature of the tasks and activities they undertook varied.

In each year of participation, POs had the flexibility to design their intervention(s) by establishing the beneficiary eligibility criteria and determining covered services for Palliative

Care, TCC, and Hospice Supplemental Benefits (described in the section "Hospice Benefit Component Interventions Implemented" later in this chapter). In addition, POs had flexibility in how they identified and reached out to beneficiaries who are eligible for Hospice Benefit component services and how they oversaw and coordinated care delivered by in-network hospices (described in the sections "Beneficiary Identification" and "Hospice Investments to Participate in VBID" in this chapter, respectively). POs also had the responsibility to oversee the delivery of Hospice Benefit component benefits to eligible beneficiaries, communicate with and oversee services provided by hospices, pay for those services, and report the data to CMS. POs must apply the same eligibility criteria for hospice care as the criteria that are used by the FFS Medicare Hospice Benefit and must cover all services included by the Medicare Hospice Benefit for beneficiaries electing hospice.

Figure 8.1. Parent Organization and In-Network Hospice Activities



NOTE: MAC = Medicare Administrative Contractor; NOE = notice of election.
[a] If contracted to do so.
[b] Also an OON hospice activity.
[c] OON hospices may provide supplemental benefits depending on the PO.

In addition to providing the full variety of services covered by the Medicare Hospice Benefit, all in-network hospices must coordinate TCC for beneficiaries who choose to receive it and may also be contracted to provide Palliative Care and Hospice Supplemental Benefits. To fulfill their VBID contractual obligations to POs, in-network hospices had to develop administrative processes to identify VBID beneficiaries; submit notices of elections (NOEs) and claims to both

POs and the CMS Medicare Administrative Contractor (MAC); and communicate with POs about beneficiary eligibility, claims, and payments (described in the section "Hospice Investments to Participate in VBID" in this chapter). Administrative systems, as well as the types and frequency of communication and data requested from hospices, varied across POs. We discuss experiences with administrative processes in Chapter 10.

Characteristics of Participating Parent Organizations and Plans

The number of participants in the Hospice Benefit component increased from nine POs and 52 plans in 2021 to 15 POs and 112 plans in 2023 (Table 8.1). Fifteen POs participated in the Hospice Benefit component in 2023, and 104 POs were eligible but did not participate in either VBID General or the Hospice Benefit component. Of the 15 participating POs, 40.0% were affiliated with Blue Cross compared with 16.4% of nonparticipating POs ($p = 0.018$). Forty percent of participating POs offered plans in one or two states, 26.7% offered plans in three to eight states, and 33.3% offered plans in nine or more states. By comparison, nonparticipating POs were much more likely to offer plans in one or two states (76.0%) and much less likely to be offer plans in nine or more states (1.9%). Participating POs also had much higher average total enrollment than nonparticipating POs (1,209,585 compared with 25,202).

Of the 112 plans entered by the 15 POs into the Hospice Benefit component in 2023, nearly all (96.4%) also offered Part D benefits. In addition, Hospice-participating plans were more likely to be DSNPs (22.3% DSNPs compared with 4.3% non-DSNPs) and were about equally likely to be C-SNPs and I-SNPs. Participating plans were similar to nonparticipating plans in terms of the percentage offering zero-premiums and average total monthly premiums. Hospice-participating plans also had a higher average enrollment of dual-eligible beneficiaries (30.1%) compared with non–dual-eligible beneficiaries (19.5%)—likely due to the higher participation of DSNPs—but similar enrollment of Part D LIS-eligible. Finally, Hospice Benefit component participating plans had a much higher average total enrollment (10,486) compared with nonparticipating plans (4,684).

Reasons for Parent Organization Participation and Nonparticipation

As in previous years, new Hospice Benefit component participants' main rationale for joining the model test was the desire to gain experience working with hospices in advance of a potential MA-wide hospice carve-in. As a representative of PO Y explained, "We wanted to prepare for it becoming part of the regular MA benefit."

Table 8.1. Hospice-Participating and Comparison Parent Organization and Plan Characteristics, 2021 to 2023

Characteristic	2021 Participants	2022 Participants	2023 Participants	Eligible Nonparticipants (2023)
Number of POs	9	13	15	104
PO geographic reach (%)				
1–2 states	66.7	46.2	40.0	76.0*
3–8 states	11.1	15.4	26.7	22.1
9 or more states	22.2	38.5	33.3	1.9*
PO MA penetration	54.3 (15.7)	53.1 (6.1)	54.7 (4.4)	50.2** (10.3)
PO enrollment	503,384 (984,759)	1,141,320 (1,835,407)	1,209,585 (2,108,613)	25,202* (38,682)
Number of plans	52	109	112	3,093
PPO (%)	17.3	26.6	26.8	36.9*
Offers Part D (%)	94.2	94.5	96.4	89.9**
DSNP (%)	28.9	18.4	22.3	4.3***
C-SNP (%)	3.9	2.8	3.6	5.6
I-SNP (%)	0.0	0.9	4.5	4.7
Dual-eligible enrollees (%)	32.9 (42.3)	25.5 (36.1)	30.1 (38.8)	19.5** (26.0)
LIS-eligible enrollees (%)	13.1 (22.6)	19.9 (27.1)	23.8 (31.3)	25.8 (26.8)
Offer $0 premium	69.2	66.1	60.7	62.9
Total premium	19.7 (37.3)	19.3 (37.3)	15.5 (30.5)	20.4 (39.2)
Maximum OOP limit	4,388 (1,599)	4,803 (1,552)	4,665 (1,774)	5,054 (1,928)
Enrollee age	72.2 (3.7)	71.4 (3.9)	71.8 (4.5)	71.5 (3.9)
Plan enrollment	11,582 (16,117)	9,405 (12,146)	10,486 (12,816)	4,684*** (10,461)

SOURCES: Multiple sources of PO and plan characteristics data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, assessed using the unequal variances *t*-test. The mean values are shown with standard deviation in parentheses unless noted otherwise. Nonparticipating plans are those plans that were eligible but did not participate in either VBID General or the Hospice Benefit component in any year from 2020 through 2023. Please see Appendix A for additional information on VBID eligibility. Statistical significance is shown for eligible nonparticipating plans in 2023 compared with participating plans in 2023. Statistical significance for the participating plans is shown compared with the year prior. For example, 2023 statistical significance for participating plans is compared with 2022 participating plans.

Representatives of two POs that entered I-SNPs into the model test (POs BA and BE) noted that the CMS Center for Medicare and Medicaid Innovation recruited them to participate in VBID because their approach to care delivery involves extensive care management of seriously ill beneficiaries. One PO BE representative said,

> Because we are the payer, the provider, because these nurse practitioners have developed really long, very close relationships with members and their families, this was a perfect fit to basically allow them to continue caring for members throughout their life. Because previously, as traditional hospice benefit is designed, when someone goes on hospice, those primary care providers go hands off. And so, VBID allowed us to design a benefit where those NPs were

> continuing to follow them and collaborating with the hospice care team to continue to take care of those members.

Moreover, several POs noted that joining or expanding their participation in the Hospice Benefit component was important to providing better care to their members and helping address rising health care costs at the end of life. PO R representatives noted a desire to better manage care for beneficiaries "because we were seeing that there was a huge increase in the use of Part D benefit [and] inpatient services in people that [sic] were basically a month away from their deaths."

However, for many POs that chose to participate in VBID General but not to offer the Hospice Benefit component, the need to build a hospice network was viewed as a barrier. A representative of PO AX said,

> Our desire to have favorable contracts for a hospice benefit would require renegotiating a lot of facility contracts. So, it would've been a huge lift to not only fill the gaps to make sure that we had facilities available but could also open up the gateway to renegotiating other terms that are already in place with certain providers as well.

Four 2023 Hospice Benefit component participants indicated that they were not planning to reapply to participate in the model test in 2024; two participants shared the reasons behind those plans. A PO Y representative said that the costs to administer the model were outweighing participation benefits. A PO L representative reported that the administrative burden was too large given the small number of beneficiaries who can benefit from this model component:

> It's administratively complicated for us to administer. It's very hands-on. Even though it's a very small number of members, it's always on the top of our list [of issues because we always get] . . . another hospice issue, we have another thing we found out that we have to fix. So just in the grand scheme of things, it's resource-intensive to support it.

Hospice Benefit Component Interventions Implemented

POs reported offering the same Palliative Care services, TCC, and Hospice Supplemental Benefits across all their model test service areas and plans. Although most POs offered similar benefits from year to year, a few made changes for 2023. For example, PO G began providing pulse oximeters to beneficiaries receiving palliative care in response to provider requests; PO W discontinued its pre-hospice consultation due to low uptake; and, based on the feedback from another PO participating in the model, PO X expanded its Hospice Supplemental Benefits by adding an allowance for beneficiaries electing hospice to apply to a variety of different needs.

Palliative Care

All Hospice-participating POs were required to offer palliative care services to seriously ill beneficiaries who are either not yet eligible for or who have not yet chosen to receive hospice

services (that is, *non-hospice* palliative care services). Most of the 15 participating POs reported that palliative care was provided to their VBID beneficiaries by palliative care specialists, including physicians, NPs, or nurses ($N = 11$); palliative care programs affiliated with in-network hospices ($N = 9$); or hospital-based palliative care programs ($N = 7$). About one-quarter of POs reported that PCPs were providing some or all of the palliative care delivered ($N = 4$). Eight of 11 POs continuing to participate in the Hospice Benefit component provided palliative care through programs affiliated with a hospice compared with just one of four POs that were new to the model. This may have been because the hospice networks of continuing POs were more established.

POs BA and P reported having a contract or partnership with palliative care provider groups. A PO BA representative said,

> We contract with a provider group . . . [and we have a] very close relationship with that provider group that's seeing our members on a monthly/weekly/daily sometimes basis. . . . The medical director of the plan and the medical director of the group are both palliative care-certified.

In prior years, PO P mostly used a national palliative care provider across its large service areas. In 2023, the PO expanded to include additional hospice-based providers in their market:

> Primarily, we had a single national standalone provider that we had a long-term partnership with, that as we entered the demonstration, we carried with us to offer Palliative Care. They still offer Palliative Care to a greater than majority of our plan members in the demonstration today, but we are also expanding our palliative offering, contracting with . . . hospices who offer palliative services.

Several POs provided palliative care in more than one setting. Palliative care was most often provided in-home ($N = 13$) or in a nursing or assisted living community ($N = 10$). About one-half of POs delivered palliative care via telemedicine ($N = 7$) and inpatient care ($N = 7$). Fewer offered this care in a physician's office ($N = 6$) or hospital outpatient setting ($N = 4$).

Representatives of POs that entered I-SNPs into the model test reported that all their VBID beneficiaries received palliative care, because they live in nursing homes. One PO BE representative said,

> Palliative care is provided to all patients because the primary care model that we provide is a palliative primary model. So, because these patients are 85 plus, they are in I-SNP. The way these NPs and primary care doctors provide primary care is palliative. . . . [Patients] have to meet criteria to be in an I-SNP plan.

PO W, which operates in an area with few palliative care specialists, reported that palliative care is typically delivered by hospice staff. PO L representatives said that their interdisciplinary palliative care teams may also include other specialists, such as behavioral health and clinical pharmacy.

Although all POs reported offering comprehensive care assessments, pain management, and symptom management as part of palliative care, some POs offered additional services, including

home visits (POs W, BA, and G), medication reconciliation (PO BA), caregiver support (PO BA), meals (PO G), and transportation (PO G).

Transitional Concurrent Care

As in prior years, all Hospice-participating POs in 2023 were required to offer TCC to beneficiaries who were eligible for hospice, elected to receive hospice care from an in-network hospice, and wished to receive both hospice services and curative care. However, POs had flexibility regarding the criteria they used to identify beneficiaries eligible for TCC, the services they covered, and the duration of TCC services.

In 2023, two-thirds of POs ($N = 10$) allowed any beneficiary electing hospice services to receive TCC. Three POs offered TCC only to beneficiaries with end-stage renal disease, cancer, or CHF; two POs offered it to those with COPD or a recent ischemic stroke; and one PO offered it to those with other specific diagnoses on a case-by-case basis using an individual care plan. POs continuing their participation in the Hospice Benefit component were less likely than new participants to allow any beneficiary electing hospice to receive TCC (six of 11 continuing POs versus all four new POs).

POs offered a variety of services under TCC. For example, PO L, which had an expansive set of TCC-qualifying conditions, covered physical therapy, radiation therapy, paracentesis, and catheter placement. PO G also included dialysis and transfusions. PO W representatives noted that, in addition to covering such disease-specific cancer services as chemotherapy and immunotherapy for cancer, they were flexible and willing to cover "some services that the member will need, depending on the condition."

PO AJ relied on its existing medical necessity policy to determine which services should be permitted under TCC. This allowed the PO to cover any curative or restorative treatments within the first 30 days of hospice election. As a PO AJ representative described it, "We did not put any parameters around that. . . . The only parameter is, it has to meet medical necessity criteria that we already have in place for the organization or under the plan."

Slightly more than one-half of POs ($N = 8$) reported offering TCC services for one month; five POs reported having no limit on the number of TCC days. PO B representatives noted that they relied on the hospice to determine the appropriate number of days. PO X extended the limit for TCC from 30 days to 60 days in 2023 to allow beneficiaries and their families more time to make the choice to elect hospice:

> When an individual and a family make the decision to go into hospice, it's a very emotional one, and it's one that they've put a lot of thought to. . . . It's like, "Either I continue down the road with aggressive treatment, or I decide that it's time to stop". . . . It will be interesting to see if the 60 days gives people more time to have that curative care and, so, that they're more apt to do it. I think 30 days makes it too quick if they haven't made the decision to move on to hospice.

PO W also expanded the number of allowable days of TCC for beneficiaries on an as-needed basis, up to 45 days:

> We have been more flexible in our TCC process in order to increase utilization. . . . We start with 15 days. Then we reevaluate if the member needs that treatment in order to maintain the member in hospice, we can approve for 15 days more, up to 45 days, to be flexible in the process of TCC in order to the member to choose hospice earlier.

Hospice Supplemental Benefits

As in prior years, POs participating in the Hospice Benefit component in 2023 could offer Hospice Supplemental Benefits to beneficiaries who elect hospice. POs could also limit these benefits to those who receive hospice care from an in-network hospice, are eligible for LIS, or have one or more chronic conditions.

The majority of POs (N = 11) offered Hospice Supplemental Benefits. Nine POs eliminated cost-sharing for hospice drugs and biologicals and inpatient respite care; two of these POs (B and AJ) restricted the benefit to beneficiaries receiving care from in-network hospices. Nine POs offered other types of Hospice Supplemental Benefits; with the exception of PO B, all participating POs restricted these benefits to beneficiaries receiving care from in-network hospices. The benefits offered included expanded access to in-home respite care or other support for caregivers (POs B, G, P, R, X, and AJ) and allowances that beneficiaries could apply to a variety of different needs (POs P, X, and BE).

PO X and BE representatives reported that beneficiaries were allowed to make requests, depending on their needs, up to a certain value each year. In-network hospices reported that allowances were used to purchase a variety of items, such as air conditioners, security cameras, and nutritional shakes (Hospice T) and lift chairs, bedding, and down payments needed for housing (Hospice AK).

PO X representatives explained why they waited until 2023 to add supplemental benefits:

> For the first two years, we wanted just to see how things were going and then we really threw a couple of ideas out as to what would be a good supplemental benefit. . . . We actually reached out to [another PO], and they were really good with just sharing their experience with their supplemental benefit, how they operationalized it, and we decided to do something similar with a hospice care allowance.

Beneficiary Identification

All but one PO used provider referrals to identify beneficiaries eligible for Palliative Care, TCC, and hospice services. Because PCPs play a crucial role in the identification process, a PO M representative described the need to educate PCPs on the available services and benefits of those services:

> I think part of the initial issue is just the education of what's available first, and once providers understand what's available and what their patients can benefit from, how that helps them out in taking care of their patients.

All POs also reported using at least one additional beneficiary identification method, such as regular check-ins with beneficiaries, case management reviews, and claims or EHR-based algorithms. Approaches were similar for both new and continuing POs.

