

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

First Two Years of Implementation (2020–2021)

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About This Project Report

This report presents the RAND Corporation team’s findings from its evaluation of Phase II of the Medicare Advantage (MA) Value-Based Insurance Design (VBID) model test, initiated by the Center for Medicare & Medicaid Innovation (CMMI), for the years 2020 and 2021. VBID allows participating MA parent organizations (POs) to offer supplemental benefits and financial and nonfinancial incentives to beneficiaries, hospice benefits (an MA hospice benefit, palliative care, transitional current care, and hospice supplemental benefits), and wellness and health care planning (WHP) 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. Other VBID benefits must be offered to all beneficiaries within a VBID plan.

In this report, we describe findings from interviews with representatives of both participating and nonparticipating POs, vendors, and in-network and out-of-network hospices. We also report initial findings on the estimated association between VBID and a variety of key outcomes for 2020 and 2021, given data availability. We analyze outcomes including beneficiary participation, enrollment, bids, premiums, and projected costs of supplemental benefits to the Centers for Medicare & Medicaid Services (CMS). A separate appendix provides additional information on research questions, 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.

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Summary

EVALUATION HIGHLIGHTS

Phase II of the Medicare Advantage Value-Based Insurance Design (MA VBID) Model test started in 2020. Parent organizations (POs) that volunteered to participate could implement different Benefit Design Innovations (BDI), including VBID Flexibilities, Rewards and Incentives (RI), and Cash or Monetary Rebates (2021 and 2022 only). Starting in 2021, participants could also implement the Hospice component, which includes palliative care, transitional concurrent care, and hospice supplemental benefits.

Targeting



- POs could target VBID Flexibilities, RI, and hospice supplemental benefits to beneficiaries with certain chronic conditions or based on socioeconomic status (SES). Targeting based on SES increased over time. POs could also make the receipt of VBID Flexibilities and RI conditional on participation in care management.

PO and Plan Participation



- PO and plan participation in the BDI component grew substantially between 2020 and 2021, but participation among targeted beneficiaries was low (10–12 percent) in plans with participation requirements.
- Uptake of the Hospice component was low among eligible POs and plans during the first year of implementation. The number of beneficiaries in participating plans who received hospice care was comparable to 2020.

Implementation and Outcomes

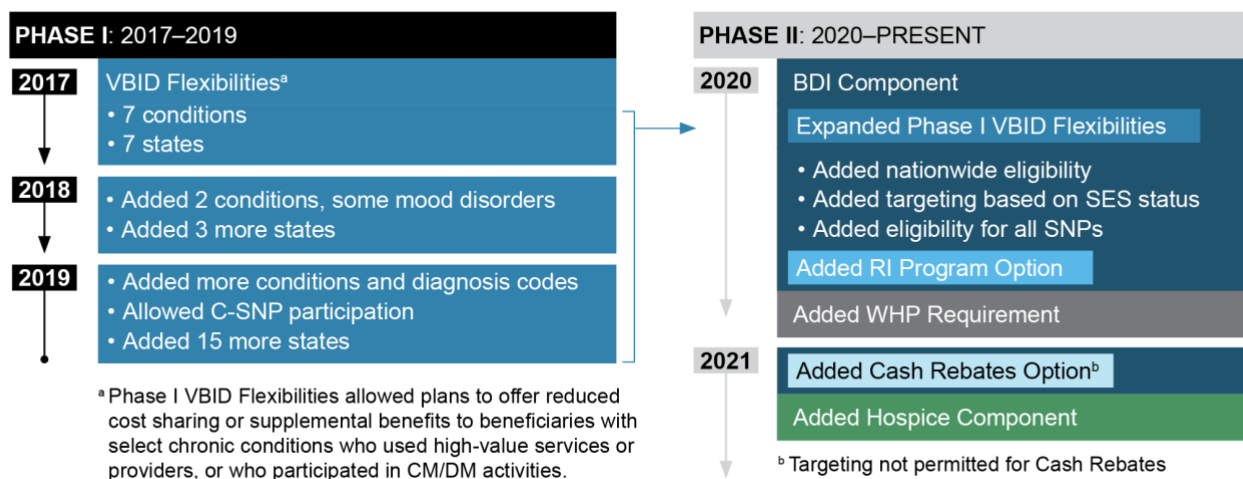


- POs generally reported that implementation went more smoothly for BDI than the Hospice component.
- In 2021, BDI implementation was associated with a marginally significant increase in enrollment, statistically significant declines in per-member per-month (PMPM) MA Prescription Drug (MAPD) bids, and statistically significant increases in premiums and projected costs of mandatory supplemental benefits. Of these, the increase in the cost of supplemental benefits was the most substantial, representing a 23 percent increase. The estimated change in the average monthly premium was the next largest effect, representing an 8 percent increase.
- Estimates of enrollment, combined MAPD bids and premiums, and the projected cost of mandatory supplemental benefits did not change significantly with Hospice component implementation in 2021.

In January 2020, the Centers for Medicare & Medicaid Services (CMS) began a new phase of a voluntary Medicare Advantage (MA) Value-Based Insurance Design (VBID) model test to offer a variety of innovative benefit design options to certain enrollees of participating MA plans. The concept of VBID originated in employer insurance plans and has traditionally aimed to increase the use of high-value services for people with specific chronic conditions, such as by reducing co-payments for statins for people with high cholesterol. Phase I of the model test, which ran from 2017 through 2019, marked the entry of VBID into MA and thus the expansion of value-based benefits to people ages 65 and older who are enrolled in MA. In the first phase, the model test allowed eligible MA parent organizations (POs) that volunteered to participate to tailor their benefit designs to offer reduced cost sharing for high-value services and providers, additional supplemental benefits, or incentives to use care management (CM) or disease management (DM) to beneficiaries with specific chronic conditions. Initially, the model was available in certain states and was not available to Special Needs Plans (SNPs). As Phase I progressed, the scope widened to include additional chronic conditions and states eligible to participate; chronic condition SNPs (C-SNPs) became eligible to participate in 2019.

Phase II, which began in 2020 and will run through 2024, expanded the model test to all categories of SNPs and allowed POs to offer innovative benefits that go beyond traditional VBID through a Benefit Design Innovations (BDI) component and through a Hospice component (Figure S.1). In accordance with the Bipartisan Budget Act of 2018, Phase II also expanded the model to include all states and territories. Under Phase II, the options available in Phase I became a subcomponent of the BDI component called VBID Flexibilities and were extended to allow targeting to individuals based on socioeconomic status (SES), defined by eligibility for the Part D low-income subsidy (LIS) or for both Medicare and Medicaid in territories where LIS is not available, and those with chronic conditions. Other options available through the BDI component include allowing POs to offer Rewards and Incentives (RI) to beneficiaries to encourage the use of high-value care and to provide Cash or Monetary Rebates (called “Cash Rebates” in this report) to beneficiaries. The Hospice component allows POs to include the Medicare hospice benefit in their benefit packages. Participating plans must offer palliative care to eligible enrollees, make transitional concurrent care (TCC) available to enrollees who elect hospice through in-network hospices, and may offer hospice supplemental benefits. Phase II of the model test adds a requirement for participating POs to offer Wellness and Health Care Planning (WHP). These innovations retain the Phase I emphasis on encouraging beneficiaries to actively engage and participate in CM/DM and build on that through features that promote patient- and family-centered care; increase beneficiary choice and access to high-quality, timely, and clinically appropriate care; and reduce the cost of care.

Figure S.1. Timeline of the VBID Model Test



Benefit Design Innovations Component

The BDI component of the model test enables participating POs to tailor their MA plan offerings using one or more of the following approaches:

- **VBID Flexibilities:** Beginning in 2020, interventions using the VBID Flexibilities subcomponent may offer additional supplemental benefits, including primarily health-related benefits, non–primarily health-related benefits, or new and existing technologies or medical devices approved by the U.S. Food and Drug Administration to their beneficiaries. They may also offer reduced cost sharing for high-value medical items, medical services, or outpatient prescription drugs. These benefits can be
 - targeted to beneficiaries based on chronic conditions or SES
 - conditioned on using high-value providers or participating in CM/DM programs.
- **RI:** Starting in 2020, POs may establish RI programs that offer rewards and/or incentives to enrollees through, for example, gift cards to encourage activities that promote health, prevent illness and injury, and encourage the efficient use of health care resources. RI programs can be targeted to specific beneficiaries based on their chronic disease or SES, or they can be offered to all enrollees. While RI programs can be offered outside of VBID, the model test allows RI to be tied to Part D benefits—for example, by conditioning rewards on medication adherence. In addition, the model test allows the value of the reward to reflect the value of the health benefit of the activity, up to a maximum value of \$600 per year. Potentially, this approach enables POs to offer larger rewards through the model test than would otherwise be permitted.
- **Cash Rebates:** MA plans are eligible for a rebate from CMS if the projected cost of offering the plan (i.e., the bid) is below a geography-based benchmark amount, generally based on the cost of traditional, Fee-for-Service (FFS) Medicare. Rebate amounts are adjusted based on plans’ Star Ratings (i.e., quality scores), and plans must achieve a minimum overall Star Rating to receive a rebate. Outside of the model test, rebates must be incorporated into the plan benefit package, such as by lowering premiums, paying for supplemental benefits, or reducing beneficiary cost sharing. In 2021, participating POs could instead share rebates directly with beneficiaries as a cash benefit through the Cash Rebates subcomponent of the VBID model test. Unlike other BDI subcomponents, Cash Rebates must be offered to all enrollees and cannot be targeted based on chronic condition or SES. The Cash Rebates subcomponent of the model test was discontinued after 2022.

Hospice Component

Typically, hospice care is *carved out* of MA, meaning that it is paid through FFS Medicare and not incorporated into MA plans’ benefit packages. Starting in 2021, POs could participate in the Hospice component of the VBID model test, which allowed them to offer hospice benefits within MA through a network of hospices. The Hospice component is designed to consolidate overall financial responsibility and accountability for the cost, quality, and outcomes of MA enrollees in hospice, with the goal of improving care coordination. In addition to incorporating hospice care into their plans, POs offering the Hospice component must provide access to palliative care services for seriously ill enrollees who are not eligible for, or prefer not to receive, hospice services. They must also make available TCC services for those who are eligible for hospice, elect hospice through an in-network hospice, and wish to receive both hospice services and curative care. POs may define their own TCC eligibility criteria, such as offering TCC for

specific diagnoses. Participating POs may also offer hospice supplemental benefits, including items and services that extend beyond Medicare hospice care, such as additional respite care and access to additional in-home services, and they may target these benefits to enrollees with certain chronic conditions or based on their SES. The Hospice component is designed to encourage smoother and timelier transitions to hospice when appropriate and preferred, thereby promoting use of services that are aligned with beneficiary needs and preferences and reducing use of avoidable acute care services.

Wellness and Health Care Planning Requirement

All POs participating in the VBID model test must offer and promote the use of WHP services, which include advance care planning (ACP) and annual wellness visits, among other services, to all beneficiaries enrolled in their VBID-participating plans.

Approach to the Evaluation

The RAND Corporation is evaluating Phase II of the VBID model test along multiple dimensions over a base period that runs from 2020 through 2023 and an option period that extends to 2028. Though RAND also conducted evaluations of Phase I of the model test, it is important to note that the Phase II evaluation is substantially different from previous evaluations because of the greatly expanded scope of the model test. This report is the first annual report during the evaluation period, covering Phase II implementation of the model test during 2020 and 2021.

We conducted this evaluation using a mixed-methods approach that draws from the qualitative data we collected from participating and nonparticipating POs, vendors, and hospices; descriptive data analysis of beneficiary participation in the model; and regression analyses comparing outcomes in participating plans with a weighted comparison group of nonparticipants. Outcomes analyzed in this report include enrollment, plan bids, premiums, and the projected costs of mandatory supplemental benefits, which are additional covered items and services included in a plan's benefit package that go beyond what is included in FFS Medicare. In future reports, we will address additional outcomes, such as associations between the model test and changes in utilization and care quality, and we will incorporate additional perspectives on the model test, such as from beneficiaries.

Because the BDI and Hospice components are so different, not only in terms of benefits but also in terms of participating plans and beneficiaries, we conducted separate analyses for these components of the model test. Our regression analyses relied on a difference-in-differences (DD) framework, in which we compared VBID-participating plans with a comparison group designed to match the VBID participants on key dimensions. We weighted the comparison group using a procedure called entropy balancing, which ensured that the comparison group matched the VBID-participating group on the means and variances of selected characteristics (Hainmueller,

2012). We conducted analyses at the plan level. There were 140 plans participating in BDI in 2020, 377 plans participating in BDI in 2021, and 52 plans participating in Hospice in 2021. We compared these with 2,433 eligible nonparticipating plans, although the effective sample size varied with each analysis because of weighting.

Description of Participants

A total of 22 POs participated in VBID at some point during the first two years of Phase II by entering one or more plans into the model test. Relative to eligible nonparticipants, participating POs were more likely to have a national presence, had larger average enrollment, and tended to offer plans in areas with lower average income and higher MA penetration. Four of these POs had also participated in Phase I of the model test. We next offer more detail on participation by component.

BDI. Fourteen POs offered BDI interventions in 2020. In 2021, three of these POs left the model test while three new POs joined, leaving the total number of participants constant across both years. In 2020, the 14 participating POs offered 140 plans in the BDI component of the model test; this number grew to 377 plans in 2021. Relative to eligible nonparticipating plans, plans participating in the BDI component were more likely to be Dual-Eligible Special Needs Plans (D-SNPs) and, on average, had lower premiums and higher out-of-pocket (OOP) maximums. They also had a somewhat lower proportion of males and non-Hispanic White beneficiaries than eligible nonparticipants.

Hospice. Nine POs offered hospice interventions in 2021; some of these POs (four of nine) also offered BDI interventions. In 2021, POs using the Hospice component offered 52 plans in the model test. Those plans were more likely to be D-SNPs and to have \$0 premiums and lower OOP maximums than eligible nonparticipating plans. Plans participating in the Hospice component had a substantially lower proportion of non-Hispanic White beneficiaries, which could be attributed to several Puerto Rico–based plans that implemented this component.

Reasons for Joining or Not Joining

Our interviews with representatives of POs that participated in either the BDI or Hospice components in 2021 revealed three main reasons for joining the model test: (1) the model aligned with their organizational goals, (2) they valued the opportunity to offer additional benefits, and (3) they believed the model could improve health outcomes and health care quality. In contrast, nonparticipating POs (NPPOs) described reasons for staying out of the model test, including competing corporate priorities, resource constraints, perceived burden, uncertain return on investment, and concerns about beneficiary confusion.