POs typically used different approaches for identifying beneficiaries eligible for Palliative Care, TCC, and hospice. However, PO X representatives reported using the same algorithm to identify different groups of beneficiaries for all of these service types but varying the time horizon to predict expected mortality: "[TCC] has a tool, the same as the Palliative Care. [Palliative Care] uses 12 months and [TCC] is six months [time horizon]. So, they can identify someone that is six months because of the same kind of criteria."

Palliative Care

In addition to the provider referrals used by 14 of 15 POs, eight POs used claims-based algorithms, four used EHR-based algorithms, and three contracted with vendors to identify beneficiaries who would be eligible for Palliative Care. One PO W representative described their use of a claims-based algorithm and outreach from a case manager:

> We have some reports from our analytics department. And we reach out [to] the member [via] our case managers in order to offer the program. We don't refer the cases to our providers, only our case managers do the first intervention with the member. They explain the purpose of the program and what palliative care is, because our member[s] do not know what it is and what the difference between palliative care and hospice is.

At least three POs that continued with the Hospice Benefit component refined and updated these beneficiary identification algorithms over time. For example, representatives of PO L described their expansion of electronic medical record- (EMR-) and claims-based Palliative Care algorithms to capture beneficiaries who were more upstream in their disease progression:

> In 2022, the data identification that we used to identify the patients . . . eligible for palliative care was more refined to focus on higher-risk population that had more of a limited prognosis. In 2023, the criteria were expanded, so that they actually target a little bit broader of a population, so those that have more of a moderate risk level. And we also kind of expanded the algorithm to include more population that has chronic and serious illness.

Representatives of the three POs that entered I-SNPs into the model, however, noted that they did not need to assess whether beneficiaries were eligible for Palliative Care because, by virtue of their need to live in a nursing home over the long term, all of their members are eligible for Palliative Care.

TCC

In contrast with the approaches used to identify beneficiaries for Palliative Care, POs reported relying almost exclusively on provider referrals to identify beneficiaries for TCC. Representatives of PO AJ explained that beneficiaries are already connected to a PCP and palliative care provider who can identify whether the beneficiary would be well suited for TCC. A representative said,

> We are not specifically identifying members for transitional concurrent care. We feel like by having those conversations with PCPs and palliative care physicians that they would be the ones that would be identifying members that would qualify for those services.

Hospice Care

POs' approaches to identifying beneficiaries who could benefit from hospice care were similar to their palliative care approaches. All but one PO used provider referrals as their primary source of identification. Four POs contracted with vendors to identify hospice-eligible beneficiaries through data algorithms or outreach and three used EMR-based algorithms.

Although POs reported investing in their beneficiary identification processes, hospice representatives indicated in interviews that VBID had changed little regarding patterns of referral for palliative and hospice care patients. Collectively, representatives of six of ten hospices we interviewed reported getting referrals of VBID beneficiaries for palliative or hospice care directly from at least five different POs. However, these hospice representatives noted that traditional referral channels were still the most important. For example, clinical providers were still the main source of beneficiary referrals to hospice in the model, including providers working at hospitals (Hospices T, AH, and AM), SNFs (Hospices A and T), physician offices (Hospices T and AM), and home health agencies (Hospice T). Representatives of three hospices (Hospices AI, AL, and AN) said that they saw no changes in beneficiary referral patterns at all.

Hospice Supplemental Benefits

Hospice representatives reported that POs pursued several processes for identifying beneficiaries for Hospice Supplemental Benefits. For example, Hospice AJ representatives reported that PO G identified beneficiaries for Hospice Supplemental Benefits itself and communicated this information to its in-network hospices, whereas PO B deferred to the hospice to identify beneficiaries for Hospice Supplemental Benefits. Hospice AK representatives reported that PO P reviewed hospice-submitted clinical documentation to identify beneficiaries who might benefit from additional services.

Hospice Investments to Participate in VBID

The hospice representatives we interviewed described extensive investments in the processes required to operate as in-network providers, including communication and care coordination with POs, billing for services provided and resubmitting denied claims, and reporting requested data to POs.

Communication and Care Coordination with POs

As part of providing care to VBID beneficiaries as in-network hospices, hospices had to establish new communication channels and processes with POs to facilitate beneficiary identification (Hospices AK and AM) and improve processes of clinical care (Hospices T, AI and AO). The frequency and format of these communications varied across hospices and the POs with which they contracted. Although Hospice AI representatives reported that they communicated with PO BE after every visit, others reported biweekly (Hospice AN), quarterly (Hospice AI), or biannual (Hospice AM) check-ins. Hospice AK representatives said that their PO required just some "extra phone calls" with the PO case manager. Communication related to clinical care for VBID patients included grand rounds-style meetings with PO managers, physicians, and NPs (Hospice T) and a real-time group text application (Hospices AI and AO). One hospice was required to use text messages in addition to paperwork (Hospice AI).

In contrast, one hospice (AH) indicated that there was no communication with the PO: "We're not asked for any documents. There's no care coordination required. They don't call us up. We don't call them up. [Our teams report that] there's no involvement."

Billing and Claims Adjudication

In-network hospices had to adjust their billing approaches and spend a substantial amount of time resubmitting denied claims, many of which, from their perspective, should not have been denied to begin with. Hospice representatives reported that billing and claims adjudication processes differed for VBID and non-VBID patients and varied by PO. Such differences, along with CMS' requirement to submit claims to both the PO and MAC, resulted in more labor-intensive processes (Hospice AK). For example, although all in-network hospices were required to submit separate NOEs to POs and the MAC, the NOE forms also differed by PO, creating an additional administrative hurdle for hospices that contracted with more than one PO.

Hospice AH representatives indicated that their PO did not give sufficient training on clinical or billing processes:

> Certainly, we did not get a lot of training about this. . . . Our billing staff, the only way that they knew to submit some of this was that [our] manager in the finance area, she actually Googled what she needed to do and what she needed to submit in order to process a claim.

Hospices also reported that some of their claims were rejected by POs. Hospice AM representatives noted that medications were the most common cause for rejection of submitted claims.

Reporting to POs

Overall, hospice representatives indicated that the data POs asked hospices to report was more extensive than what Medicare required outside the model. POs requested that hospices share medical records (Hospices AL and AN), care plans (Hospice AN), clinical notes (Hospices AO and AK), annual health assessments (Hospice AM), information about hospice provider visits to patients and their hospital admissions (Hospices AO and AI), certification of terminal illness (Hospice AL), and lists of eligible patients who could benefit from Hospice Supplemental Benefits (Hospice AK). Hospice AL representatives noted that their PO required that medical records be submitted to a third-party auditor, not the PO.

Hospice representatives also said that POs varied in their data submission requirements, methods, and frequency of data collection and that these differences complicated reporting processes and required additional investments. POs requested that clinical information be shared by email (Hospices AI and AN), by fax (Hospice AN), and through an online portal (Hospice AK) in varying formats (for example, pdfs or spreadsheets). Deadlines and time frames for submission also varied across POs (Hospice AI). One Hospice AJ representative said that information was reported during regular bimonthly meetings with the PO staff. Another noted that, in addition to the information provided every ten to 14 days, the hospice must undergo an auditing process every three months (Hospice AN). Some clinical notes needed to be shared within five days of admission (Hospice AM), weekly (Hospice AO), or every two weeks (Hospice AK). The challenges hospices faced from these reporting processes are discussed in Chapter 10.

Summary

In 2023, 112 plans from 15 POs participated in the Hospice Benefit component, an increase from 109 plans from 13 POs in 2022 and 52 plans from nine POs in 2021. Four POs indicated that they would not be reapplying to participate in the model in 2024, citing high administrative burdens.

As in prior years, participating POs in 2023 had a much higher average enrollment and were more likely to offer plans in nine or more states than nonparticipating POs. Participating plans were more likely to be DSNPs and were about equally likely to be C-SNPs and I-SNPs as nonparticipants.

POs had flexibility in how they identified and reached out to beneficiaries eligible for Hospice Benefit component services. All but one PO relied on provider referrals to identify

beneficiaries for palliative care. Nine POs also used EHR- or claims-based algorithms, with some POs refining algorithms over time to identify more beneficiaries.

Participating POs had the flexibility to design their intervention(s) by establishing the beneficiary eligibility criteria and determining covered services for palliative care, TCC, and Hospice Supplemental Benefits. As in prior years, some POs covered all treatments as part of TCC, and others limited TCC benefits to certain service types or determined TCC plans on a case-by-case basis. Eight POs capped their TCC benefit at one month, but others did not limit the number of TCC days. Two POs extended the maximum number of days in TCC for 2023 from 30 days to 45 days and 60 days to allow beneficiaries and their families more time to make the choice to elect hospice.

Nine of 15 participating POs offered a hospice supplemental benefit that eliminated cost-sharing for hospice drugs and biologicals and inpatient respite care; two of these POs restricted the benefit to beneficiaries receiving care from in-network hospices. Nine POs offered other types of Hospice Supplemental Benefits, such as expanded access to in-home respite care and allowances that beneficiaries could apply to a variety of different needs; seven of these POs restricted these benefits to beneficiaries receiving care from in-network hospices.

To operate as in-network providers, hospices made extensive investments in processes to communicate and coordinate care with POs, bill for services provided and resubmit denied claims, and report requested data to POs. The level of investment needed varied across POs.

Chapter 9. Hospice Networks

Key Findings

- To meet network adequacy requirements that were phased in for continuing POs in 2023, three POs noted that they needed to contract with many more hospices than in prior years.
- Hospices continued to cite long-term business viability and a desire to be at the forefront of MA hospice policy changes as their main reasons for joining PO networks.
- Although some POs reported paying the full FFS rate for in-network hospice services, five POs (including three that account for more than two-thirds of VBID beneficiaries starting hospice in 2023) reported paying 5% to 15% less than the FFS rate for these services. Several hospices cited lower-than-FFS rates as their major concern about the model.
- The proportion of VBID beneficiaries receiving hospice care from in-network hospices continued to increase (55.1% in 2023 compared with 37.3% in 2021 and 47.8% in 2022), likely due to network adequacy-related hospice network expansions and increased PO efforts to guide beneficiaries to in-network hospices.
- Across all POs, 1,570 hospices provided care to at least one VBID beneficiary in 2023, up from 596 in 2021 and 1,168 in 2022.
- The proportion of hospices that provided care to VBID beneficiaries that were in-network rose to 23%, up from 17% in 2021 and 22% in 2022. As in prior years, in-network hospices were larger and more likely to be chains than OON hospices.

Since the start of the Hospice Benefit component in 2021, participating POs have been responsible for setting up in-network arrangements with hospice providers. Such networks allow POs to negotiate rates with in-network hospices; POs are required to pay OON hospices full Medicare FFS rates. Beneficiaries can choose any hospice provider, regardless of network status. However, only beneficiaries who use in-network hospices may access TCC benefits, and POs can limit Hospice Supplemental Benefits to beneficiaries who use in-network hospices.

Starting in 2023, CMS adopted a phase-in approach for POs to develop and meet network adequacy standards for hospice providers. Plans that have participated in the model for more than one year are required to have a minimum number of providers (MNP) in each county in their service area (as specified by CMS) and to develop a comprehensive strategy for providing adequate access to hospice care in their service areas. CMS uses a multistep formula to calculate the MNP for every county in each participating PO's service area (CMS, 2022a). The formula is designed to account for historical hospice utilization patterns, MA market penetration rates, and the number of enrollees a typical PO serves.

Both new and continuing plans within participating POs are encouraged to implement a voluntary hospice consultation program to help beneficiaries understand the difference between choosing an in-network and OON hospice before they access hospice care.

In this chapter, we discuss the **approaches POs used to establish their hospice networks**, explain the **main reasons why hospices joined POs' VBID networks**, illustrate **contractual arrangements between POs and hospices**, describe the **use and characteristics of in-network and OON hospices**, and summarize **hospice perspectives on future participation in VBID**. To

conduct the analysis, we used CMS administrative data, POs' lists of network hospices, and data from PO and in-network hospice interviews and questionnaires completed prior to PO interviews. The surveys and interviews were conducted prior to CMS' announcement that the Hospice Benefit component would conclude at the end of 2024. Appendix E provides details on the PO and hospice interviews and pre-interview questionnaires.

Parent Organization Approaches to Establishing Adequate Hospice Networks

As in prior years, eight of 14 PO representatives that we interviewed described selecting hospices for their networks based on quality metrics (for example, claims-based indicators, such as the Hospice Care Index), and five PO representatives noted that they prioritized hospices that already care for a large share of their beneficiaries. As a representative of PO B described, the PO knew that they "would want to have frequent touchpoints in engagement" with in-network hospices, which would be more feasible and efficient if each in-network hospice cared for a larger number of the POs' beneficiaries.

As network adequacy requirements were phased in for continuing POs in 2023, representatives of some POs, including POs M, V, X, and AJ, reported that they did not change their approach for establishing hospice networks. In contrast, representatives of three POs (L, R, and W) described notable changes in the number or type of hospices with which they contracted. Representatives of POs R and W, which serve the same geographic area, noted that the MNP that CMS published for the counties in their service area seemed higher than needed and that they therefore were compelled to contract with more hospices than their beneficiaries needed to meet the MNP threshold. A representative of PO W reported that the PO more than doubled its hospice network between 2022 and 2023 in response to CMS network adequacy guidance but noted that the PO "really didn't need so many hospices." A representative of PO R echoed this sentiment, noting that

> [i]n one of those counties, [we have] 20 members, and [CMS] required us to have 14 hospices there . . . 14 hospices! And it's fairly close to other municipalities. . . . [Our service area] is fairly small, and we don't need that much [sic] providers. And we're not able to provide them with volume, because we are not deciding who will be entering hospice. So, the volume versus the amount [sic] of providers required by the adequacy rules were not . . . aligned.

Representatives of PO L agreed that expanding the hospice network resulted in beneficiaries being spread across more hospices and said it was difficult to maintain strong relationships with hospices "when we have a lot more relationships and with agencies that really aren't seeing a lot of members." Representatives of this PO also reported contracting with hospices that did not meet the PO's quality standards, just to meet network adequacy requirements: "I don't think we added a lot, but we did end up approaching some that didn't meet our criteria to get the count up."

PO representatives also identified specific challenges to establishing contracts with hospices. Representatives of POs L and W noted that some hospices declined to join the networks of POs that pay lower-than-FFS rates for hospice services, because they know that POs must pay the full FFS rate to OON hospices. PO W representatives specified additional reasons that hospices may be disincentivized to join PO networks:

> Right now, probably, the non-contracted [hospices] are in a better position. First, if I don't have a contract, you cannot audit me. Oh, you have to pay me the Medicare rate. . . . So, what has happened is that the ones that are contracted said: "Listen, you're paying me at a discount. I have to put additional resources, so I'm available for your case managers. You come and audit me, my processes, and you're paying me less than the non-contracted [hospice]. Why should I contract with you?"

Finally, representatives of PO P noted that there were few hospices to contract with in some geographic areas, particularly in states with Certificate of Need (CON) policies that limit the number of hospices that can operate. One PO P representative said,

> In states where there is the CON, we're kind of at the mercy of those providers if they are wanting to contract with us or not. . . . We always reach out to them year over year and ask that they do participate in the demonstration, but it kind of varies from provider to provider as to if they're interested.

Reasons for Becoming an In-Network Hospice Provider

During the 2023 interviews, in-network hospice representatives cited two main reasons why they joined PO networks. First, some hospices, such as Hospices A, AI, AL, and AN, saw these contractual arrangements as an opportunity to ensure their long-term business viability. As a representative of Hospice AL noted,

> We want to be able to care for as many patients as possible, and most patients have Medicare Advantage plans. . . . So, if we're not staying ahead of it and trying to get these contracts and trying to play the game of VBID, we would be behind the times once it actually is a full program.

Representatives of hospices serving markets with high MA penetration were particularly attuned to this concern, noting that they were willing to sustain pay cuts to ensure that they would be included in PO networks. A representative of Hospice AN described the situation starkly: "If we don't join the model, we die. Period. . . . If we didn't join, we would have to fire people. So, we'd rather take a pay cut than not be in in it."