In describing competing priorities, many NPPOs cited the ability to offer “VBID-like” benefits outside of the model test. Since 2019, CMS has made several value-based initiatives

available to all POs, enabling them to offer more-flexible benefits to their enrollees. These include the following:

- **Uniformity Flexibility (UF):** allows MA plans to offer reduced cost sharing or supplemental benefits to beneficiaries based on chronic disease status; these flexibilities apply only to medical items and services, not drugs
- **Special Supplemental Benefits for the Chronically Ill (SSBCI):** an opportunity for MA plans to offer additional benefits to beneficiaries who are chronically ill as defined by the Secretary of Health and Human Services based on the presence of medically complex comorbid conditions, high risk of poor health outcomes, and need for intensive care coordination (see the 2018 Bipartisan Budget Act, Sec. 50322)
- **New Primarily Health-Related Supplemental Benefits (PHRSBs):** an expansion in the definition of *supplemental benefits* that allows additional primarily health-related benefits, such as adult day care or home-based palliative care, to be offered to beneficiaries
- **Part D Senior Savings (PDSS):** a model test that allows MA plans to offer beneficiaries with diabetes a fixed, maximum \$35 co-payment for a one-month supply of insulin; participating plans also have the option of offering a Part D RI program to beneficiaries with prediabetes or diabetes.

More than 90 percent of MA plans entered into the model test by participating POs and the majority of all plans that were eligible but did not participate in VBID participated in at least one of these other initiatives (Table S.1). The other initiative offered most often was the new PHRSB option, followed by PDSS.

Table S.1. Participation in Other Initiatives, 2020 and 2021

Initiative (N, %)	2020	2020	2021	2021	2021
	BDI- Participating Plans (N = 140)	Eligible Nonparticipating Plans (N = 2,436)	BDI- Participating Plans (N = 377)	Hospice- Participating Plans (N = 52)	Eligible Nonparticipating Plans (N = 2,436)
Participation in at least one other initiative:	130 (93%)	1,911 (78%)	369 (98%)	51 (98%)	2,181 (90%)
UF	7 (5%)	136 (6%)	11 (3%)	27 (52%)	251 (10%)
SSBCI	13 (9%)	177 (7%)	74 (20%)	18 (35%)	442 (18%)
New PHRSB	130 (93%)	1,856 (76%)	366 (97%)	48 (92%)	2,000 (82%)
PDSS	N/A	N/A	120 (32%)	27 (52%)	740 (30%)

SOURCE: RAND analysis of publicly available PBP benefits data, MA VBID participation data, and the PDSS landscape file.

NOTES: N/A = not applicable. Numbers will not add up to the number of participating and eligible nonparticipating plans because plans can participate in multiple initiatives. Plans were assigned their 2021 identification (ID) to facilitate analysis across years, and data for plans that consolidated or split across years were rolled up to the 2021 ID. Eligible nonparticipating plans include all plans that were eligible in either year (2020 or 2021) and did not participate in the model test.

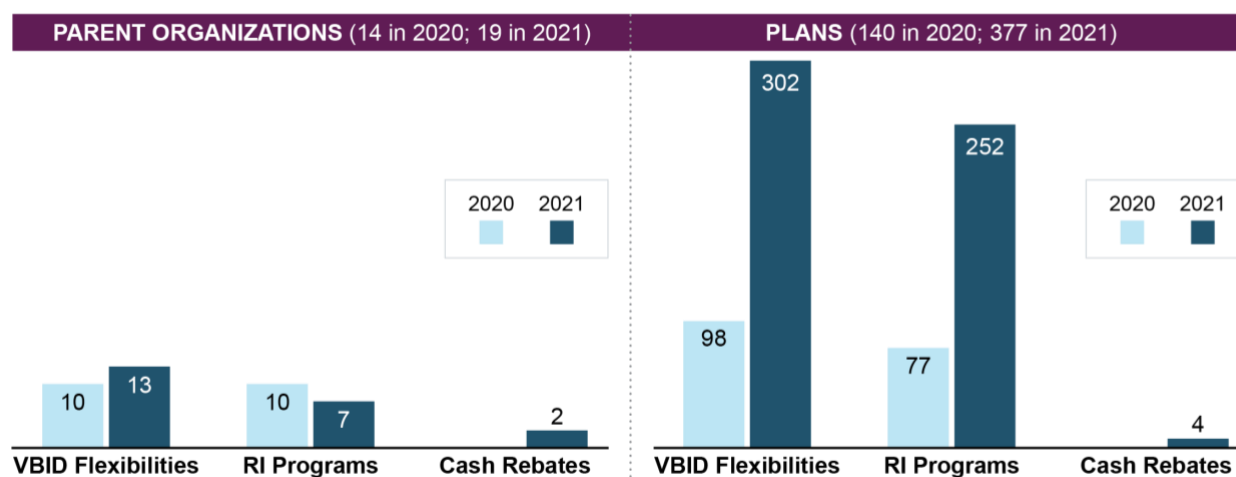
Findings Related to Benefit Design Innovations

Our analyses examined the types of BDI interventions offered, POs' experiences with implementing those interventions, and initial associations to be made between BDI interventions and changes in key outcomes including plan enrollment, bids, premiums, and provision of supplemental benefits.

Interventions

Figure S.2 shows the types of BDI interventions that were implemented in 2020 and 2021 by POs and plans. VBID Flexibilities was the BDI subcomponent offered most often in both years, followed by RI. Reduced cost sharing for high-value services and Part D–covered outpatient prescription drugs was the most commonly implemented category of VBID Flexibilities in both years. Only two POs implemented the Cash Rebates option in four of their plans; this option was available only in 2021. Note that the numbers in Figure S.2 do not sum to the total number of PO and plan participants; this is because some POs and plans implemented more than one intervention subcomponent.

Figure S.2. VBID BDI Interventions Implemented by Parent Organizations and Plans, 2020 and 2021



In both 2020 and 2021, POs implementing VBID Flexibilities and RI interventions were more likely to target beneficiaries with chronic conditions than beneficiaries eligible based on SES. POs targeting their interventions toward individuals with chronic disease, such as diabetes and heart disease, cited the high costs of these conditions and the significant risk of complications requiring hospitalization as reasons for their intervention focus. However, the number of plans targeting beneficiaries based on SES increased substantially, growing from 33 in 2020 (24 percent of BDI-participating plans) to 144 in 2021 (38 percent of BDI-participating

plans). Representatives of POs using this targeting criterion noted that these enrollees were relatively easy to identify within existing data; POs also expressed a desire to address social determinants of health, such as food insecurity.

Implementation Experiences

POs reported that the most challenging aspects of BDI component implementation included compliance with model test reporting requirements, working with vendors for intervention delivery, communicating about VBID to providers and beneficiaries, and incorporating CMS review of marketing materials into communication processes. However, on pre-interview questionnaires, PO representatives typically rated them as only “moderately” or “slightly” challenging, and most POs indicated in interviews that they did not view model implementation as burdensome.

PO representatives frequently cited corporate leadership support, cross-team functionality, and financial investments as the main facilitators of successful implementation of BDI interventions. They also stated that having a continuous quality improvement mindset was helpful.

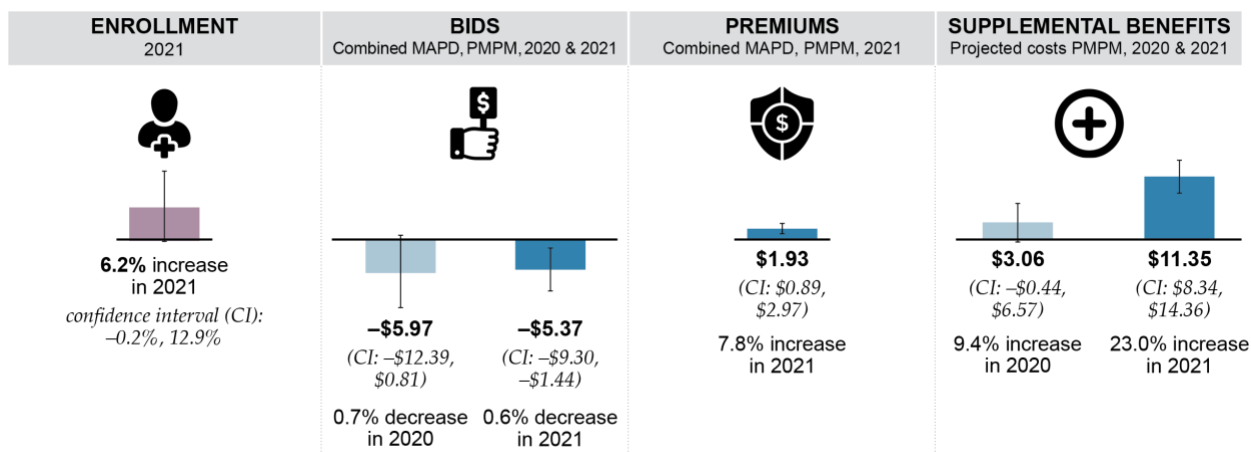
Views on whether the coronavirus disease 2019 (COVID-19) pandemic affected POs’ VBID interventions varied substantially, with some PO representatives seeing no apparent impact on implementation. Although pandemic restrictions clearly affected in-person service delivery, POs were often able to modify some of their services to allow beneficiaries to engage with providers remotely. PO representatives also observed some positive impacts from the COVID-19 restrictions, including increased use of telehealth services, greater engagement from beneficiaries who had more free time, and increased demand for farmers markets and mail-order pharmacy benefits.

Outcomes

Beneficiary participation in the model varied substantially across POs and the BDI components they implemented. Depending on the type of VBID Flexibilities offered, some eligible beneficiaries were required by POs to complete participation requirements, such as meeting with a care manager, to become eligible to receive VBID benefits. Indeed, more than 60 percent of plans that offered VBID Flexibilities in 2020, and about half of plans that offered VBID Flexibilities in 2021, conditioned the receipt of VBID benefits on completing activities such as CM/DM. In many cases, interactions with care managers were an integral part of the POs’ overall intervention strategy to improve care coordination. However, the percentage of beneficiaries who completed such requirements varied dramatically across POs, from less than 2 percent to nearly 98 percent in 2020, and from 4 percent to 97 percent in 2021. Similarly, for RI interventions, the share of eligible beneficiaries who completed the requirements to receive RI (such as completing a preventive screening) varied from less than 2 percent to nearly 97 percent in 2020 and from 5 percent to 78 percent in 2021.

We used DD models to analyze the association between BDI implementation and changes in enrollment, plan bids, premiums, and supplemental benefits provision in 2020 and 2021. These models allowed us to compare trends for these outcomes among participating plans with a weighted group of comparison plans designed to resemble participants along key dimensions including beneficiary characteristics, benefit design, and community-level factors. We anticipated that changes to these outcomes could materialize relatively quickly because they are driven by prospective decisions. For example, beneficiaries decide whether to enroll in an MA plan during an open enrollment period that occurs prior to the start of the plan year, based on the benefits described in the plan’s marketing materials, premiums, and other factors. Similarly, the per member, per month (PMPM) values for the bids, premiums, and projected costs of supplemental benefits are estimated prior to the start of the plan year, based on actuaries’ expectations about future costs. Next, we summarize the marginally statistically significant ($0.05 \leq p\text{-value} < 0.1$) and statistically significant ($p\text{-value} < 0.05$) findings related to the association between BDI implementation and these outcomes (Figure S.3).

Figure S.3. Summary of BDI Implementation Outcomes



SOURCE: RAND analysis of CMS and other data. The complete list of data sources and variables is in Table C.5 in Appendix C.

NOTE: MAPD = Medicare Advantage plan that includes Part D coverage.

Our DD models estimated the relationship between VBID and key outcomes over and above any general trend observed in comparison plans. We estimate that BDI participation was associated with a

- 6.2-percent increase in enrollment in 2021 ($p = 0.06$, 95% CI [-0.2 percent, 12.9 percent]), over and above the trend in comparison plans
- \$5.97 (0.7 percent) PMPM decrease in combined MAPD bids in 2020 ($p = 0.09$, 95% CI [-\$12.39, \$0.81]), driven by a \$7.30 PMPM decline in the MA bid ($p = 0.05$, 95% CI [-\$14.71, \$0.11])

- \$5.37 (0.6 percent) PMPM decrease in combined MAPD bids in 2021 ($p = 0.01$, 95% CI [−\$9.30, −\$1.44]). This change was driven by a \$8.78 ($p < 0.01$, 95% CI [−\$12.74, −\$4.81]) decrease in the MA component of the bid; Part D bids increased by a statistically significant \$4.77 ($p < 0.01$, 95% CI [\$3.73, \$5.81]) in 2021
- \$1.93 (7.8 percent) increase in combined MAPD beneficiary premiums in 2021 ($p < 0.01$, 95% CI [\$0.89, \$2.97]), driven partly by an increase in the Part D premium (\$1.53, $p < 0.01$, 95% CI [\$0.89, \$2.97]) and other factors such as an increase in projected spending on mandatory supplemental benefits and PO decisions regarding how to allocate rebates
- \$3.06 (9.4 percent) increase in PMPM projected spending on mandatory supplemental benefits in 2020 ($p = 0.09$, 95% CI [−\$0.44, \$6.57])
- \$11.35 (23.0 percent) increase in the PMPM projected costs of mandatory supplemental benefits in 2021 ($p < 0.01$, 95% CI [\$8.34, \$14.36]). While the trend in the projected cost of mandatory supplemental benefits increased in BDI-participating plans relative to comparison plans, in descriptive analysis, we found no evidence of differential growth in the number of benefits offered in participating relative to nonparticipating plans.

Overall, BDI implementation was associated with increases in enrollment, reductions in plan bids, increases in premiums, and increases in the projected cost of supplemental benefits relative to trends in comparison plans. The changes in enrollment nearly doubled the annual average increase in enrollment among VBID-participating plans, which grew by 7–8 percent per year in the pre-period (2017–2019). The increase might reflect that beneficiaries saw BDI offerings, such as reduced cost sharing and additional supplemental benefits, as a selling point, increasing their likelihood of joining participating plans. However, we have not yet interviewed beneficiaries to confirm this possibility.