Second, others noted that their hospices wanted to be "in on the ground floor" of a potential CMS hospice carve-in to MA (Hospices A, AH, AK, AJ, and AO). A representative of Hospice AK said,

> We have long felt that VBID and the hospice carve-in into the Medicare Advantage world is something that will happen, and we wanted to be involved from the get-go to learn what it was like to build a relationship, to learn how to

> negotiate what partnerships look like, and to be able to potentially help influence it with the MA plan and with CMMI . . . what the value of hospice and palliative care brings to this experience. . . . We want to be a part of the pilot so that we can figure this out knowing this may be the future and we want to do it well. We just know right out of the gate it's going to take some change management.

Besides these two main reasons for joining VBID as in-network providers, representatives of Hospices AJ and AK also noted that joining PO networks enabled them to build on their existing strong relationships with POs. Moreover, representatives of Hospices A and AK indicated that their decision to join a PO's VBID network was driven by the desire to provide palliative care earlier in beneficiaries' care trajectories, either in an institutional setting or through the identification of enrollees with advanced chronic illness living in the community.

Although the hospices we interviewed in previous years shared the reasons described above, they also named TCC as a compelling reason for joining a PO network. However, our 2023 interviewees did not cite TCC as a reason for doing so.

Contractual Arrangements Between Parent Organizations and Hospices

Hospice representatives described a variety of approaches that POs pursue in developing contracts, with some offering contracts similar to those used for non-VBID hospice services and others working collaboratively with the hospice to define contract terms specific to VBID. One Hospice AO representative reported that they "warmly welcomed" an opportunity to be highly involved in specifying the contract:

> Some payers are very engaged with us as operators in defining the specifics of what goes in a contract from pay rates to delivery expectations, communication expectations, and quality metrics. Others have been more of a perfunctory "sign the contract, [and] you're in" and that's it. So it's been a very varied experience. [PO BE] took a very different approach. . . . They actually engaged us as well as some other hospice programs before contracting with anyone to really engage hospice providers in conversation around helping them define or helping us collectively define what quality looks like. What quality measures we would recommend that they consider building into the contract. And the conversations were focused on that but went into an array of other areas as well and were differently collaborative ahead of signing a contract with them.

As in 2022, representatives of most hospices that have been in-network for more than one year (Hospices A, T, AH, AL, and AM) indicated that there were no changes to the terms of their VBID contracts with POs from year to year and that no changes were planned for 2024. An exception was Hospice AK; this hospice's PO added Palliative Care to its contract with Hospice AK in 2023. However, regardless of how long they had been in-network, some hospices noted that they hoped to see updates to their contracts in future years. Representatives of Hospice AJ noted that they would like to see a clearer definition of services covered by TCC in their 2024 contract.

Representatives of Hospices AL and AN, not currently contracted with a PO to provide palliative care, expressed a desire to start offering palliative care as part of the model test. Hospice AN observed that palliative care has become a pipeline for hospice referrals among the hospices that offer it. Hospice AL representatives also noted that providing both hospice and palliative care would allow their organization to provide a greater continuity of care.

Representatives of two other hospices (A and AH) noted that the lack of a clear, standardized definition of Palliative Care for the Hospice Benefit component made it challenging to contract for the service. One Hospice A representative said, "Most of the difficulties in the contracting was [sic] trying to define palliative roll-in period before hospice. . . . Defining what it is, what service is, what was the plan scheduled for that. There were really a lot of issues." Moreover, a representative of Hospice AH highlighted differences in how POs were implementing Palliative Care: "Even during the negotiations . . . plans wanted [Palliative Care] to be different things. Someone wanted telephonic. Some wanted to use whatever existing vendor that they had."

Payment Arrangements for In-Network Services

Of the 13 POs interviewed in 2023, six reported paying at least the full FFS rate for in-network hospice services, and five reported paying between 5% and 15% less than the full FFS rate. One PO reported paying 5% less than the FFS rate but making up the difference via an annual quality bonus payment of 5% to 8% if hospices met benchmarks on quality measures, such as timely admission to hospice, professional visits in the last days of life, and hospital readmission rates. Notably, in 2023, more than two-thirds of Hospice Benefit component beneficiaries who started hospice care were from three POs, which paid their in-network hospices less than the full FFS rate.

As in prior years, payment terms sometimes differed across hospices within a given PO's network. For example, PO X representatives reported paying full FFS rates to most of their in-network hospices, but slightly more than FFS rates to a select few. One PO X representative said, "There are some health systems who require a little bit more. So instead of 100%, maybe they're asking for 103%. And because we value the relationship that we have with them for all the other services that they offer, we're willing to pay the extra money."

Representatives of PO BA, a new VBID participant in 2023, explained that they set their in-network rate lower than the FFS rate. This was because the PO "didn't have a lot of insight on what the spend would look like from a risk perspective for the plan, and so [the lower rate was] something to try to offset and buffer the potential supplemental use," due to the added cost of Hospice Supplemental Benefits and the PO's financial risk associated with live discharges and subsequent hospitalization. PO L representatives noted that they tried to set the rate so that they would "be net neutral" on what they were paying hospices: "If we're paying 100% of Medicare and we have to do TCC, that's not going to work. We're going to need to make them both fit within the rate that we're getting paid [by CMS for each beneficiary enrolled in hospice]." PO B

took a different approach to this challenge by requiring its in-network hospices to cover the cost of TCC.

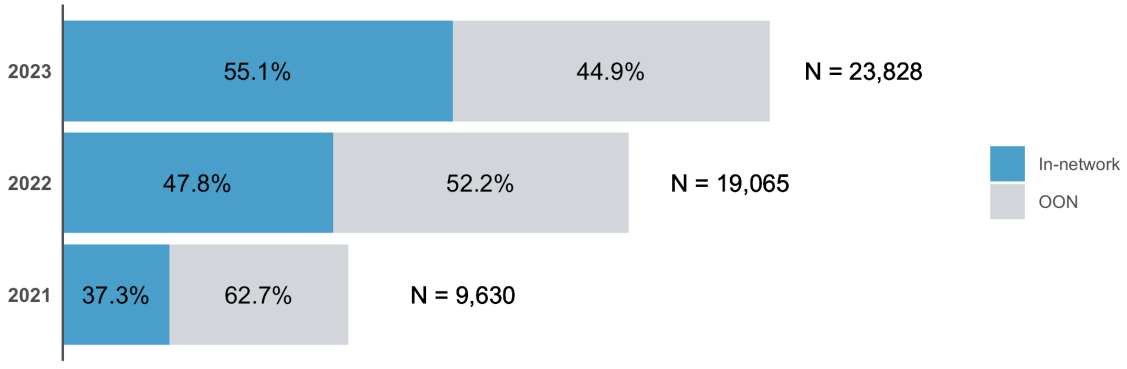
Several hospices noted struggles with accepting less than the Medicare FFS rate. Hospice AL representatives said that, although they hesitated to accept a rate that was much lower than FFS, they did so because the PO assured the hospice that "they are really pushing their patients to only use in-network providers. . . . So, we were like, okay, we'll take less money to hopefully have more patients versus not have patients at all." Others described the dilemmas they faced with a lower-than-FFS payment rate. Hospice AN representatives reported that they were "not at all" satisfied with their contract's payment rate for hospice services (10% lower than FFS rates) but noted that they could not do anything about it: "So we suck it up." A representative of Hospice AM explained that lower rates were particularly difficult to absorb in 2023 because they had "to increase the salary of the nurses, and we receive the same amount [from the PO]. They don't change the contract every year."

Hospice AO representatives reported that they declined to sign contracts with POs that offered 20% less than the FFS rate, explaining that the hospice is only willing to accept payment rates below FFS rates if they have the opportunity to recoup the difference via bonus payments. Hospice AM representatives said that they received a quarterly shared savings payment from the PO. The payment, which ranged from $30,000 to $80,000 in the first two quarters, was calculated as 30% of the amount that the PO saves from beneficiaries being able to live at home rather than in the hospital during their hospice care.

Use and Characteristics of In-Network and Out-of-Network Hospices

Of all VBID beneficiaries starting hospice care in 2023, 55.1% received care from in-network hospices compared with 47.8% in 2022 and 37.3% in 2021 (Figure 9.1).

Figure 9.1. Proportion of VBID Beneficiaries Receiving Hospice Care from In-Network Hospices, 2021–2023



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

The proportion of beneficiaries receiving care from in-network hospices varied across POs, from 24.1% in PO BA, which was new to the Hospice Benefit component in 2023, to 97.4% in PO M, which included all hospices in its service area in its network (Table 9.1).

Table 9.1. Proportion of Beneficiaries Starting Hospice Care in In-Network and Out-of-Network Hospices in 2023, by Parent Organization

PO	All Beneficiaries Starting Hospice Care (*N*)	Beneficiaries in In-Network Hospices (%)	Beneficiaries in Out-of-Network Hospices (%)
PO B	505	57.8	42.2
PO G	576	42.0	58.0
PO L	7,708	53.0	47.0
PO M	698	97.4	2.6
PO P	6,005	43.3	56.7
PO R	960	64.5	35.5
PO V	441	39.9	60.1
PO W	3,461	58.0	42.0
PO X	132	82.6	17.4
PO Y	703	91.2	8.8
PO AI	36	44.4	55.6
PO AJ	1,817	72.9	27.1
PO BA	116	24.1	75.9
PO BE	559	46.2	53.8
PO BI	111	52.3	47.7
All POs	23,828	55.1	44.9

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

POs reported using a variety of approaches to inform beneficiaries about the advantages of using in-network hospices, including distributing written guides or flyers to beneficiaries, hospital or nursing home case managers, and the PO customer service team (POs B and BA). Some also conducted voluntary pre-hospice consultations or discussions with case managers or NPs (POs V, X, and BE). In contrast, representatives of POs Y and BI reported that they do not make efforts to help beneficiaries identify in-network hospices.

In 2023, 1,570 hospices across all POs provided care to at least one VBID beneficiary compared with 596 hospices in 2021 and 1,168 in 2022 (Table 9.2). More than one-fifth (22.9%) of these hospices were in-network for one or more POs in 2023, up from 17.3% in 2021 and roughly the same percentage as in 2022 (22.3%). Although a large proportion of hospices are OON, as in prior years, OON hospices delivered care to a much smaller median number of beneficiaries from model-participating plans than in-network hospices in 2023. The median number of beneficiaries served by OON hospices was 2.0, whereas the median number of

beneficiaries served by in-network hospices was 15.0, ranging from 5.0 beneficiaries per hospice for POs G and BA to 125.0 beneficiaries per hospice for PO W.

Table 9.2. Number of In-Network and Out-of-Network Hospices Delivering Care to at Least One VBID Beneficiary, by Parent Organization, 2023

PO	All Hospices (*N*)	In-Network Hospices (%)	Out-of-Network Hospices (%)
PO B	58	25.9	74.1
PO G	123	21.1	78.9
PO L	471	20.2	79.8
PO M	28	35.7	64.3
PO P	497	15.3	84.7
PO R	51	25.5	74.5
PO V	115	3.5	96.5
PO W	77	13.0	87.0
PO X	8	50.0	50.0
PO Y	35	51.4	48.6
PO AI	6	33.3	66.7
PO AJ	131	50.4	49.6
PO BA	29	20.7	79.3
PO BE	126	7.1	92.9
PO BI	54	40.7	59.3
All POs	1,570[a]	22.9[b]	77.1

SOURCE: Authors' analysis of data submitted by POs as part of the VBID Model.
[a] The total reflects the distinct number of hospices, deduplicating hospices that provide care to beneficiaries from more than one PO.
[b] The percentage reflects hospices that provided care on an in-network basis to beneficiaries from one or more POs; this includes 68 hospices that were in-network for at least one PO and also provided OON care for at least one other PO.

As in previous years, in-network hospices tended to be larger than OON hospices in 2023 (Table 9.3): 43.9% of in-network hospices served 500 or more beneficiaries, and 27.2% of OON hospices served at least 500 beneficiaries ($p < 0.01$). Likewise in 2023, and similar to 2021 and 2022, a substantially higher proportion of in-network hospices were part of a chain compared with OON hospices in 2023 (53.1% versus 35.8%, respectively; $p < 0.01$). In-network hospices were more likely than OON hospices to operate in rural areas (11.1% in-network versus 7.1% OON, $p < 0.01$), to have slightly higher proportions of patients with a length of stay (LOS) of 180 days or more (12.9% in-network versus 11.5% OON, $p < 0.01$), to have slightly lower rates of live discharge (17.6% in in-network versus 19.6% OON, $p = 0.02$), and to have higher proportions of patients receiving professional visits in at least two of the last three days of life (68.3% in-network versus 62.4% OON, $p < 0.01$). A similar proportion of in-network and OON hospices were for-profit (71.7% versus 69.6%, respectively). In-network and OON hospices had

similar proportions of patients with short lengths of stay and had the same average summary CAHPS Hospice Survey score.

Table 9.3. Characteristics of In- and Out-of-Network Hospices Providing Care to at Least One VBID-Participating Beneficiary, 2023

Characteristic	In-Network Hospices (*N* = 360)	Out-of-Network Hospices (*N* = 1,278)	Significance
Size (number of Medicare beneficiaries per year) (%)			<0.01
<50	1.7	12.3	
50–100	6.1	11.5	
101–249	23.9	25.0	
250–499	24.4	18.7	
500+	43.9	27.2	
Ownership (%)			0.69
For-profit	71.7	69.6	
Nonprofit	19.4	18.9	
Other	8.9	8.5	
Part of a hospice chain (%)	53.1	35.8	<0.01
Provides care in rural area (%)	11.1	7.1	<0.01
Provides care to beneficiaries from more than 1 PO (%)	23.1	16.2	<0.01
<1% of hospice decedents in freestanding hospice inpatient unit (%)	75.0	72.5	0.57
Mean length of final episodes of hospice care (%)			
Less than 3 days	9.3	9.7	0.09
Less than 7 days	27.3	27.6	0.15
More than 180 days	12.9	11.5	<0.01
Rate of live discharge (mean)	17.6	19.6	0.02
Percentage of decedents who received professional visits in at least two of the last three days of life (mean)	68.3	62.4	<0.01
Summary CAHPS Hospice Survey score (mean)	80.8	80.8	0.06

SOURCE: Authors' analysis of data submitted by POs as part of the VBID Model.
NOTE: The rows for some characteristics do not add up to 100% because of missing data for a small number of hospices. In-network hospices and OON hospices include hospices that cared for at least one beneficiary enrolled in a model-participating plan. Hospices can count toward both columns due to varied network engagement with different POs. Columns reflect the distinct number of in-network and OON hospices. Appendix J describes the approach to statistical significance testing.

Hospice Perspectives on Future VBID Participation

Representatives of eight of ten interviewed in-network hospices indicated that they would be interested in joining the networks of additional POs, with some conditions. A representative of Hospice AH said,

> We like the opportunity to . . . grow our program, and, so, if there was an opportunity to work with—I don't think I'd want to have 20 contracts, but

> another two, three that were in this area that were likeminded organizations that we could partner with, I would say yes. . . . We want to be an innovative organization. We want to try to test new waters. But there'd have to be the reimbursement that goes along with it, because the other problem that we seem to get stuck on is that nothing ever covers our cost.

Representatives of the remaining two hospices noted that, because it is "a lot of work to go through contracting and all of the administrative setup, etc., to bring on additional contracts" (Hospice T) and because the anticipated beneficiary volume and reimbursement are low, they were not interested in negotiating in-network contracts with new POs.

Summary

Starting in 2023, CMS adopted a phase-in approach for POs to develop and meet hospice network adequacy standards. Plans that had participated in the model for more than one year were required to have a minimum number of hospices in each county in their service areas and to develop a comprehensive strategy for providing adequate access to hospice care. Some POs reported that these new network adequacy requirements compelled them to contract with more hospices than needed to serve beneficiaries in 2023, sometimes even including hospices that did not meet POs' minimum quality standards.

Consistent with prior years, hospices' primary reasons for joining PO networks were financial viability and the desire to be involved early in a potential change to MA hospice policy. Most in-network hospices expressed interest in joining additional PO networks, if the reimbursement covered their costs.

Contractual arrangements varied, with some POs paying the full FFS rate for hospice services, others paying lower-than-FFS rates, and still others pairing lower-than-FFS rates with potential bonuses for hospices' high-quality performance. The three POs that account for more than two-thirds of hospice beneficiaries paid lower-than-FFS rates. Several hospices cited lower-than-FFS rates as a major concern, noting that they agreed to join PO networks despite lower-than-desired reimbursement to ensure that they could continue to care for MA beneficiaries, who are critical to their business model, particularly in areas with high MA penetration. One hospice indicated that it was willing to accept payment rates below FFS rates if there was an opportunity to recoup the difference via bonus payments.