We estimated that BDI was associated with a decline in MAPD bids, which is consistent with the requirements of the model test. Specifically, to participate, POs needed to project savings over the life of the model test. Lower bids could reflect POs' assumption that BDI will encourage beneficiaries to take a more active role in managing their health, potentially averting costly complications, such as avoidable hospitalizations and emergency department (ED) use. However, prior research outside of the model test has shown that POs might use benefit design to attract enrollees who receive high-risk adjustment payments relative to expected spending (Carey, 2017), which could also result in lower bids. This possibility might warrant further exploration, given the change in enrollment described earlier. However, compared with the size of the bid, the VBID-associated reduction was small, representing a decrease of less than 1 percent.

BDI implementation was also associated with a \$1.93 ($p < 0.01$, 95% CI [\$0.89, \$2.97]) increase in monthly beneficiary MAPD premiums in 2021. This change represents a small dollar value in many contexts (e.g., less than the price of a cup of coffee) but is nearly 8 percent of enrollees' monthly premium spending. The increase in premiums despite lower MAPD bids could partly reflect that Part D bids increased, regardless of the decline in the combined MAPD bid. In addition, the sharp increase in mandatory supplemental benefits costs, particularly for 2021, could contribute to this result. The cost of mandatory supplemental benefits is not included

in the bid, and plans generally must fund these costs through premiums or rebates. Of note, in CMS's request for VBID applications, participating POs were instructed to price the cost of VBID Flexibilities interventions as mandatory supplemental benefits (CMS, 2020b).

Accordingly, at least a portion of increased mandatory supplemental benefit costs associated with BDI interventions reflects costs associated with additional benefits for VBID-eligible beneficiaries only, rather than expanded availability of supplemental benefits to all enrollees. The implication is that beneficiaries who were not targeted by the plans' BDI intervention might face slightly higher premiums because of their plan's offer of additional benefits to other enrollees. However, a growing share of VBID-participating plans are D-SNPs, which generally offer VBID benefits to all enrollees.

Findings Related to Hospice Implementation

Our analyses also examined the features of the Hospice component interventions offered, POs' and hospices' experiences with implementing those interventions, and initial associations to be made between Hospice component interventions and changes in key outcomes, including utilization of in-network and out-of-network (OON) hospice services and plan enrollment, bids, premiums, and the projected cost of mandatory supplemental benefits.

Interventions

Nine POs implemented Hospice component interventions in 2021 in 52 of their plans. Most (five of nine) of the participating POs had an ownership stake in at least one hospice during the performance year. Participants were required to offer both palliative and TCC options to beneficiaries. Palliative care services, including consults, comprehensive care assessments, 24/7 access to interdisciplinary care teams, ACP, and psychological and spiritual support, were often provided through nonhospice providers rather than hospices. TCC, which was available to beneficiaries who elected to receive hospice care through an in-network hospice, typically included chemotherapy and radiation therapy for cancer patients and dialysis for end-stage renal disease patients. Participants could also offer hospice supplemental benefits to beneficiaries receiving care from an in-network hospice and target them only to beneficiaries with certain chronic conditions or low SES. Seven participating POs offered hospice supplemental benefits, which included elimination of cost sharing for hospice drugs and inpatient respite care, and access to additional in-home services. These POs chose not to implement additional beneficiary targeting criteria for hospice supplemental benefits.

Implementation Experiences

Representatives from POs offering interventions in the Hospice component reported that the model was challenging to implement, although experiences improved over time as they became accustomed to the model. In addition to setting up hospice networks, substantial investment was

necessary to ensure that staff within the PO and at hospices, as well as other providers, understood the new services offered by the model and who was eligible to receive these services. POs also had to configure new processes for identifying VBID-eligible beneficiaries, tracking Notices of Election (NOEs), processing and reconciling claims, overseeing care plans, and reporting required data to CMS. Two key implementation facilitators were having a strong commitment from PO leadership and well-functioning collaboration across multiple departments within the PO (e.g., claims processing, member services, enrollment).

Representatives of a sample of hospices that provided care to beneficiaries in VBID-participating plans described challenges regarding the administrative burden of identifying VBID-participating hospice beneficiaries and handling the submission of hospice claims. In addition, hospices mentioned challenges related to PO oversight and reporting requirements, as well as confusion and lack of clarity regarding which benefits are covered by TCC and for how long. Delays in claims approval were also a noted challenge. Hospices considered educating the hospice team and nonhospice clinicians about model eligibility and processes and having an open line of communication or prior relationship with the participating POs to be key implementation facilitators.

Representatives from both in-network and OON hospices indicated that the model test did not change how patients were referred to hospice or when hospice referrals occurred in beneficiaries' care trajectory. Some in-network hospices noted challenges in implementing PO-specific administrative and reporting requirements, given the limited impact on referrals and the generally low census of enrollees of a plan who were also part of the model test (see "Outcomes" discussion that follows).

PO and hospice representatives stated that the COVID-19 pandemic constrained hospices' ability to provide in-person services and also limited in-person interactions that could have helped facilitate strong relationships between POs and hospices. Both PO and hospice representatives described the pandemic as a major competing priority during the process of implementing the Hospice component.

Outcomes

The utilization of services offered under the Hospice component was low during 2021. For example, POs reported that a total of 2,596 beneficiaries received palliative care, which was lower than all POs' expectations. Some POs conveyed to CMS that they had difficulty in tracking and reporting palliative care use; this may have led to an underestimate of palliative care utilization for 2021. Just 146 beneficiaries used TCC across all plans entered into the model test by Hospice-participating POs. Across the seven POs that offered hospice supplemental benefits, a total of 525 beneficiaries received such benefits. In 2021, a total of 9,630 VBID beneficiaries across all POs received hospice care, similar to the number of beneficiaries in participating plans who received hospice care in 2020. Of these, 37.3 percent received care from in-network hospices and 62.7 percent from OON hospices. Although more beneficiaries received care at

OON hospices than in-network hospices, the median number of beneficiaries receiving care at each in-network hospice (ten) exceeded the median number receiving care at each OON hospice (two). These findings imply that in-network utilization was concentrated among a smaller number of hospices than OON utilization. This concentrated utilization might increase over time as PO hospice networks expand and CMS permits POs participating in the model to use a more traditional provider network approach.

In our DD models, we found no statistically significant associations between the plans' participation in the Hospice component and their total enrollment, MAPD bids, beneficiary premiums, or supplemental benefits costs. However, in examining MA bids separately, we estimated a statistically significant \$22.40 PMPM decline ($p = 0.01$, 95% CI $[-\$38.12, -\$6.68]$). These findings are consistent with the possibility that plans participating in the Hospice component anticipated higher utilization of palliative and hospice care and, as a result, expected lower utilization of costly inpatient and ED visits. (MA bids do not include the projected cost of hospice care, so observed changes in bids are not due to expected use of hospice.) However, in interviews with POs and hospices, some representatives commented that increases in the use of this type of care had not yet occurred. Because bids are developed prospectively, they are driven by expectations about future effects, which might lead to differences between the assumptions used in developing the bids and POs' experiences in the first year of implementation. The findings should also be interpreted with caution given the relatively small number ($N = 52$) of plans that participated in the Hospice component in 2021.

Findings Related to Wellness and Health Care Planning

Participating POs were required to offer WHP services to all beneficiaries in their VBID plans. Most viewed WHP activities as important offerings, and some mentioned that the model test encouraged them to expand their WHP services and to look for novel ways to deliver them, including using online platforms and increasing individual outreach activities. The majority of participating POs offered WHP services through multiple approaches such as a care management program, annual wellness visit, in-home assessment, and health risk assessment and through both representative-guided and self-guided services.

Because the majority of POs offered services similar to those intended for inclusion in WHP before the model test, the representatives we interviewed generally reported positive experiences with the requirements of the WHP component. POs reported that engaging beneficiaries in guided conversations about their preferences for end-of-life care that would eventually lead to the creation of a written document seemed to be a desirable strategy for WHP delivery. Challenges to implementation included tracking WHP service use accurately, communicating with providers about their delivery of WHP services, and addressing emotional and cultural barriers to ACP engagement.

Summary and Next Steps

CMS implemented the VBID model test to modernize the MA program and to allow participating POs to test a variety of benefit design options to reduce Medicare spending, increase the use of high-value care, enhance care quality, and improve beneficiary health. With the number of participating plans more than doubling between 2020 and 2021, it appears that interest in the model test has increased substantially since Phase II of the model test began. POs largely reported that implementation of BDI interventions went smoothly. Some POs had experience with elements of the BDI component through Phase I of the VBID model test, which may have facilitated their implementation during Phase II. POs might also be becoming more familiar with adding these benefits to their plans because multiple initiatives, including SSBCI, also allow POs to offer similar benefits outside of the model test. Likewise, most POs indicated that they were already providing WHP services and did not find the WHP component burdensome to implement. In contrast, the Hospice component was introduced in 2021 as an entirely novel feature of the model test. Perhaps not surprisingly, both POs and hospices described challenges with its implementation, although some of the difficulties subsided during the first year of experience with that component.

Initial results suggest an association between implementation of both the BDI and Hospice components and reductions in plan bids, which would be broadly consistent with the model's intention to reduce Medicare spending. However, plan bids are prepared prospectively—that is, they are based on actuarial projections and past experience rather than realized outcomes—so these results should be interpreted with caution. Conceptually, the goal of the VBID model test is to improve beneficiary health and to reduce costly complications that stem from poorly managed chronic conditions, socioeconomic barriers that might lead to suboptimal utilization, and poor care coordination. However, it is too early to assess the actual effects of the model test on beneficiaries' utilization, spending, and health care quality. As a practical matter, data from the initial years of Phase II implementation are not yet finalized. In addition, it might take several years for a meaningful relationship to develop between VBID and outcomes, because part of the goal is to stave off costly, downstream complications of chronic disease that might unfold slowly over a beneficiary's lifetime, and because POs are establishing new hospice networks and developing new approaches for identifying and delivering care to seriously ill beneficiaries.

As the evaluation of the VBID model test progresses, RAND will be able to probe deeper to assess the impacts of the model using a broader range of outcomes and a wider variety of perspectives, including from beneficiaries. These additional findings will be analyzed in future annual reports.

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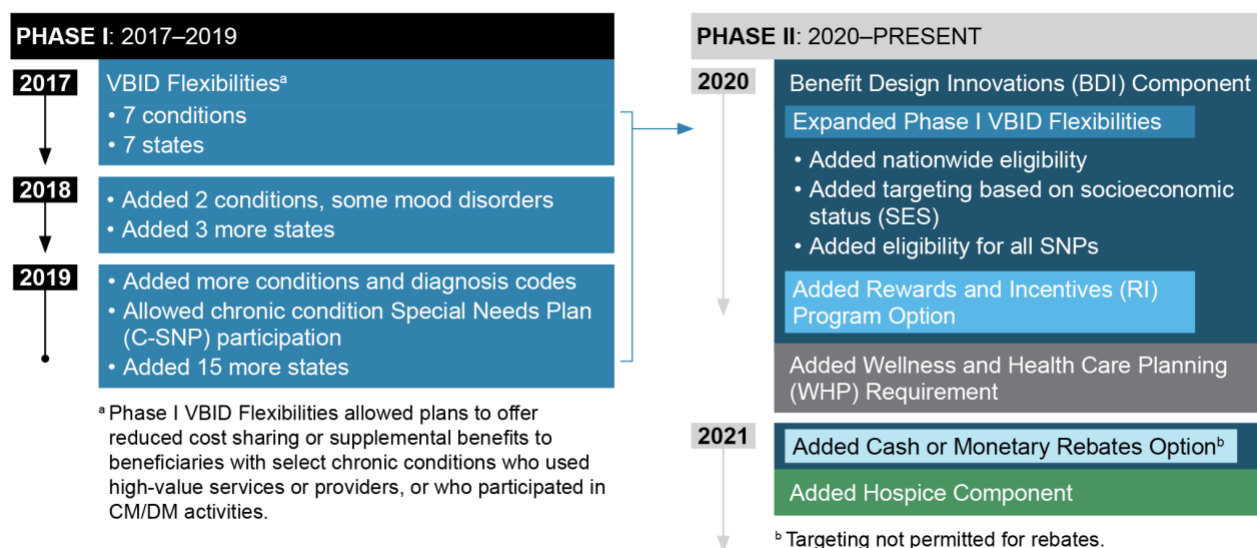
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PART I: SETTING THE STAGE

Chapter 1. Introduction

In January 2020, the Centers for Medicare & Medicaid Services (CMS) began a new phase of the voluntary Value-Based Insurance Design (VBID) model test to offer a variety of innovative benefit design options to certain enrollees of participating Medicare Advantage (MA) plans (Figure 1.1) (CMS, 2022b). Phase I of the model test (2017–2019) allowed MA parent organizations (POs) to offer reduced cost sharing for select Part C and D benefits, high-value providers, additional supplemental benefits, or incentives to use care management (CM) or disease management (DM) to encourage enrollees with targeted conditions to better manage their chronic disease. Private insurance plans outside Medicare had previously offered value-based benefits, but 2017 marked the first time such benefits had been offered in MA. We reported on the findings of the Phase I evaluation in prior reports (Eibner et al., 2018; Eibner et al., 2020). Briefly, Phase I was associated with increased use of more than half of VBID-targeted services, but we found few short-term effects on outcomes related to spending or health care quality.

Figure 1.1. Timeline of the VBID Model Test



Phase II of the VBID model test builds on the VBID Flexibilities offered in Phase I and adds new innovations to promote patient- and family-centered care; increase beneficiary choice and access to high-quality, timely, and clinically appropriate care; and reduce the cost of care. In addition to allowing POs to target reduced cost sharing, supplemental benefits, and CM/DM to beneficiaries with chronic conditions, Phase II of the VBID model test allows for direct sharing of rebates, financial RI programs; supplemental benefits that cover new and existing medical devices and technologies beyond what traditional Medicare can cover; and hospice benefits.

Medicare Advantage Primer

Throughout this project report, we use the following terminology as defined in the *Medicare Managed Care Manual* (CMS, 2016b).