Compared with prior years of the model, there were increases in both the number of hospices providing care to VBID beneficiaries and the proportion of VBID beneficiaries receiving care from in-network hospices in 2023. These increases are likely attributable to some POs' expansion of their hospice networks in response to network adequacy requirements and efforts to guide beneficiaries toward in-network hospices. As in prior years, in-network hospices tended to be larger and were more likely to be chains than OON hospices.

Chapter 10. Implementation Experiences of Parent Organizations and Hospices

Key Findings

- Two-thirds of the POs and one-half of the hospices we interviewed that continued their participation in the Hospice Benefit component from prior years reported that model implementation was a small lift that required few new investments because they relied on processes established in earlier years. The remaining POs and hospices reported investing considerable effort and resources into Hospice Benefit component implementation.
- POs' and hospices' top implementation challenges continued to be related to administrative processes, such as the timely submission of NOEs and claims submissions and adjudication.
- Hospices cited delayed payments, varying data-reporting and communication requirements across POs, and a lack of a definition of Palliative Care and TCC as additional challenges. Hospice representatives noted that it was particularly difficult to make investments to implement the Hospice Benefit component in the context of the lower-than-FFS rates they received from POs to provide care to VBID patients.
- Most continuing POs and in-network hospices indicated that Hospice Benefit component implementation was manageable in 2023 because beneficiary volume was low, but they noted that any substantial increase in the number of Hospice Benefit-eligible beneficiaries would greatly increase the burden of implementation and require more resource investments.

In this chapter, we describe Hospice Benefit component **implementation experiences** using data from PO and in-network hospice interviews and questionnaires completed before the interviews. Appendix E provides details on the PO and hospice interviews and pre-interview questionnaires.

Overall Implementation Experiences

Parent Organizations

POs that participated in the Hospice Benefit component had different perspectives on the ease of implementing the model. Six POs reported that implementation of the Hospice Benefit component was a "large lift," two POs reported a "moderate lift," and six POs reported a "small lift." Among the six POs that reported implementation was a "large" lift, three were continuing their model test participation and three were new to the Hospice Benefit component in 2023. As mentioned in Chapter 9, representatives of PO L reported that their organization made the decision not to continue its participation in the Hospice Benefit component in 2024 due to the challenges they encountered.

Only representatives of POs that previously participated in VBID noted that implementation of the Hospice Benefit component in 2023 was a "small" lift ($N = 6$) or "a breeze," according to a representative of PO X. As reported in previous evaluation reports, such POs relied on previously established processes.

Hospices

Representatives of the ten interviewed in-network hospices were also split on how burdensome it was for them to implement the model in 2023. Five hospices reported that implementation was a "small lift," three hospices reported a "moderate lift," and two hospices reported a "large lift." Those that reported small lifts noted that implementation was "business as usual" for them (Hospice AH). In general, hospices that joined POs' networks before 2023 and those with a relatively small number of VBID patients reported that implementation was a "small lift." Some hospice representatives we interviewed, including Hospices T, AH, and AJ, said that if they had had more VBID patients, the burden of implementation would have been much larger: "Based on volume, it hasn't been a big lift. But if the volume were different, it would be a bigger lift for sure," said one Hospice AJ representative.

Those reporting that implementation was a "moderate lift" had challenges with billing and additional communication responsibilities, but they were able to resolve those challenges through good collaboration with their POs. Large implementation lifts generally stemmed from burdensome communication with and oversight from POs, which required additional investments to resolve. In addition, Hospice AL representatives noted that it was challenging for them to identify VBID-eligible patients, train staff to ensure correct billing and other administrative processes, and absorb the extra costs required to update their internal processes for VBID.

Implementation Challenges

POs

As in previous evaluation years, we sent PO representatives a pre-interview survey and asked them to rate aspects of their implementation experiences. We describe below the results provided by representatives of the 15 POs that participated in the Hospice Benefit component in 2023. Table 10.1 provides an overview of survey responses about Hospice Benefit component implementation challenges. The results are organized around four categories of challenges: administrative processes, communication and training, care delivery, and creating and maintaining a hospice network. In general, both continuing and new POs had similar perspectives on implementation challenges. We did not detect any major differences in the ratings of challenges from either new or continuing POs, which may be in part due to the small sample size ($N = 4$ new POs, $N = 11$ continuing POs).

Administrative Challenges

Administrative processes continued to be the most challenging aspect of implementation in 2023, as they were in 2022. On the questionnaire, PO representatives gave administrative processes a median rating of "moderate" on a five-point scale (which ranged from 1 = "not at all" to 5 = "a great deal"). Reporting data to CMS as part of the model test requirements

Table 10.1. Hospice Benefit Implementation Challenges Reported by Parent Organizations (*N* = 15)

Implementation Challenge	Not at All	Slightly	Moderately	Considerably	A Great Deal	Not Applicable	Median
Administrative processes							
Tracking care plans for beneficiaries in hospice	2	2	2	3	1	4	Moderately/ Considerably
Receiving NOEs in a timely manner	0	4	5	3	3	0	Moderately
Processing hospice claims	0	5	4	3	3	0	Moderately
Distinguishing care related and unrelated to terminal condition during claim adjudication	2	4	3	1	2	2	Moderately
Reporting data as part of model participation activities	0	4	6	4	1	0	Moderately
Working with vendors or subcontractors that help implement your VBID intervention(s)	3	5	1	0	1	4	Slightly
Identifying beneficiaries eligible for palliative care, TCC, or hospice	1	8	4	1	0	1	Slightly
Communication and training							
Communicating with hospices about beneficiary eligibility and claims processing	0	6	2	5	2	0	Moderately
Training providers about availability of palliative care, TCC, or hospice	1	6	5	1	2	0	Slightly/ moderately
Communicating with beneficiaries about the benefits of receiving care from in-network hospices	5	4	2	2	1	1	Slightly
Communicating with beneficiaries about their potential eligibility for palliative care, transitional concurrent care, or hospice	5	6	2	1	1	0	Slightly
Care delivery							
Managing transitions between palliative, transitional concurrent, and hospice care	3	6	1	2	1	2	Slightly
Coordinating TCC between hospices and other care providers	2	3	3	0	1	6	Slightly
Provision of hospice supplemental benefits to eligible beneficiaries	6	1	2	2	0	4	Not at all

Implementation Challenge	Not at All	Slightly	Moderately	Considerably	A Great Deal	Not Applicable	Median
Creating and maintaining a hospice network							
Negotiating hospice payments	3	3	4	1	1	2	Moderately
Promoting hospice network adequacy	6	2	1	3	2	1	Slightly
Establishing a network of hospices	6	1	4	1	2	1	Slightly

SOURCE: Authors' analysis of 2023 MA VBID PO questionnaire data.

remained a moderate challenge in 2023, as it was in the previous two evaluation years. A representative of PO V noted, "We've established our infrastructure for data-reporting, but I think no matter what, [implementation of the Hospice Benefit component will] always be a large lift for us." Claims processing and receiving NOEs in a timely manner continued to be a moderate operational challenge in 2023, and POs described needing to work with and educate providers about billing. POs also reported a need to educate providers and hospices about submitting NOEs in a timely manner.

Tracking care plans was also considered a moderate challenge because of a lack of an integrated system for processing care plans that both the PO and hospice can use. As a representative of PO X described, "We work in different systems that don't speak to each other," which created challenges for the PO in terms of the visibility of care plans. Relatedly, distinguishing care that is related or unrelated to the terminal condition was also considered moderately challenging. Representatives described having a team to adjudicate claims for delivered care that was not related to the beneficiary's terminal diagnosis or to go through a medication reconciliation process with the hospice. As a representative of a new PO noted,

> We've got a whole claims team that has taught themselves how to adjudicate hospice claims and claims to members that are on hospice but aren't related to hospice care, whether those are post live discharge care, whether those are unrelated care. All of this is fairly disjointed. (PO BE)

Slight implementation challenges included working with vendors or subcontractors to help implement the Hospice Benefit component and identifying beneficiaries eligible for Palliative Care, TCC, and hospice care. The identification of beneficiaries for TCC was considered challenging by some POs because of low awareness among referring providers of TCC availability and hesitancy from beneficiaries regarding the discontinuation of treatment for a serious illness, among other reasons. One PO V representative said,

> The TCC component is a little bit different because working on getting . . . that [group of patients] who would not have come on hospice earlier because they want to finish the treatment . . . [is] a little harder to identify. They're not just a serious illness population. It's a specific group of people that might be eligible

> for TCC, and so the awareness around that is a continuing education process with our providers and anyone that might touch that patient.

Communication and Training

Overall, POs rated issues related to communication and training as slightly to moderately challenging in 2023, similar to 2022. Most notably, POs rated communication with hospices about beneficiary eligibility and claims processing as moderately challenging, particularly with OON hospices. A representative of PO BE noted that communicating with hospices was an "enormous" challenge because of the difference, from typical operations, in how hospices have to collaborate with the PO:

> These expectations of collaborating with us, it represents a paradigm shift compared to business as usual for hospices. [Hospices] have not been accustomed to having regular touchpoints on a bimonthly basis, where we are reviewing in-depth every ER [emergency room] visit, every revocation, every grievance, every delay in a prescription being filled. We are trying to hold them accountable, not to mention the daily communication that's taking place through our secure messaging platform.

POs described the importance of ensuring that hospices understand how to properly bill and send in the NOE, and they noted that educating and reeducating hospices was a significant lift:

> It was a matter of outreaching continuously to [hospice] providers. Reviewing the process, getting everybody [ready] to follow the same process, so that we can have clean reports, our notices are being received timely which affects the claims, and continuing to walk through the expectations with the [hospice] provider step by step. (PO B)

POs also reported that training non-hospice providers about the availability of Palliative Care, TCC, and hospice care was slightly to moderately challenging. Trainings often included a continuous education process that incorporated seminars, site visits, online materials, and direct communication to providers. Relatedly, a few POs, including POs W, AJ, and R, reported that they needed to educate some non-hospice providers on the difference between palliative and hospice care: "A lot of our providers still think that palliative care and hospice are the same thing," said a PO AJ representative. In addition, POs noted less awareness about TCC and a need to educate providers regarding when TCC may be appropriate.

Overall, POs reported that communicating with beneficiaries about their potential eligibility for Palliative Care, TCC, or hospice care was slightly challenging. As noted in previous evaluation reports, engaging in conversations about death, dying, and end-of-life care with beneficiaries and their family caregivers can be challenging for POs because these discussions are "still very much taboo" (PO X). POs reported that beneficiaries and family caregivers often were confused about what the Hospice Benefit component included and asserted that education to beneficiaries and family caregivers was important. Educating beneficiaries and family caregivers about TCC was particularly challenging because of the time frame of care provided under TCC:

> I think that the main barrier . . . is when you put a date for a member to decide to opt out of the treatment, it's very hard to engage the member in the TCC process. It's not easy for a member to decide to say, 'I'm going to have the treatment for seven days and then switch to hospice.' (PO W)

In addition, one new administrative challenge emerged in the 2023 interviews that was not captured in the pre-interview questionnaire: Representatives of POs R and W reported that the POs recouped some payments already made to hospices. This situation occurred when a beneficiary elected hospice care and the PO paid hospice providers for their services, but CMS did not receive the NOE within five days, as required (that is, CMS did not receive timely notification that the beneficiary enrolled in hospice). One PO W representative explained,

> When we identify that we have a member that CMS do[es] not recognize . . . as a hospice member, we have a reconciliation process and we have to call the hospice provider, in-network and out-of-network, in order to submit to us the evidence that they submitted the documentation to CMS.

Care Delivery

POs generally considered hospice care delivery processes slightly challenging, consistent with the findings from 2022. Managing transitions between Palliative Care, TCC, and hospice care was considered a slight challenge, in part because of a slow uptake with these types of care and in part because of "late" referrals to hospice care. A representative of PO V explained that part of the challenge with transitioning to TCC stems from beneficiary resistance to accepting a limited time frame for the continued receipt of curative care:

> The curative treatment that is different in palliative [care] is one of the [reasons] why TCC is not so successful. Because then the patient that still is fighting, that still is having hope, they don't want to move to hospice because they want to continue with the curative treatment. So, they prefer to stay in palliative care out of hospice because they are basically receiving the support that they need and still receiving the curative treatment.

Similarly, coordinating TCC between hospices and other care providers was also considered a slight challenge. POs indicated that education for POs, hospices, and beneficiaries is critical for managing challenges related to care delivery and the continuity of care.

Finally, providing Hospice Supplemental Benefits to eligible beneficiaries was considered a moderate challenge for new POs but not at all challenging for continuing POs in 2023, due in part to low utilization of these benefits. One PO X representative said, "We rolled it out and no one is utilizing it. I think this is another area that, depending on volume, the way that we're doing it today, it's not scalable."

Creating and Maintaining a Hospice Network

Chapter 9 outlined the main issues regarding the creation and maintenance of a hospice network. On the survey, POs indicated that these tasks were slightly challenging. The most challenging of the network creation tasks, negotiating hospice payments, was rated as a moderate

challenge. A representative of PO L noted that some hospice providers would not consider a contract if the rates did not meet FFS rates, which made it challenging to build a robust hospice network. Establishing or promoting a hospice network was considered a slight challenge in part because of the CMS requirement for in-network adequacy.

Hospices

Similar to previous years (2021 and 2022)—and parallel to the challenges cited by POs—hospice representatives reported that the most pressing implementation challenges were related to billing and payments, PO oversight and communication, and the provision of Hospice Benefit component benefits. Unlike previous years, however, hospice representatives attributed many of their challenges to the way POs set up their communication systems and processes, noting that the need to navigate multiple systems that were unique to each PO, but different from Medicare's system, exacerbated these challenges. Hospices noted that the extra efforts they were making to implement the model were particularly challenging, given the lower-than-FFS rates they were getting from POs for providing care to VBID patients. Although most hospice representatives reported disappointment at the low volume of VBID patients, some noted that the small numbers also made implementation challenges manageable (Hospices T, AH and AJ). For at least two hospices, having good relationships and collaboration with the PO representatives helped mitigate their implementation burden (Hospices AK and AN).

Billing Processes and Payments

The hospice representatives we interviewed considered inefficient billing processes and delayed payments to be their biggest implementation challenges. Prior to enrolling VBID beneficiaries and submitting their NOEs and claims, hospices first needed to determine if each presenting patient was VBID-eligible. Representatives of seven hospices reported that it was a "huge challenge on our end to figure out the eligibility" of beneficiaries for VBID services (Hospice AL). Hospice AO said it has been "trying to build better ways of identifying [eligible beneficiaries] at or near the time of admission versus at the time the claim [is] submitted." Hospices also reported needing to check beneficiary eligibility for VBID on a monthly basis because, in some cases, beneficiaries may switch plans during the year, such as when they are dual-eligible for Medicare and Medicaid. Providing beneficiaries with VBID services when they are not eligible for VBID could lead to serious financial complications for the hospice:

> Of course, nobody notifies us [when beneficiaries switch plans]. So, we keep providing the [VBID] services, and when we come to bill, they say: "What? That's not a patient. . . . Now it's not our patient, so go to the other company." And then, they start ping-ponging, play ping pong with us who pays for what. Meanwhile, we don't get reimbursed. (Hospice AN)

Representatives of three hospices specifically called out the need to submit NOEs to both the PO and the MAC as a burden. Other hospice representatives cited such burdens as glitches in

POs' systems (Hospice AK), cumbersome requirements to submit billing documentation on paper (Hospice AO), lost faxes that caused payment delays of a whole month (Hospice AN), paper checks mailed to the wrong office of the hospice organization (Hospice AL), and rejected claims for preauthorized patients who had been referred directly to the hospice by the PO (Hospices AK and AN describing experiences with two different POs). Hospice AN representatives blamed a lack of communication between their PO's claims and case management departments for information technology–related issues that caused delays in claim processing:

> [PO staff] always say, well, [the system] hasn't properly configured. So, for example, once we were three years receiving the same error because nobody cared to fix a contract improperly set up in the system. Three years. And they would pay but after a year, a year and a half, you know?

Resolving previously denied claims was another big challenge that six hospices attributed to unwieldy systems for communication and data-sharing with POs. Hospices reported that POs' claims submission systems were not ready for prime time and caused "a big frustration" (Hospice AL), because they required labor-intensive corrections and subsequent communication. Hospice representatives attributed the poor communication to PO staff turnover (Hospices AI and AL), the discontinuation of in-person meetings, and an inability to "get ahold of somebody" (Hospice AN). Some hospices reported that communication challenges hampered the ability of their staff to understand why claims were denied (Hospices AI, AL, and AN).

According to the representatives of four hospices, differences between POs' systems contributed to billing and NOE documentation challenges. Representatives of one hospice that contracted with multiple POs indicated that these POs or their third-party billing agencies all used different NOE forms—all of which also differed from the one used by Medicare. This created confusion because hospice staff had to check first, whether the new patient is in VBID and then, fill out the form specific to that PO to avoid a claims denial:

> Honestly, just [the POs] requiring a different election statement than what we have for all of our other patients is a big issue because we have to make sure that whoever is going out to see the patient gets that [right] one signed. . . . If we don't have it or it happens on the weekends and whoever's admin[istrator] on call doesn't realize we need the extra form, then it becomes an issue. And, like I said, I think that they're requiring way more of us than Medicare ever did. (Hospice AL)

Hospice AJ representatives also said that they have five different documentation submission portals for each VBID PO they interact with, adding that "every insurance has the right to do it their own way, and there's no consistency there." One Hospice AO representative called VBID "a fragmented approach, it's plan by plan." Finally, Hospices AL and AM representatives said that POs can sometimes have much shorter document submission deadlines (30 days for POs versus one year for Medicare), which can lead to claims rejection and adjudication challenges.

Concerns regarding payment delays were similar to those reported by hospices in prior evaluations of the VBID Model test. Representatives of four interviewed hospices reported waiting more than one month to receive payments for VBID patients, which caused a significant cash flow problem for Hospice AM. However, this experience was not universal; representatives of three hospices (T, AI, and AJ) did not report any challenges related to timely payment.

Parent Organization Oversight and Communication

Hospice representatives said that POs' requirements for communication and oversight of hospices' clinical processes continued to be a challenge in 2023. Hospice A representatives indicated that there was some confusion about which individuals from the hospice, PO, and providers should be communicating about VBID beneficiaries and when. In addition to grand rounds to review cases (Hospice T), representatives said that POs added new care oversight approaches, including weekly calls (Hospice AM), audits (Hospices AM and AN), and group texting to allow for continuous communication with hospices (Hospices AI and AO).

Representatives of two hospices reported that the texting approach required them to be "constantly communicating" with PO staff about updates and questions, noting that this was "burdensome" (Hospice AI) and "a lot to ask of your RNs to . . . not only document on the patient in the EMR but also send a long summary in a text" (Hospice AO). They also indicated that there was confusion about what clinical developments or care changes should trigger a group text. It took the hospice staff six to nine months to settle into their current communication process with the PO. Although several PO representatives also discussed communication challenges with hospices, the challenges of using the group chat application appear to have been notably more burdensome to hospices than to the PO that required it.

Provision of Palliative Care and Transitional Concurrent Care

The provision of Hospice Benefit component services continued to be challenging for hospices. Representatives of eight hospices indicated that a lack of standard care definitions for Palliative Care and TCC complicated implementation. Representatives of two hospices perceived that transitions to hospice, in particular, were delayed by POs' provision of complex care management or hospice-like programs that may substitute for palliative or hospice care, which hospices could be contracted to provide under VBID (Hospices AH and AJ).

A lack of standardization of TCC eligibility and covered services also presented administrative challenges to hospices. According to one Hospice AJ representative, the PO with which they contracted "never outlined exactly who meets that eligibility criteria." Others noted that hospices do not provide TCC for FFS beneficiaries, so they had to learn how to coordinate with outside providers to deliver that care:

> We have lived in the world of the Medicare hospice benefit that once [beneficiaries] elect hospice, hospice is their main provider. There's [sic] no other providers out there. And so just having that juxtaposition of what Medicare hospice is versus what [the Hospice Benefit component] is, or what [the Hospice

> Benefit component] hospice election looks like, just requires a ton of work and just uncertainty around the whole process. (Hospice AL)

Finally, Hospices AJ and AL also noted the financial burden of providing TCC, which required hiring new staff and implementing new processes. Hospice AL representatives specifically noted that their VBID contract does not compensate them for coordinating TCC services for their patients. Hospice AJ representatives reported that one PO even requires them to cover the costs of curative care that beneficiaries receive under TCC, which is both logistically and financially infeasible:

> When you go into [the Hospice Benefit component] and the funding is . . . maybe a lower daily payment . . . then to be asked to kind of create an over and above program on your own budget, there's really no way. Could you do it in a one-off scenario to satisfy a patient? Sure. Can you build a program that's sustainable around it? Not really, right?

In contrast to prior years, hospices did not report challenges with delivering Hospice Supplemental Benefits, perhaps because some POs are now identifying beneficiaries in need of these benefits and identifying staff to deliver respite care (PO P).

Summary

As described in previous evaluation reports, VBID-participating POs and their in-network hospices continued to experience a variety of implementation challenges. Most POs we interviewed considered implementation to be a large or a moderate lift. All POs that considered implementation to be an easy lift were continuing model test participants who benefited from existing processes they had implemented in prior years.

Key implementation challenges for POs in 2023 were similar to those we reported in 2022 and 2021 and included administrative burdens, such as tracking care plans and processing claims, and the need to work with hospice providers on continuous communication and education about the nuances of palliative and hospice care distinctions.

Most in-network hospices we interviewed, particularly those that joined hospice networks before 2023 and those that did not provide care to many VBID patients, reported experiencing implementation as either a small or moderate lift. Those reporting a moderate or large lift highlighted significant burdens related to adapting to POs' systems and managing additional administrative requirements.

The biggest implementation challenges cited by interviewed in-network hospices included billing processes, POs' communication and oversight requirements, and unclear definitions of Palliative Care and TCC. Although the hospice representatives we interviewed in previous years attributed many implementation challenges to a lack of automation in POs' systems, our 2023 interviews suggest that their challenges stemmed from updated but still onerous systems. Challenges were exacerbated by variations among the systems that POs used and the differences of those systems from Medicare's requirements. Payments from some POs continued to arrive

substantially later than those from Medicare, and some hospices noted that lower-than-FFS payments from POs were insufficient to cover the costs of implementing VBID.

Both POs and hospices noted that implementation challenges were manageable in 2023 due to a low volume of beneficiaries but highlighted that they would need to invest more resources to participate in VBID should volume increase.

Chapter 11. Utilization and Care Quality

Key Findings

- Palliative care utilization remained lower than most POs' expectations. In 2023, 12,317 beneficiaries received palliative care through a VBID-participating PO, with most POs (11 of 15) reporting palliative care delivery to less than 25% of beneficiaries who died in 2023.
- Across all POs, 23,828 beneficiaries started hospice care in 2023. Of these, 157 received TCC, corresponding with 0.7% of beneficiaries in VBID-participating POs who started hospice care in 2023. POs and hospices said that difficulty reaching beneficiaries prior to hospice eligibility, low TCC awareness among the non-hospice providers who refer to TCC and hospice, and beneficiaries' preference not to stop curative treatment after a certain number of days contributed to low TCC uptake.
- The utilization of Hospice Supplemental Benefits was also low in 2023. Among beneficiaries starting hospice care in 2023 across POs, 4.5% of beneficiaries received reduced or eliminated cost-sharing, and 2.9% of beneficiaries received other supplemental benefits, such as home modification, transportation, meals, or in-home respite care. Some hospice representatives explained that few beneficiaries were eligible for, needed, or were able to get the right Hospice Supplemental Benefits at the right time. POs explained that the utilization of these benefits could be improved by increasing awareness of their availability and improving strategies for identifying beneficiaries who need them.
- We did not find statistically significant evidence that the Hospice Benefit component was associated with hospice enrollment, most hospice care patterns, or quality-of-care outcomes in 2022, which is generally consistent with our 2021 findings. Some interviewed hospice representatives attributed stable hospice utilization to little or no change in how VBID beneficiaries are identified and referred to hospice and in how hospices provided care to their VBID patients.

In this chapter, we describe the **utilization of Palliative Care, TCC, and Hospice Supplemental Benefits** in 2023 using data reported by POs to CMS as part of model monitoring activities. We used preliminary hospice claims data for 2023 to describe hospice utilization across POs. Perspectives from interviews with representatives of POs and in-network hospices provided context for these utilization numbers.

We also used DD modeling to compare **hospice enrollment, hospice care patterns, and caregiver-reported hospice care experiences** in the period before the Hospice Benefit component's introduction (2019 rather than 2020 due to the COVID-19 pandemic) and the first two years after its introduction (2021 and 2022). Appendices A, C, and J describe our DD modeling approach.

Palliative Care

As in prior years of the Hospice Benefit component, palliative care utilization was lower in 2023 than what most POs projected in their applications to CMS. In 2023, 12,317 beneficiaries received palliative care through VBID plans, with individual POs serving between two beneficiaries (PO BA) and 7,705 beneficiaries (PO L) (see Table 11.1). Across all POs, the proportion of 2023 decedents enrolled in Hospice-participating POs who received palliative care ranged from 1.1% of decedents in PO BA to 100% of decedents in PO BE, both of which have I-

SNPs participating in the model. Like other POs, those with I-SNPs varied in how they defined and reported palliative care. Some reported limited use, reflecting the POs' perception that their beneficiaries "just have less of a need . . . [for palliative care] because of [twenty-four hours a day, seven days a week] nursing support in nursing facilities" (PO BA). PO BE representatives reported palliative care use by all beneficiaries, noting that "the way the NPs and primary care doctors provide primary care [in the PO's facilities] is palliative." POs that reported increases in palliative care utilization due to the Hospice Benefit component attributed these increases to greater outreach from the POs' NPs (PO G) and an increase in the number of palliative care providers in their network (PO W). PO L representatives reported expanding eligibility for palliative care in 2023 to include beneficiaries with a moderate or high risk of mortality, regardless of whether they had prior patterns of high acute care utilization. This broader eligibility criteria may have contributed to higher use of palliative care in this PO relative to others.

Among those beneficiaries who received palliative care, the average number of days in care was 162.7. Across POs, the average number of days ranged from 1.0 (PO BA) to 221.7 (PO X).

Table 11.1. Number of Beneficiaries Receiving Palliative Care and Palliative Care Length of Stay, by Parent Organization in 2023

PO	Number of Beneficiaries	Average Number of Days	Percentage of 2023 Deceased Beneficiaries
PO B	179	190.1	24.3
PO G	294	91.0	27.3
PO L	7,705	181.3	57.3
PO M	177	48.6	14.2
PO P	829	114.1	7.8
PO R	335	159.1	11.0
PO V	82	43.1	13.4
PO W	878	139.3	9.1
PO X	90	221.7	23.1
PO Y	106	39.6	10.1
PO AI	6	143.3	2.3
PO AJ	100	3.7	3.6
PO BA	2	1.0	1.1
PO BE	1,444	157.2	100.0
PO BI	90	122.4	43.3
All POs	12,317	162.7	27.0

SOURCES: Authors' analysis of data submitted by POs as part of the VBID model and 2023 enrollment data.

Hospices that contracted with at least one PO to provide palliative care services as part of the model test had mixed perspectives on the effects of the Hospice Benefit component on palliative

care utilization. Although representatives of Hospices AM and AK reported growth in palliative care referrals from participating POs, Hospice A representatives noted that volume had been very low (less than 12 VBID palliative care patients).

Representatives of POs X and BI reported receiving very positive feedback from their beneficiaries regarding palliative care, particularly with regard to the frequency of visits and availability after hours. As a representative of PO X described it, beneficiaries "love having their NP [nurse practitioner] come in as often as they can. . . . The families love it because they can call somebody, and they can get them anytime."

Transitional Concurrent Care

As in 2021 and 2022, POs reported that few beneficiaries received TCC in 2023 (Table 11.2). Of the 23,828 VBID beneficiaries who started hospice care in 2023, POs reported that just 157 received TCC. In data submitted to CMS, 12 of 15 POs that participated in the Hospice Benefit component in 2023 indicated that 11 or fewer beneficiaries used TCC. Across all POs, 0.7% of beneficiaries starting hospice in 2023 received TCC, ranging from zero in six POs to 9.6% in PO M. This corresponds with 1.2% of beneficiaries who started hospice care in in-network hospices in 2023. As in prior years, PO M had the highest TCC rate of use; this PO has the highest proportion of beneficiaries receiving care from in-network hospices.

Representatives of most interviewed POs and hospices concurred that there had been limited to no use of TCC, citing a number of potential reasons for low uptake. These reasons included difficulty reaching beneficiaries "upstream and work[ing] with their other PCP providers and specialists to increase awareness" (PO P); reliance on non-hospice providers to refer beneficiaries to TCC (Hospice AM); beneficiaries declining to participate (PO R), perhaps because they do not want to have to stop curative treatment after a certain number of days (PO W and Hospice T); and lower applicability of TCC services for beneficiaries residing in nursing homes (POs BA and BE). In addition, representatives of Hospice AJ reported that one PO expected hospices to pay for curative care provided as part of TCC and that this might discourage hospices from promoting TCC to their patients.

Representatives of POs G and V, which both noticed an increase in TCC use, attributed this change to earlier identification of beneficiaries for referral and enrollment in hospice. A representative of PO G put it this way:

> We are seeing a little increase in the concurrent care that we can provide to [beneficiaries because we are getting them into hospice earlier]. Before this program began, we were getting members too late in their hospice journey, so they didn't have that concurrent care need. But now that we have them identified earlier, we are seeing an increase in that.

Table 11.2. Number of Beneficiaries Receiving Transitional Concurrent Care and Transitional Concurrent Care Length of Stay, by Parent Organization in 2023

PO	Number of Beneficiaries	Average Number of Days	Percentage of Beneficiaries Who Started Hospice Care in 2023
PO B	0	N/A	0.0
PO G	11	3.9	1.9
PO L	31	16.9	0.4
PO M	67	4.2	9.6
PO P	5	29.8	0.1
PO R	0	N/A	0.0
PO V	8	41.6	1.8
PO W	4	11.8	0.1
PO X	0	N/A	0.0
PO Y	24	15.3	3.4
PO AI	0	N/A	0.0
PO AJ	6	26.2	0.3
PO BA	0	N/A	0.0
PO BE	1	1.0	0.2
PO BI	0	N/A	0.0
All POs	157	12.1	0.7

SOURCE: Authors' analysis of data submitted by POs as part of the VBID model.
NOTE: N/A = not applicable because PO had zero beneficiaries receiving TCC.

According to representatives of POs L and V, beneficiaries who received TCC and their family members were satisfied with these services:

> When we've been able to provide TCC interventions, the families are appreciative of being able to have those opportunities to help transition them on to hospice. . . . Since we don't cap TCC currently, they're able to discontinue TCC when they no longer feel . . . that it's showing benefit. (PO V)

Hospice Supplemental Benefits

As in 2021 and 2022, the utilization of Hospice Supplemental Benefits was low in 2023 (Table 11.3). Eleven POs offered Hospice Supplemental Benefits in 2023, with nine reducing or eliminating cost-sharing for inpatient respite care and hospice drugs and biologicals and another group of nine offering other types of Hospice Supplemental Benefits. Approximately 7% of VBID beneficiaries who started hospice care in 2023 received either reduced or eliminated cost-sharing, other types of Hospice Supplemental Benefits, or both.

A total of 1,073 beneficiaries received reduced cost-sharing, which corresponds with 4.5% of all VBID beneficiaries who started hospice care in 2023 and 19.3% of VBID beneficiaries who were enrolled in POs that offered this benefit and were eligible to receive it.

A total of 694 beneficiaries received other Hospice Supplemental Benefits across five POs, which corresponds with 2.9% of all VBID beneficiaries who started hospice in 2023 and 11.0% of VBID beneficiaries who were enrolled in POs that offered these benefits and were eligible to receive them. These beneficiaries included 322 from PO P, which offered in-home respite care and $500 yearly care assistance for caregivers; 254 from PO Y, which offered a readmission prevention program, including home modifications and bathroom safety devices, transportation, and meals; and 83 from PO G, which offered in-home respite care, an emergency response system, meals, and transportation.