Medicare beneficiary eligibility and entitlement

- Beneficiaries are entitled to Part A and eligible for Part B starting at age 65 or if they are disabled or have end-stage renal disease (ESRD); beneficiaries with both Parts A and B are eligible to enroll in an MA plan; starting in 2021, beneficiaries with ESRD may enroll in an MA plan

Key parts of Medicare

- **Part A** covers hospital care; this part of Medicare also pays for **hospice care** for those beneficiaries who elect hospice
- **Part B** covers physician visits and other outpatient items and services
- **Part C** is another term for MA, in which private insurers contract with CMS to provide coverage for hospital and physician services (Parts A and B) to beneficiaries who opt to enroll in MA insurance plans rather than traditional Medicare; MA plans can offer only Parts A and B benefits (MA-only plans) or offer plans that also include Part D (MA Prescription Drug [MAPD] plans)
- **Part D** is outpatient prescription drug coverage administered by private insurers either through a stand-alone prescription drug plan or through an MAPD

Plan structure and types

- **Parent organization (PO):** a legal entity with a controlling interest in one or more MA Organizations (MAOs), which are insurers that offer MA plans
- **Contract:** a suite of plans offered by the same MAO and governed by the same agreement with CMS
- **Plan:** a set of specific MA benefits offered to potential enrollees; plans are also sometimes referred to as plan benefit packages (PBPs)
- **Segment:** an offering within a plan that targets a specific geographic area and may offer differentiated Parts A and B benefits
- **Coordinated Care Plans:** an umbrella term that describes the types of MA plans offered, including local health maintenance organizations and local and regional preferred provider organizations; as the name implies, these plans are intended to coordinate care for enrollees, using provider networks and other mechanisms to encourage beneficiaries to seek care at in-network providers
- **Special Needs Plans (SNPs):** a type of MA plan that limits enrollment to certain special needs beneficiaries and offers specific care designed for the population; there are three types of SNPs, reflecting the types of populations they target: chronic condition, institutional, and dual-eligible

Benefit design

- **Bid:** the plan's projected cost of providing coverage for Medicare-covered (Parts A and B) services
- **Benchmark:** a county- or regional-level amount against which plan bids are compared; benchmarks are established annually by CMS and are generally based on average Fee-for-Service (FFS) costs for the area but are adjusted according to an individual plan's Star Rating and other factors
- **Rebate:** a proportion of any difference between the plan bid and the benchmark, when the bid is lower than the benchmark, that is returned to plans as an additional payment; plans must use rebate dollars to provide extra benefits to enrollees, such as lower cost sharing or supplemental benefits
- **Cost sharing:** the amount a beneficiary pays out-of-pocket (OOP) for a covered item or service
- **Premium:** the amount a beneficiary pays for receiving MA plan benefits; all Medicare beneficiaries eligible for Part B pay the Part B premium, regardless of whether they choose FFS Medicare or enroll in an MA plan; beneficiaries may pay an additional premium for enrolling in an MA plan; however, MA plans may also "buy down" beneficiary premiums, including Part B, C, or D premiums, using rebate dollars
- **Supplemental benefits:** additional covered items or services offered by a plan that are above and beyond the coverage offered by FFS Medicare (CMS, 2016a); there are two types of supplemental benefits:
 - **mandatory:** included in the benefit package and available to all plan enrollees
 - **optional:** available as "add-on" benefits to beneficiaries who elect them, for an additional premium

Extra help for beneficiaries

- **Low-income subsidy (LIS):** a subsidy for qualifying Part D enrollees in which CMS pays for premiums and cost sharing in part or total, according to four subsidy levels that are based on income
- **Help for "dual eligible" beneficiaries:** beneficiaries eligible for both Medicare and Medicaid are automatically eligible for the Part D LIS and may pay lower premiums and cost sharing for their MA benefits

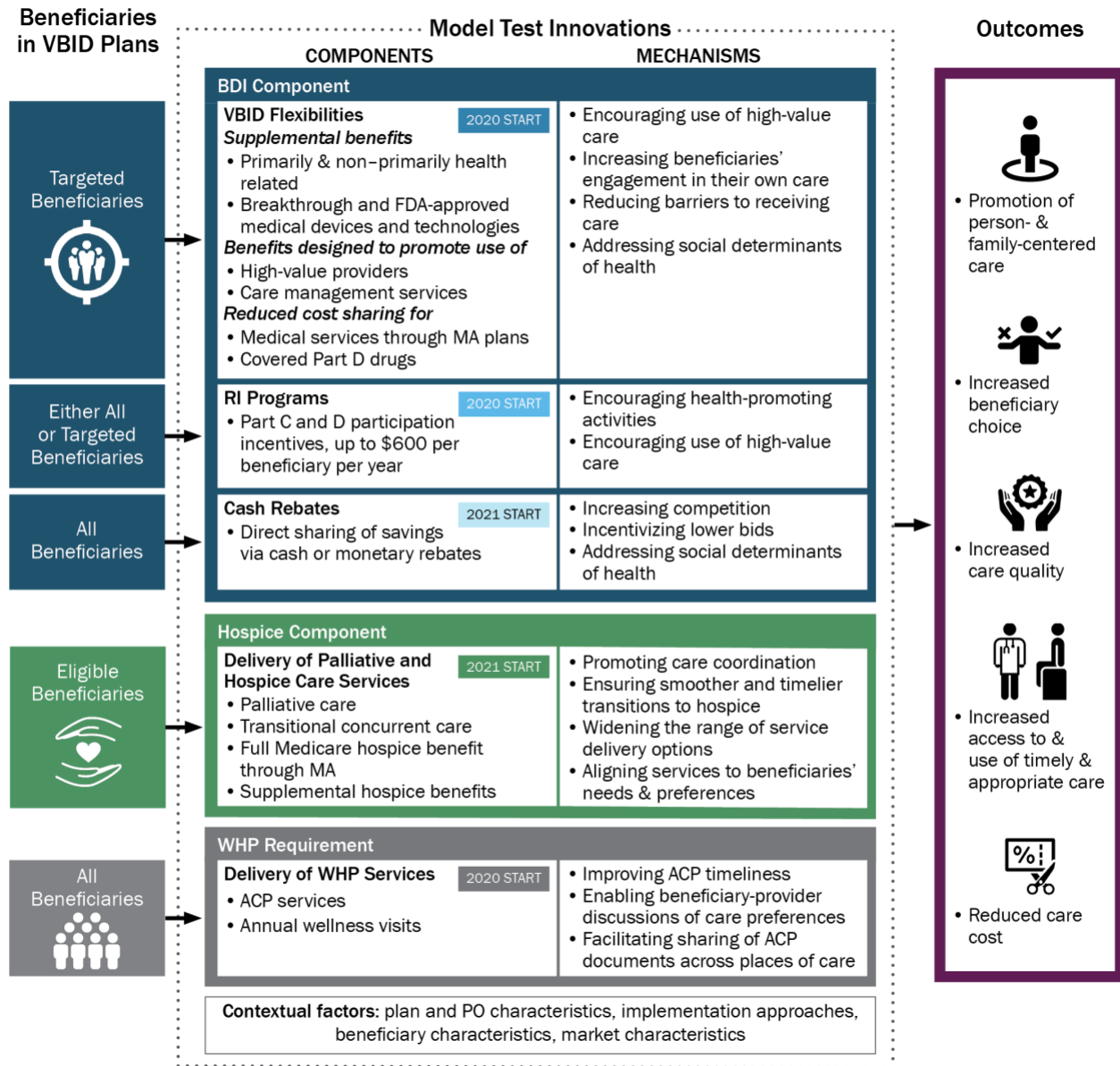
Phase II of the model test also allows POs to target VBID benefits based on socioeconomic status (SES), defined as being eligible for the Part D LIS or being dually eligible for Medicare and Medicaid in territories where LIS is not available, in addition to chronic condition status. All participating POs must now incorporate Wellness and Health Care Planning (WHP), which consists of offering advance care planning (ACP) and promoting the utilization of annual wellness visits, among other services, into their VBID benefits and offer them to all beneficiaries in their VBID-participating plans. Phase II of the VBID model test began in 2020, although the Cash or Monetary Rebate (called “Cash Rebate” in this report) and the Hospice benefit components were not made available until 2021. Phase II of the model test will run through 2024.