Table 11.3. Number of Beneficiaries Receiving Hospice Supplemental Benefits, by Parent Organization in 2023

PO	Reduced Cost-Sharing	Percentage of Beneficiaries Who Started Hospice Care in 2023	Other Supplemental Benefits	Percentage of Beneficiaries Who Started Hospice Care in 2023
PO B	131	25.9	0	0.0
PO G	72	12.5	83	14.4
PO L	N/A	N/A	N/A	N/A
PO M	28	4.0	N/A	N/A
PO P	N/A	N/A	322	5.4
PO R	0	0.0	3	0.3
PO V	234	53.1	N/A	N/A
PO W	N/A	N/A	N/A	N/A
PO X	130	98.5	0	0.0
PO Y	0	0.0	254	36.1
PO AI	N/A	N/A	N/A	N/A
PO AJ	477	26.3	0	0.0
PO BA	N/A	N/A	0	0.0
PO BE	1	0.2	32	5.7
PO BI	N/A	N/A	N/A	N/A
All POs	1,073	4.5	694	2.9

SOURCE: Authors' analysis of data submitted by POs as part of the VBID model.
NOTE: N/A = not applicable because PO did not provide supplemental benefits or reduced cost sharing.

Representatives of POs offering reduced or eliminated cost-sharing noted that this is a "passive" supplemental benefit, meaning that neither POs nor hospices need to use any procedures or rely on any algorithms to identify beneficiaries who should receive this hospice supplemental benefit. In contrast, POs or hospices must identify beneficiaries in need of other Hospice Supplemental Benefits, including respite care. As a representative of PO B described it, "If no one is talking about it, then the member is not going to utilize it or think about it. And so, it just really needs to be driven by the social worker."

Some hospice representatives noted that few beneficiaries were eligible for, needed, or were able to get the right benefits at the right time. A representative of Hospice AJ stated,

> Not everyone is in need of [respite care]. And so, it's been used just very seldomly. Once you narrow down the plans that are participating and then narrow down further to the particular patient need, it becomes a select opportunity.

A representative of PO P explained that the "driving reason" for increases in hospice supplemental benefit use in that PO was "more awareness and education and maturity with our in-network providers around how and when to offer those supplemental benefits and really coordinating with the clinical team to do that."

PO representatives generally described the utilization of Hospice Supplemental Benefits as "low," even if they observed increased utilization over time. Some POs changed their benefit offerings to increase utilization. As a PO G representative described it,

> We're also learning which benefits are the most helpful to members. . . . [I]t's all well and dandy to have these benefits, but we really want members to use them and have them be beneficial. So as we offer them, that's something that we're keeping an eye out too, is do we need to change how it's offered? Do we need to expand it? What other ones are we looking at?

Nonetheless, Hospice AK representatives said that Hospice Supplemental Benefits had a positive impact on the few who received them because these benefits "allow for us to provide our patients with things that they need to support their well-being and allow them to continue to live successfully in the home environment . . . which was very exciting to us."

Regression Findings on Hospice Enrollment, Care Patterns, and Care Experiences in 2021 and 2022

We assessed whether the Hospice Benefit component was associated with the proportion of decedents who enrolled in hospice, hospice care patterns, and caregiver-reported experiences of hospice care using data from 2019, 2021, and 2022. Our analyses examined several outcomes that reflect the degree to which the model achieved its goals of improving timely access to high-quality hospice care: hospice enrollment, LOS, the proportion of beneficiaries discharged alive, the proportion of beneficiaries receiving visits from professional staff in the last three days of life, and the caregiver-reported experience of hospice care (weighted average of eight CAHPS Hospice Survey measures) (Anhang Price et al., 2020).

To conduct these analyses, we compared beneficiaries in Hospice-participating plans to entropy-balanced comparators using DD methods (see Appendix J). Although these models are similar to those used to evaluate VBID General beneficiary-level outcomes, there are key differences in the Hospice Benefit component models that reduce our confidence in the findings in a way that is not captured by the *p*-values. First, because we cannot track individuals' end-of-life related outcomes over multiple years (because episodes of care immediately prior to the end

of life occur only once), the Hospice Benefit component models do not balance on pre-period trends as is done for VBID General models. Second, because of the large differences between groups defined by participation status and year, in many cases, we found large lingering imbalances between the groups, even after entropy-balancing weights had been applied (and even though the effective sample sizes fell drastically, meaning that we downweighted many noncomparable beneficiaries and still had difficulty achieving balance).

To address these imbalances, if the absolute standardized mean differences (ASMDs) were greater than 0.2, even after entropy balancing, then we removed these variables from the balancing algorithm and instead controlled for them as covariates in our regression models. Because entropy-balancing weights require fewer assumptions about the relationship between the covariate and outcomes (such as an assumption of a linear relationship) than regression controls, we consider the application of balancing weights to be a superior approach for resolving observed differences between the Hospice-participating and nonparticipating groups. However, when reasonable balance is not possible to achieve, controlling for these covariates in the outcomes model is our method of last resort to address differences between the two groups. As a sensitivity analysis, we also estimated the models, including all covariates of interest in the entropy-balancing weights, even when they could not be balanced within an ASMD of 0.2. Because the DD analyses do not require balance—only parallel trends—sensitivity analyses that corroborate primary findings would strengthen their credibility.

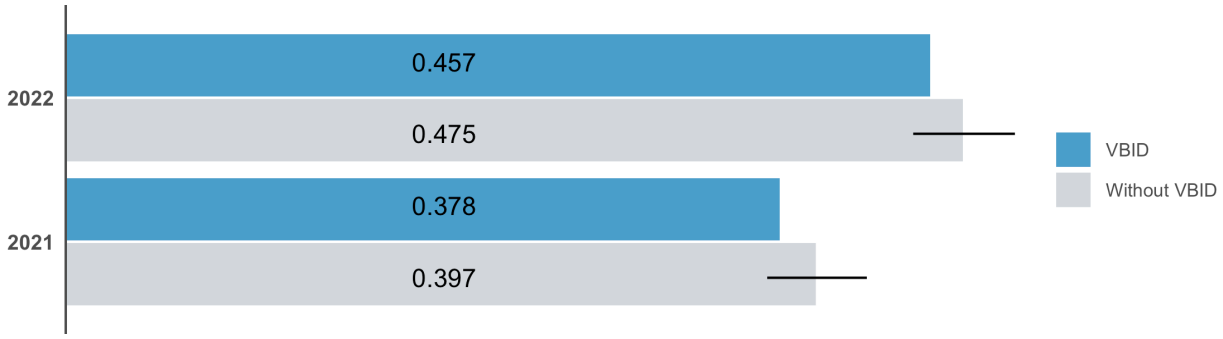
Hospice Enrollment

The Hospice Benefit component was not associated with statistically significant changes in hospice enrollment in 2021 or 2022 (Figure 11.1). For 2021, our estimate implied a non-statistically significant, 1.9 percentage point reduction in the probability of hospice enrollment among decedents ($p = 0.16$, 95% CI [–4.5 to 0.7] percentage points); for 2022, the estimate implied a non-statistically significant 1.7 percentage point reduction ($p = 0.21$, 95% CI [–4.4 to 1.0] percentage points).

In general, rates of hospice enrollment among VBID decedents (45.7% in 2022) were somewhat below the national average for hospice enrollment among MA decedents (49.2% in 2022) (Medicare Payment Advisory Commission, 2024). Lower hospice enrollment rates in POs Hospice-participating POs are largely explained by the high proportion of beneficiaries in Puerto Rico, which has the lowest rates of hospice use in the country at 21.4% (National Alliance for Care at Home, 2024).

Consistent with our regression results, most POs responding to our pre-interview survey (eight of 14) reported no impact of the model on the utilization of hospice care. The remaining POs reported either an increase ($N = 5$) or a decrease in hospice utilization ($N = 1$). Representatives of PO G, which experienced an increase in hospice utilization, said that hospice enrollment increased every year of their participation in the model because of proactive

Figure 11.1. Estimated Association Between the Hospice Benefit Component Interventions and the Probability of Hospice Enrollment Among Decedents, 2021 and 2022



SOURCE: Authors' analysis of 2019, 2021, and 2022 FFS claims data.
NOTES: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively, from the DD models comparing VBID-participating plans with a weighted sample of comparison plans. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented the Hospice Benefit component, holding other factors constant. The black lines indicate a 95% confidence interval for level of outcome without VBID. The differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

engagement with potentially eligible beneficiaries earlier in their care trajectory:

> These members may not have elected hospice at all if it wasn't for this program and for our nurse practitioners, and educating them, and being there when they have questions or providing the services that they do. So I definitely can see . . . before the program to now . . . that there's been a significant increase in the engagement and members that are participating in the program, which has been huge.

Some interviewed hospice representatives attributed stable hospice utilization to little or no change in how VBID beneficiaries are identified and referred to hospice. For example, representatives of three interviewed hospices said that their census was the same as before joining the model test "because we are doing the same [hospice introduction and enrollment processes]" for hospice, and there are no additional beneficiaries electing hospice as a result of the Hospice Benefit component (Hospice AM).

One-half of the interviewed hospices stated that they had some increase in referrals or volume, including a representative of Hospice AL, who said that VBID patient volume "just creeped up [to] where we're doing multiple a week or even a month." However, regardless of whether they had experienced an increase, eight interviewed hospices reported providing care to a small number of VBID beneficiaries.

Hospice Care Patterns and Quality

The Hospice Benefit component was not associated with statistically significant changes in most other utilization outcomes, which included very short hospice lengths of stay, long hospice lengths of stay, live discharge rates, and caregiver-reported hospice care experiences, although in a few cases, the results were marginally significant. Our primary regression model indicated that

the Hospice Benefit component was associated with a 2.8 percentage point reduction in the probability of beneficiaries receiving two or more visits from professional staff in the last days of life in 2022 ($p \leq 0.01$, 95% CI [–4.7 to –0.9]). However, this result was not robust to including difficult-to-balance covariates in the entropy-balancing model, which weakened the overall level of evidence for this possible association.

Similar to what we estimated in our prior report, we found that the Hospice Benefit component was associated with a 1.94-point improvement in reported care experiences in 2021, although this result was marginally significant in the current report ($p = 0.08$, 95% CI [–0.21 to 4.08]). Differences in the statistical significance of the results are likely due to the inclusion of additional variables in the balancing weights used for the updated models presented in this year's report. We found no statistically significant association between the Hospice Benefit component and caregiver experiences in 2022, and the direction of the association changed (estimate: –0.05, $p = 0.94$, 95% CI [–1.26 to 1.17]).

Nine of 13 POs responding to our survey reported that they perceived that hospice care quality was better due to the model. Although most POs reported that they did not formally assess hospice care quality or beneficiary experiences with the Hospice Benefit component, six POs mentioned informally receiving positive feedback from beneficiaries about their care experiences.

Other marginally significant results in our data modeling included a 1.3 percentage point increase in the probability of having an LOS of less than seven days in 2022 ($p = 0.09$, 95% CI [–0.2 to 2.9] percentage points) and a 1.0 percentage point reduction in the probability of a live discharge in 2022 ($p = 0.08$, 95% CI [–2.0 to 0.1] percentage points). The marginally significant reduction in the probability of a live discharge is explained in part by a statistically significant 1.2 percentage point reduction in the probability of revocation in 2022 ($p < 0.01$, 95% CI [–2.1 to –0.4] percentage points), a type of live discharge. However, none of these results remained statistically or marginally significant in more than one year, and only the revocation result remained significant in the sensitivity analyses discussed above. These factors weaken our confidence in these findings.

Representatives of five hospices we interviewed reported that they had not changed how they provide care to patients due to VBID. However, others noted greater care continuity with "high involvement with [the patients'] NP and physician," who were treating the patients before enrolling in hospice (Hospice AI), and increased collaboration with POs, which allowed for better medication reconciliation and appropriate medication discontinuation for hospice patients (Hospice T).

POs reported that their key metrics for assessing the effectiveness of the Hospice Benefit component were hospice LOS (POs B, L, R, W, and X) and live discharge rates (POs W and X). In keeping with our regression results, eight of 14 POs responding to our survey reported no change in hospice LOS. Five POs reported an increase in LOS, and one reported a decrease. PO L representatives said that, when their beneficiaries receive palliative care or TCC, the

beneficiaries tend to have a longer hospice LOS. This PO works to extend LOS by identifying beneficiaries at risk of live discharge through visits or calls shortly after their admission to hospice:

> [For] any of the members that are admitted to an in-network hospice, we do outreach to them usually within the first five to seven days of their hospice stay. And we ask a series of questions. Mostly what we're trying to understand from the member and their family is, did the transition go well? Do they have everything that they need? Do they feel like the hospice level of care is the right level of care for them? And we also try to do some assessment of their risk of live discharge. And then, if there are any issues noted during that call, then the care advocate works to try to resolve those concerns. And so, where we've been able to perform those calls with the members, we've seen a reduction in [the] live discharge rate, which ultimately ends up creating a longer length of stay.

In contrast, some hospice representatives, including those from Hospices T, AH, AK, and AM, reported that LOS was shorter for VBID beneficiaries from some POs than for their other patients. According to Hospice AM representatives, one-third of patients referred to hospice as part of the model test die within 30 days, as opposed to 65 or 70 days for the remainder of the hospice's patients. Hospice AK representatives indicated that their PO is "targeting and finding patients that are just prior to a hospice referral," noting that these beneficiaries have a shorter hospice LOS than other patients who come through the hospice's supportive care management program.

Some hospice representatives attributed shorter LOS to "the patients being referred . . . later in their disease process" (Hospice T). Representatives of Hospices AH and AJ hypothesized that POs' care management and palliative care programs may be keeping beneficiaries "upstream" in the care trajectory for an extended period, thereby reducing hospice referrals and LOS. One Hospice AH representative described the possible scenarios this way:

> [The PO is] holding on to [beneficiaries] in terms of their palliative care realm later, right? So, they're delivering palliative care later into the course of the illness, right before the conversion to hospice, either because they see a benefit for themselves or because the patient declines hospice enrollment. . . . They are providing a lot of these . . . hospice-like [services]. This is already happening, and it's impacting already length of stay and then what services are kind of being discussed, you're getting more shorter hospice cases.

A representative of Hospice T added that some beneficiaries receiving palliative care prefer not to enroll in hospice when they become eligible because they do not want to switch care teams near the end of life. This can result in lower hospice enrollment or reduced hospice LOS among those delaying hospice enrollment.

Summary

Overall, the utilization of Hospice Benefit component services continued to be low in 2023, consistent with prior years. Palliative care utilization remained lower than most participating

POs' expectations. POs also reported that few beneficiaries received TCC in 2023 ($N = 157$, about 0.7% of beneficiaries in a VBID-participating PO who were enrolled in hospice care). This number is virtually unchanged from 2021 ($N = 146$) and 2022 ($N = 152$). POs and hospices cited potential reasons for the low uptake of TCC, including difficulty reaching beneficiaries prior to hospice enrollment, low TCC awareness among providers who refer to TCC and hospice, and beneficiaries preferring not to stop curative treatment after a set number of days, among others.

The utilization of Hospice Supplemental Benefits was low in 2023, similar to what we found for 2021 and 2022. Across all participating POs, 1,073 of the beneficiaries who started hospice care in 2023 received reduced or eliminated cost-sharing (4.5%) compared with 239 beneficiaries in 2021 (2.5%) and 875 beneficiaries in 2022 (4.6%). Similarly, 694 beneficiaries who started hospice in 2023 received other supplemental benefits (2.9%), such as home modification, transportation, meals, or in-home respite care, compared with 286 beneficiaries in 2021 (3.0%) and 377 beneficiaries in 2022 (2.0%) (Eibner et al., 2023). Hospices explained that the limited use of Hospice Supplemental Benefits may reflect limited eligibility and need for the benefits. POs noted that increasing awareness of the availability of the benefits and improving strategies for identifying beneficiaries who need them could help to increase use.

There was no statistically significant evidence that the Hospice Benefit component was associated with hospice enrollment. Although we identified a few associations with care patterns and quality of care, these did not hold up over time or in sensitivity analyses and were generally marginally significant. Overall, these findings are consistent with the results of our interviews with hospice representatives, most of whom said that there had been no change in how VBID beneficiaries were identified and referred to their hospices and that they had not changed how they provided care to patients due to the Hospice Benefit component.

Chapter 12. Hospice Plan-Level Outcomes: Enrollment, Bids, Costs, and Supplemental Benefits

Key Findings

- The Hospice Benefit component was associated with statistically significant reductions in standardized MAPD bids of $20 PMPM ($p < 0.01$, 95% CI [–$36 to –$5]) in 2021 and $16 PMPM ($p = 0.04$, 95% CI [–$31 to –$1]) in 2022. However, there was no statistically significant reduction in 2023.
- We generally found no statistically significant associations between Hospice Benefit component implementation and plan enrollment, costs to CMS, plan premiums, or the number of MSBs offered.
- PO surveys and interviews supported our quantitative results because representatives of most POs did not think that their Hospice Benefit component interventions affected any plan-level outcomes.

In this chapter, we examine whether the Hospice Benefit component was associated with a series of plan-level outcomes, including **enrollment, MAPD bids, costs to CMS, premiums**, and **the number of MSBs offered** to all plan enrollees. We supplement the results of our quantitative data analysis with the results of our PO questionnaire and interviews. We analyzed changes in **total plan enrollment** to determine whether Hospice Benefit component implementation affected beneficiary enrollment in participating plans. We also analyzed the impact of Hospice Benefit participation on **MAPD bids** because anticipated reductions in medical and prescription drug spending for beneficiaries electing hospice could reduce plan's bids for MA and Part D coverage. Lower MAPD bids could reduce the overall **costs to CMS** and **MAPD premiums** paid by enrollees. Finally, participation in the Hospice Benefit component could be associated with changes in the number of **MSBs** offered to all plan enrollees, because model participants may shift not only costs but also coverage to incorporate Hospice Benefit component services into their plan offerings.

Our methods are described more fully in Appendix A. As with the analyses reported in Chapter 5, we follow a DD approach combined with entropy balancing of outcome measure trends in the pre-period, along with the balancing of key plan characteristics. Unless otherwise noted, we analyzed outcomes for the 2017 through 2023 contract years, with the Hospice Benefit component beginning in 2021 or later.

Plan-Level Enrollment

We analyzed whether the Hospice Benefit component was associated with plan enrollment as of July 1 of each implementation year (2021, 2022, and 2023) but found no statistically significant effects. (We note that this plan enrollment outcome is distinct from hospice enrollment near end of life for decedents, which is considered in a beneficiary-level analysis reported in Chapter 11.) Appendix Table G.1 provides point estimates and CIs.

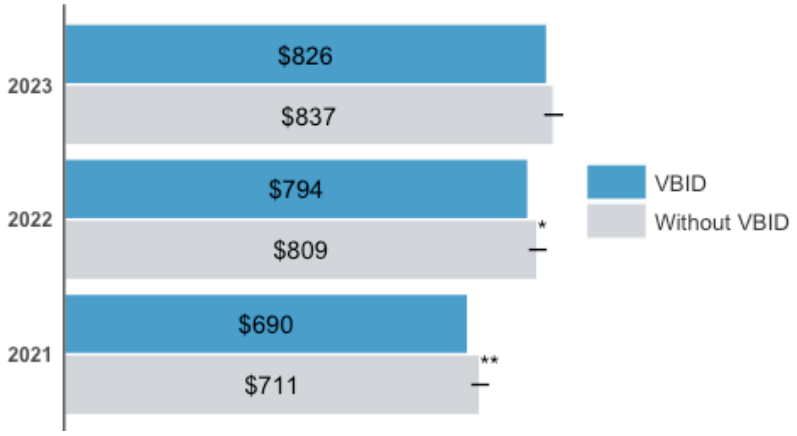
In response to our survey, representatives of 12 of 14 POs also reported that they did not observe any impacts of Hospice Benefit participation on plan enrollment or retention, largely because hospice is not a benefit that helps attract beneficiaries to a plan. Only two smaller POs, one of which offered the Hospice Benefit component in an I-SNP, reported an increase in plan enrollment.

Plan Bids

We analyzed the sum of the standardized MA and Part D plan bids submitted to the OACT, which are the projected cost of providing statutorily required Medicare Parts A, B, and D benefits.

In most years, the Hospice Benefit component was associated with a reduction in plan bids. For example, the Hospice Benefit component was associated with a decrease of $16 PMPM ($p$ = 0.04, 95% CI [–$31 to –$1]) in MAPD bids in 2022 and a decrease of $20 PMPM ($p$ = 0.01, 95% CI [–$36 to –$5]) in 2021. However, the association was smaller and not statistically significant in 2023 (–$11, p = 0.18, 95% CI [–$27 to $5]).

Figure 12.1. Estimated Association Between Hospice Benefit Component Interventions and Medicare Advantage Prescription Drug Bids



SOURCE: Authors' analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented the Hospice Benefit component, holding other factors constant. The black lines indicate a 95% confidence interval for level of outcome without VBID. Differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

Our 2023 PO survey results generally support the 2023 finding of no impact on MA and Part D bids. Representatives of nine of 14 POs reported no impact from the Hospice Benefit component on MA bids, and 13 POs reported no impact on Part D bids; two POs reported decreased MA bids, and three reported increased MA bids. The following quotation from a PO W representative illustrates a common sentiment about the absence of an impact on MA bids:

> Carving out that hospice component, we're expecting those hospice claim dollars to be covered by the hospice revenue dollars. And then, any other service outside of hospice would be covered the same way it would be covered if we didn't participate in hospice VBID. So essentially, no impact.

Nonetheless, nine of 15 POs reported that participation in the Hospice Benefit component increased administrative costs. These increases were attributed to costs associated with setting up and administering the model, such as developing predictive models, dashboards, and tracking tools (PO X).

When probed about the impact of the Hospice Benefit component on their bottom line, representatives of several POs, including POs G, AJ, BA, BE, and BI, indicated that data lags or sparse data prevented them from calculating their ROI. A representative of PO AJ described the problem the following way:

> We're unable to even start the analysis to answer [questions about financial outcomes of model participation] due to some of the gaps in tying revenue, fully identifying who's in the program. And so, it's a real challenge for the financial management of this program.

Among those POs that have calculated ROI, POs M and W reported that they were breaking even, and POs R and Y said that they were operating at a little bit of loss or at a lower margin than would typically be deemed successful. A representative of PO M explained, "We continue to show breakeven, and, internally, we continue to identify this program as consistent with our intent and our mission, and, so, that's why we stayed in the model." A representative of PO W further commented that they expect that it will "take a while to . . . be able to measure if that impact is coming through."

POs X, BA, and BE reported that they were looking at hospice LOS rather than revenues as the key metric to determine the effectiveness of the model.

Costs to Centers for Medicare & Medicaid Services

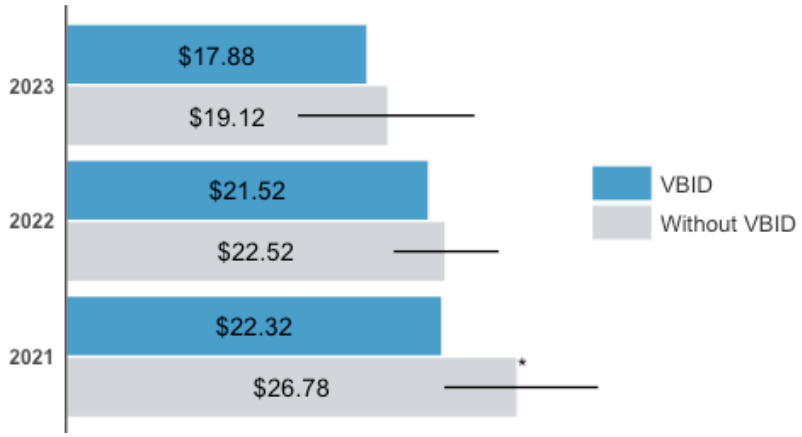
We calculated total costs to CMS as the sum of MA and Part D payments made by CMS to MAPDs for the cost of MA and Part D coverage. The construction of our total costs measure is described more fully in previous reports (Eibner et al., 2023; Khodyakov et al., 2022). Costs to CMS for 2023 were not available at the time of this writing in 2024 because of data lags associated with key components of Part D costs. The Hospice Benefit component was not associated with a statistically significant change in total cost to CMS in either 2022 or 2021. Moreover, the estimated associations changed direction over time, with a non-statistically significant decrease of –$13 PMPM in 2022 ($p = 0.52$, 95% CI [– $45 to $22]) and a non-statistically significant increase of $7 in 2021 ($p = 0.70$, 95% CI [–$29 to $45]). PO questionnaire and interviews did not include questions about the impact of the Hospice Benefit component on costs to CMS.

Premiums

We analyzed the association of the Hospice Benefit component with total monthly premiums for MA and Part D coverage, which are one component of beneficiary costs. As described in Chapter 5, plan-level premiums were drawn from the approved plan data within the Health Plan Management System and reflect the final amount that plan enrollees would pay before the application of any Part D LIS premium subsidies.

Although the Hospice Benefit component was associated with a statistically significant $4.46 decrease in beneficiary premiums in 2021 ($p = 0.04$, 95% CI [–$9.24 to –$0.12]), the association was smaller and not statistically significant in later years (–$1.00 in 2022, $p = 0.057$, 95% CI [– $4.14 to $2.09]; –$1.24 in 2023, $p = 0.66$, 95% CI [–$6.34 to $4.13]).

Figure 12.2. Estimated Association Between the Hospice Benefit Component Interventions and Medicare Advantage Prescription Drug Premium



SOURCE: Author's analysis of CMS data.
NOTE: ***, **, and * represent statistical significance at the 0.1%, 1%, and 5% levels, respectively. "Without VBID" = the level of outcome that would have been observed among the VBID plans if they had not implemented the Hospice Benefit component, holding other factors constant. The black lines indicate a 95% confidence interval for level of outcome without VBID. Differences between the blue and gray bars correspond with VBID associations reported in the text, with slight variations due to rounding.

The findings from 2022 and 2023 that the Hospice Benefit component was not associated with statistically significant changes in beneficiary premiums are consistent with the results of our PO surveys, because representatives of all 14 POs that completed our survey reported that Hospice Benefit component participation did not affect premiums.

Number of Mandatory Supplemental Benefits

As described in Chapter 5, we counted the number of unique MSBs offered by plans in each year as reported in the publicly available PBP data. We found that the Hospice Benefit component was associated with a marginally significant increase of 0.74 MSBs offered in 2022

($p = 0.09$, 95% CI [–0.12 to 1.57]) but no statistically significant changes in other years (a 0.12 MSB increase in 2021, $p = 0.85$, 95% CI [–0.97 to 1.13]; a 0.57 MSB increase in 2023, $p = 0.19$, 95% CI [–0.28 to 1.44]).

We also analyzed the costs of providing MSBs and found that the Hospice Benefit component was associated with a statistically significant increase of $14.21 PMPM in MSB costs in 2021 ($p = 0.02$, 95% CI [$2.26 to $27.42]) but no statistically significant associations in later years (a $5.14 PMPM increase in 2022, $p = 0.21$, 95% CI [–$3.14 to $14.22]; a $2.97 PMPM increase in 2023, $p = 0.62$, 95% CI [–$8.57 to $15.05]).

Although most PO representatives responding to our survey (10 of 14) indicated no change in MSB costs, four reported an increase in these costs. During the interviews, several PO representatives, including those from POs P and X, said that hospice supplemental benefit costs contributed to the increases in MSB costs.

Summary

In keeping with the perspectives shared by most surveyed and interviewed PO representatives, we found little statistically significant evidence that the Hospice Benefit component was associated with changes in plan-level enrollment, financial outcomes, or MSB offerings. The only outcome that showed a statistically significant relationship with the Hospice Benefit component in multiple years was MAPD bids, which declined in both 2021 and 2022. Lower bids may have been driven by POs' expectations of reduced Part C service use among their hospice-enrolled beneficiaries. The absence of statistically significant reductions in MAPD bids in 2023 may indicate that POs no longer expect such meaningful reductions after they have gained experience with the Hospice Benefit component.

Part III: Looking Ahead

Chapter 13. Perspectives on Model Expansion

Key Findings

- PO representatives had mixed feelings about allowing VBID General benefits to become part of standard MA benefit design. Some argued that doing so would reduce plans' administrative burden and costs, eliminate the need for additional data-reporting, and facilitate communication with beneficiaries. Others reported that plans would have a hard time differentiating their benefit offerings from those provided by competitors and that some plans would not be able to provide the same benefits outside the model test.
- POs and hospices also had mixed perspectives on the expansion of the Hospice Benefit component. Some raised concerns about the need to invest additional financial resources to scale up the model, while others reported that the standardization of the Hospice Benefit across MA would help streamline billing processes, facilitate other administrative processes, and improve care coordination. However, both POs and hospices raised concerns that smaller, independent hospices might go out of business if they do not become in-network providers. Hospices also worried that the combined impact of increased administrative costs and reduced reimbursement rates could result in reduced comprehensiveness and quality of hospice care.

In this chapter, we use the results of our interviews with the representatives of participating POs and in-network hospices to highlight their perspectives on **potential model expansion**, which would allow POs to incorporate VBID benefits into their standard benefit design.

Parent Organization Perspectives on VBID General

Representatives of POs participating in VBID General held differing views on model test expansion. Those in favor of expansion said that doing so would eliminate the need to submit model test applications annually and eliminate model-specific reporting requirements (POs C, N, AX, AW, BE, and BF). According to a PO AW representative, making VBID General part of the standard benefit design

> would be less work for a lot of people if we didn't have to go through the VBID application and reporting process, so I think there is some administrative cost savings potential. I also recognize that CMS has rules they have to follow, and so they can't just give the health plans carte blanche to go do what they want to do. . . . [But] if so many of the plans are doing the same benefit and have been using that same benefit for a series of years, then maybe it just becomes a standard supplemental benefit option, and you don't have to go through the VBID process to get there.

As described in Chapter 3, many POs experience application and reporting requirements as a key implementation challenge. Therefore, it is not surprising that the representatives of six POs specifically called these requirements out in the context of potential expansion. One PO BF representative said,

> I do wish that we could offer the benefits without actually having to do all the additional reporting requirements, just to be completely transparent. Because we're trying to do something that benefits the member in the long run but as we've mentioned, some of the challenges that we've had with materials and

> things of that nature, I think it would be great if it could be something that could be offered just under the general plan.

Representatives of three other POs said that if VBID-enabled supplemental benefits are incorporated into standard plan benefits, it would help them with marketing review and communication with beneficiaries and providers. According to a PO AG representative,

> Having these benefits as a VBID benefit and be subject to multiple disclaimers and just different administrative requirements I think creates a burden to the plans. On one hand, it makes the communication about the benefit more challenging across the board, especially in the type of plan that we are, where we may have multiple OTC offerings. So, creating materials that then have to be communicated differently for different plans, it's complicated for customer service to explain. It's complicated for just printed materials.

Because VBID benefits are often available only to certain beneficiaries in a plan, providers and beneficiaries are not always aware of the benefits that are available. According to PO Y representatives, it would be easier for providers to spread the word about supplemental benefits to their patients if anyone in a given plan is eligible to receive the benefit.

When asked about the potential drawbacks of incorporating VBID benefits as part of standard plan benefit design, some PO representatives said that plans would have a harder time differentiating themselves from their competitors because their benefits would look more similar. "Once you lose a little bit of the flexibility of the CMMI [Model test] umbrella, things become standardized. And when they become standardized, it becomes harder to be an outlier, even if you're an outlier in a positive way to the members," said a PO AF representative. PO U representatives raised a similar concern about the flexibility to offer tailored benefits being important to plans and beneficiaries:

> I think it is very beneficial to have the flexibility to customize based upon your demographic, SDOH, conditions. All of those factors differ from plan to plan, even within the plan itself. I think it helps the members themselves. . . . [I do not want plans] to have to offer a standard VBID [benefit] every year. I think that would take away some of its customization and have an impact on outcomes because it would affect other things that you're able to offer.

Some POs that offered supplemental benefits and Part D benefits in DSNPs brought up the financial feasibility of making VBID General benefits available as part of the standard benefit design. Although those offering supplemental benefits were generally in favor, PO AB representatives said that the risk score calculation should be updated to reflect SDOH and health-related social needs (HRSNs) to allow DSNPs to offer VBID General benefits as part of the standard benefit design:

> Health plans would be all for it . . . but it is going to be financially improbable to do that without stealing from other important benefits: dental, transportation, meals, vision, hearing, those types of things. [U]ntil we're ready to include elements of these particular HRSNs or SDOH in a risk score report and modify,

> then basically, we're just asking the health plans to figure out how they cut places and give the benefits to members in other places.

POs AZ and BK, both of which offered zero-dollar cost-sharing for Part D drugs in DSNPs, were opposed to making VBID benefits a standard part of plan benefit design because doing so would mean that plans would lose LICS payments:

> Part of the main reason why we go for the VBID route to offer this benefit is because this is the only channel that we can use to continue to receive the subsidies from [the] federal government for the reinsurance and the low-income premium subsidy. Because if we were to go through the regular bid route, this would be considered an enhanced benefit on a regular MAPD bid. Then we would lose all of the subsidies from [the] federal government. That would cost us way more to offer this benefit for our dual-eligible population. (PO AZ)

Parent Organization Perspectives on the Hospice Benefit component

We interviewed POs in 2023, prior to CMS' March 2024 announcement that the Hospice Benefit component would conclude at the end of 2024. During the 2023 interviews, at least six POs expressed support for the expansion of the Hospice Benefit component to all of MA. Representatives of POs G and BI noted the value the expansion could bring to beneficiaries, and representatives of POs L and M explained that the standardization of the benefit would promote consistency and clarity for both POs and hospices. A representative of PO L said,

> Some of our implementation problems would be much less if this was a standard benefit because there would just be a lot less confusion if everybody recognized that if somebody was in an MA plan, the MA plan was paying the claim. All of our operations teams would get that. All the hospice agencies would get that.

One PO M representative also highlighted the value of being able to "see all aspects of the patient" throughout their care trajectory. In contrast to prior years of this evaluation, no POs specifically mentioned TCC as a rationale for expanding the Hospice Benefit component.

A number of POs, including POs P, W, and AJ, indicated that they were uncertain about whether the Hospice Benefit component should be expanded or were withholding judgment on the issue until they could observe more outcomes. Representatives of four POs emphasized the importance of the hospice network structure to the success of the model. A representative of PO P commented, "Until we test a narrow network, it's really difficult for us to understand how we would operationalize and scale in a viable way." A PO BE representative stated that "the only way that this is a functional model, is if we can steer patients to in-network hospices that provide quality care." A PO V representative agreed, noting that closed networks will "better position us as a plan to more effectively coordinate, manage the care, [and] offer TCC more broadly, because we continue to see that a lot of members are choosing to receive hospice out of network."

Representatives of two POs acknowledged that hospices could be adversely affected by narrower networks because, as a PO W representative put it, "[I]f you start closing networks, a

lot of hospices will go out of business." One PO X representative pointed out that smaller, independent hospices would likely be the most affected by such closures, particularly if larger health plans prioritize having hospices that they own in their networks.

PO representatives also mentioned other challenges to expanding the Hospice Benefit component. Three POs anticipated needing to invest considerable resources to scale up the model. As a representative of PO G put it, "We have such a hands-on approach to the members and the providers that we have today that making it nationwide, the team would have to be substantially bigger to be able to support the full population."

Representatives of PO L cited the "significant amount of technical spend and effort" that POs would need to invest to build payment methodologies for hospice, "since it's never been part of the MA program, it's never been on anyone's radar," and "it's turned out to be a lot harder than we thought it would be." PO L representatives also noted that hospices would have to build systems to address the complexity of billing multiple POs.

Hospice Perspectives on the Hospice Benefit component

We also interviewed hospices in 2023 about their perspectives, prior to CMS' March 2024 announcement that the Hospice Benefit component would conclude at the end of 2024. During the 2023 interviews, representatives of five of ten interviewed in-network hospices cited the advantages of the Hospice Benefit component, including improved care coordination to address beneficiary needs (Hospices AI, AK, AM, and AO), better ability to reconcile medications (Hospice T), the addition of TCC and Hospice Supplemental Benefits (Hospice AK), and less disruption for beneficiaries (Hospice AO). A representative of Hospice AI said,

> I do think there is a benefit to hospices working a little bit closer from a partnership perspective when they have patients who are high risk. . . . I think any type of collaboration benefits the patient and/or the family. . . . There is a lot of communication, [and] there are some benefits to that too, especially if you have a challenging family or a patient. Being able to pull in an additional resource to help provide education and support to the family can be really helpful.

However, in keeping with hospice perspectives in prior years, representatives of nine of ten in-network hospices we interviewed in 2023 expressed concerns about the expansion of the Hospice Benefit component, most notably about financial pressures on hospices, the administrative burdens of contracting with multiple POs, and the potential effects on the comprehensiveness and quality of hospice care.

Echoing concerns expressed by some POs (previously described above), representatives of five hospices noted that the combined financial pressures of reduced reimbursement rates and being left out of PO networks were likely to cause some hospices—particularly smaller, independent organizations—to go out of business. One Hospice AM representative reported being "concerned about . . . the little hospices," noting that "they are not getting any VBID

contracts. They're going to disappear." A representative of Hospice AL described the dynamic in the following way:

> I just worry that only big hospices are going to be able to care for patients that have Medicare Advantage plans eventually. And that's going to limit the amount of good care that patients can get. . . . And a lot of these insurances say, oh, well, we've closed our panel, we have five hospices, and they're all the big players because we only wanted hospices that could serve every single one of our patients. . . . It definitely feels like they're going to contract with big players in order to have a limited amount of contracts and being able to provide this benefit because that's how insurances work.

Representatives of another group of five hospices anticipated that, should the Hospice Benefit component expand, hospices would need to take on considerable administrative effort and cost to contract with multiple POs. One Hospice AJ representative said,

> My biggest concern is [the] influx of administrative burden that is inherent with dealing with the multitude of insurances versus a single one. We bill them differently, we have to look at them differently, authorization and what they need from us is different. . . . Those things do change operations and how much you'd have to put into the office to get things through, and then that ultimately is money spent that doesn't get to the patient, right? That's one less social worker because you got to hire a different biller. . . . How much work do we put in routing the payments through various carriers, and how does that take away from what can be provided in the home?

Relatedly, other hospice representatives, including those from Hospices T, AJ, AK, AL, and AN, expressed concern that the comprehensiveness and quality of hospice care could decline as a result of the combined impact of increased administrative costs and reduced reimbursement rates. One Hospice AK representative described the concern in the following way:

> Right now, the Medicare Advantage plans are required to provide the care delivery model consistent with the traditional Medicare benefit. I do fear a little bit that if we fast forward, the Medicare Advantage plans may not be as inclined to want to support certain benefits that are part of the traditional Medicare benefit today, like bereavement services, volunteer services, or an inpatient hospice residence.

Finally, two hospices noted that, should the Hospice Benefit component be expanded, POs would face a considerable learning curve to better understand hospice care and develop systems to support hospice payment. One Hospice A representative noted that POs currently lacked the "sophistication" to "get involved with okaying the number of nursing visits, okaying the number of social visits." One Hospice AO representative noted that hospice is "a whole different clinical venue for [POs] to even be able to process the information that hospices are giving them."

Representatives of some hospices, including Hospices AL, AM, and AO, suggested that the standardization of covered benefits and payment would help relieve administrative burdens, whereas representatives of Hospices T, AM, and AN argued that educating both the general

public and health care providers regarding the role and value of hospice care would help promote greater adoption of Hospice Benefit component services.

Summary

VBID General participants expressed mixed views on expanding the model test and including VBID General benefits as part of the standard MA benefit design. Those in favor argued that expansion could reduce administrative burdens by eliminating the need for annual model test applications and model-specific reporting requirements, reduce plan administrative costs, and make it easier to communicate benefits to beneficiaries and providers. However, some POs were concerned that making VBID benefits part of the standard benefit design might reduce their ability to differentiate from competitors and tailor benefits to specific groups of beneficiaries. There were also concerns about the financial feasibility of offering zero-dollar cost-sharing for Part D drugs to low-income beneficiaries in DSNPs outside the model test because VBID allowed participating plans to keep receiving LICS payments, even if they reduced Part D cost-sharing for their LIS-eligible beneficiaries.

Prior to CMS' announcement to conclude the Hospice Benefit component in 2024, several POs supported the expansion of the benefit, citing such benefits as the standardization of billing processes and increased clarity for POs and hospices. Other POs, however, were cautious, emphasizing the need for more data on model outcomes, the need to invest considerable resources to scale up the model, and the need to have closed or restricted hospice networks to promote model success. Hospices also expressed mixed opinions regarding model expansion. Although some commented that Hospice Benefit component expansion could positively impact care coordination at the end of life, others were concerned about the financial pressures, the administrative burdens of contracting with multiple POs, and reduced comprehensiveness and quality of care resulting from the combined impact of increased administrative costs and reduced reimbursement rates. Both POs and hospices noted the potentially negative impact of hospice networks on smaller, independent hospices, which could be excluded from networks and go out of business.

Chapter 14. Conclusions

The VBID Model test offers POs the opportunity to implement a variety of benefit design innovations in their MA plans, such as VBID Flexibilities (which include reduced cost-sharing for high-value Part C and Part D benefits and VBID-enabled supplemental benefits), RI programs, and a variety of services for hospice-eligible beneficiaries. Many of these benefit design innovations can be targeted based on enrollees' chronic conditions or SES; WHP must be offered to all beneficiaries in VBID-participating plans.

Participation in the model test, which is voluntary, grew substantially over time, with the total number of VBID General plans increasing by over 800% between 2020 and 2023, and the total number of Hospice Benefit component plans roughly doubling between 2021 and 2023. Most participating POs were state-based organizations, and about one-half were for-profit organizations. Compared with nonparticipants, VBID POs were more likely to offer plans in nine or more states and to be located in areas with high MA penetration. One particularly striking trend has been the large influx of DSNPs into the model: By 2023, 82% of eligible DSNPs had entered the model test.

VBID General

In 2023, 1,218 plans participated in VBID General, and many of those plans offered multiple VBID interventions. Reduced cost-sharing for Part D prescription drugs was the most implemented intervention in 2023 (947 plans), followed by VBID-enabled supplemental benefits (649 plans), RI programs (582 plans), and reduced cost-sharing for Part C services (267 plans). This marks a shift in the most-offered VBID General intervention to Part D reduced cost-sharing; previously, the most-offered model test benefit was RI programs. About one-half of all VBID General plans targeted their interventions based on chronic conditions, and the other one-half targeted their interventions based on SES. However, there was a stark divide in targeting approach based on participating plan type: The vast majority of plans that targeted their interventions based on SES were DSNPs, and most plans targeting their interventions based on chronic conditions were non-DSNPs.

Most POs reported that VBID General implementation was a small lift. Although the implementation of Part D interventions went relatively smoothly, the implementation of card-delivered supplemental benefits—the most common VBID-enabled supplemental benefit offered in 2023—was much more challenging. Model-specific data-reporting requirements, working with vendors, communicating with beneficiaries, and administering multiple sets of benefits within a plan remained either moderately or slightly challenging to POs.

Our findings suggest that VBID General had mixed effects on the outcomes evaluated. Model implementation was associated with increases in overall Star Ratings, domain-level Star Ratings related to chronic disease management, and beneficiary adherence to certain high-value drugs and breast cancer screening recommendations. The model was also associated with reduced Part D OOP costs for beneficiaries. These findings are consistent with VBID's goal of improving adherence to recommended care and reducing beneficiary costs. However, the model was associated with increases in total costs to CMS. Higher costs were driven by higher rebate payments to VBID-participating plans and higher risk scores, which adjust payment levels to account for beneficiaries' expected spending. Standardized plan bids, which capture the health care and administrative costs of covering a population with a standard level of risk, declined.

The association of the model implementation with increased risk scores occurred at both the plan and beneficiary level and was present in multiple years. Increases in risk scores could be beneficial if the model is catching medical conditions that would have otherwise gone undetected. However, it is also possible that the model enables plans to code risk scores more intensively than they would have otherwise, without necessarily improving patient care. CMS adopted a new risk adjustment methodology in 2024 that removed certain diagnoses found to be more frequently coded in MA than Original Medicare and might not accurately reflect beneficiaries' underlying need (Seshamani, 2023).

One surprising finding is that VBID General was associated with increased non–COVID-19-related hospital inpatient utilization in both 2020 and 2021. Conceptually, one of the goals of VBID is to reduce beneficiaries' need for high-intensity treatments, such as inpatient stays, through better management of chronic conditions. However, some studies have found that increased access to high-value care can increase the use of inpatient services and low-value care, possibly due to providers recommending additional treatments (Cliff, Hirth, and Fendrick, 2019; Kaestner and Lo Sasso, 2015). It is possible that, as beneficiaries became more engaged with their care and had more interactions with the health system, their care managers and physicians may have identified a latent need for inpatient services. Although we limited the analysis to hospitalizations unrelated to COVID-19, it is also possible that unmodeled pandemic-related utilization changes may have affected our results.

The Hospice Benefit Component

In 2023, 15 POs and 112 plans participated in the Hospice Benefit component of the VBID Model. Four POs exited the model in 2024, citing administrative burdens. POs and hospices reported mixed implementation experiences, saying that they had to invest considerable resources to participate in the Hospice Benefit component and that they anticipated needing to make greater financial and staffing investments should VBID beneficiary volume increase (for example, in a full carve-in of hospice to MA). Only POs and hospices that had more than one year of experience with the model reported that Hospice Benefit component implementation was

not too burdensome in 2023. Despite growing experience with the model over time, administrative processes, particularly those related to claims submission and adjudication, were still challenging in 2023 for both POs and hospices. In particular, hospices expressed concern about delayed payments, data-reporting and communication requirements that vary across POs, and their ability to cover the costs of providing all required services under the lower-than-FFS payments offered by some POs (the ones with the largest enrollment). Several hospices cited payment rates as their major concern about the model, noting that they agreed to join PO networks despite pay cuts to ensure that they could continue to care for MA beneficiaries and maintain their long-term business viability. This concern was particularly important to hospices in service areas with high MA penetration.

Although POs reported making efforts to identify beneficiaries eligible for palliative and hospice care early in their disease trajectory, the utilization of Palliative Care, TCC, and Hospice Supplemental Benefits remained low. Moreover, we found few statistically significant or marginally significant associations between the Hospice Benefit component and hospice enrollment, care patterns, or such quality indicators as LOS, live discharge rates, or reported care experiences. Even when the results were statistically significant or marginally significant, these associations appeared in only one year and were generally not robust to sensitivity testing, weakening our confidence in these findings.

Overall, our evaluation suggests that the Hospice Benefit component changed the administrative and payment processes for the delivery of hospice care to MA beneficiaries, but there is little evidence yet that it changed the care they received before or after electing hospice.

Implications and Next Steps

VBID General continues to show promise in terms of improving beneficiary adherence and quality of care, but it is also associated with higher costs to CMS, driven in part by higher risk scores. Although higher risk scores could be appropriate for some beneficiaries, a growing body of literature suggests that payment incentives could spur MA plans to seek opportunities to code diagnoses intensively, regardless of beneficiaries' underlying need (Geruso and Layton, 2020; Jacobs, 2024; Meyers and Trivedi, 2021). Beginning in calendar year 2025, CMS signaled that it will more closely track risk score trends in VBID-participating plans (CMS, 2023).

Also starting in 2025, CMS will make other substantial changes to the VBID Model. For VBID General, these changes include an option to target benefits based on an area-level deprivation index and a requirement that participating plans offer at least two supplemental benefits that aim to address health-related social need.

CMS will discontinue the Hospice Benefit component in 2025. Our findings suggest that, despite clear conceptual reasons to believe that the hospice carve-in could improve the continuity of care for beneficiaries, low plan participation rates in this voluntary model, a slow uptake of

model benefits, and challenges related to payment and administrative issues may have kept the Hospice Benefit component from reaching its full potential.

In future reports, RAND researchers will assess the impacts of these changes and continue to evaluate the model's evolving effect on core outcomes, including health care quality and costs to CMS.

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