The RAND Corporation is evaluating Phase II of the VBID model test along multiple dimensions over a base period that runs from 2020 through 2023 and an option period that extends to 2028. Although this evaluation will draw some comparisons to experiences of stakeholders and outcomes of the first phase of the model test, the current phase is not a continuation of Phase I, and this evaluation should also be considered separate from the previous evaluation. This report is the first annual report for Phase II of the VBID model test, covering implementation during 2020 and 2021. The remainder of this chapter provides an overview of the model test and its participants, the research questions addressed in this report, a summary of the policy context in which this model test is occurring, an overview of the evaluation methods, and a synopsis of the report structure.

Model Test Overview

Benefits that POs could offer in the current phase of the VBID model test can be grouped into three components: BDI, Hospice, and WHP. Participating POs can offer BDI or Hospice benefits (or both) and—within each of those options—can customize their offerings. The breadth of design choices is particularly large within BDI, which enables POs to offer reduced cost sharing, supplemental benefits (including new and existing medical technologies), RI programs, and Cash Rebates. The Hospice component includes palliative care, transitional concurrent care (TCC), the Medicare hospice benefit, and hospice supplemental benefits. WHP is the only mandatory component of the model test. Figure 1.2 shows the overall conceptual framework of the VBID model test; it contains the key beneficiary groups targeted by the model, the intervention components, hypothesized mechanisms, and key outcomes. The outcomes examined in this report focus on the domains related to beneficiary choice (e.g., enrollment, participation in VBID) and costs (bids, premiums, and supplemental benefits costs). In future reports, we will consider other outcome domains, such as the effects on care quality.

Figure 1.2. Medicare Advantage VBID Model Test Conceptual Framework



NOTE: FDA = U.S. Food and Drug Administration.

Benefit Design Innovations Component

The BDI component includes VBID Flexibilities—most of which were available in Phase I of the model—RI, and Cash Rebates. Although Cash Rebates, if offered, must be provided to all of a plan’s enrollees, other BDI subcomponents may be targeted based on enrollees’ chronic conditions, SES, or both. The option to target benefits based on SES is a novel feature of the VBID model. This approach could lower barriers to care related to affordability concerns, which might be particularly acute for lower-income groups.

VBID Flexibilities

Through VBID Flexibilities, participating POs may offer supplemental benefits, promote the use of high-value providers or CM/DM services, or offer reduced cost sharing for high-value medical services delivered through MA plans and covered outpatient prescription drugs. Supplemental benefits can be primarily health-related (e.g., blood pressure cuffs or over-the-counter [OTC] items) or non–primarily health-related (e.g., transportation to nonmedical destinations). They may also incorporate coverage for new and existing technologies and medical devices approved by the FDA, including those not covered under traditional Medicare (e.g., continuous glucose monitoring devices for beneficiaries with diabetes). High-value care could include, for example, endocrinologist visits for those with diabetes or statin use for those with high cholesterol. Reduced cost sharing for prescription drugs for people with chronic conditions is a value-based approach that has been previously tested in the private sector (Agarwal, Gupta, and Fendrick, 2018; Choudhry et al., 2014; Hirth et al., 2016; Lee et al., 2013).

Rewards and Incentives

To encourage activities that promote health, prevent illness and injury, and encourage efficient use of health care resources, POs may establish RI programs that offer extra benefits to enrollees through, for example, gift cards. Outside of the model test, POs may offer such programs to their entire enrollee population (e.g., to encourage broadly recommended care, such as vaccines or preventive screenings). As part of the model test, however, POs can design targeted RI programs to specifically focus the incentives on certain groups of their enrollees. POs were advised to align the value of the RI offered with the value of the expected benefit of the encouraged service or activity, up to an annual limit of \$600. RI cannot exceed a value that would reasonably be expected to affect beneficiary behavior. Some restrictions apply; for example, POs may not use RI to reward beneficiaries for not taking Part D covered drugs.

Cash Rebates

Typically, CMS requires that rebates received by the plans as part of the bidding process be passed back to beneficiaries as additional supplemental benefits, reductions in cost sharing, or lower premiums. Starting in 2021, the VBID model test allowed plans to share some or all of their rebates with enrollees by directly passing them back as monetary transfers. We refer to Cash Rebates when discussing the direct monetary transfers allowed under the model test. POs that offer Cash Rebates must provide this benefit to all enrollees in the participating plan.

Hospice Component

Starting in 2021, POs could participate in the Hospice component, which allowed them to offer the traditional Medicare hospice benefit within Part C. The Hospice component is designed to consolidate overall financial responsibility and accountability for the cost, quality, and

outcomes of MA enrollees in hospice, to improve care coordination, and to reduce care fragmentation (Driessen and West, 2018; Medicare Payment Advisory Commission, 2020).

In addition to *carving in* the current Medicare Part A hospice benefit into MA-covered benefits, POs participating in the Hospice component must provide access to palliative care services for seriously ill enrollees who are not eligible for, or prefer not to receive, hospice services; must allow individualized TCC services for those who are eligible for hospice, meet PO-developed TCC eligibility criteria, wish to receive both curative care (i.e., treatment that has the intent of curing illness) and hospice services, and elect to receive hospice from an in-network hospice; and may offer hospice supplemental benefits . Supplemental hospice benefits may include a range of items and services that extend beyond Medicare hospice care, such as additional respite care and access to additional in-home services. By including palliative care and TCC services, the Hospice component is designed to encourage smoother and timelier transitions to hospice when appropriate and preferred, thereby promoting use of services that are aligned with beneficiary needs and preferences and reducing use of avoidable acute care services.

Wellness and Health Care Planning Requirement

POs must offer enrollees of VBID plans timely access to WHP services as part of the model's WHP requirement. ACP is a critical element of WHP for the VBID model test. ACP services might involve discussing care preferences with patients and their family members; completing advance directives, including a living will and durable power of attorney for health care (Carr and Khodyakov, 2007a; Carr and Khodyakov, 2007b); or completing a Physician or Medical Order for Life-Sustaining Treatment (POLST or MOLST) form (Institute of Medicine of the National Academies, 2015; Sudore and Fried, 2010). POs are also encouraged to promote the use of annual wellness visits and invest in infrastructure that can help them track the receipt of ACP services. Requiring POs to offer WHP services to all beneficiaries in their VBID-participating plans is expected to improve timeliness of ACP activities; encourage care preferences discussions between beneficiaries and their providers during annual wellness visits and the sharing of these conversations' outcomes with family members; facilitate sharing of ACP documents across sites of care; and, ultimately, improve the value and quality of care for beneficiaries by aligning care received with their preferences and goals.

Plan Eligibility Requirements

To enter the model test, plans must meet certain criteria related to plan type, length of existence, plan performance, and enrollment. Because VBID applications are due more than six months before the start of the VBID plan year, most of the data CMS uses to determine

eligibility come from one or two years before participation begins. Details on CMS’s eligibility criteria for all years of the model test can be found on the CMS website.¹

Model Participants

In total, 22 POs participated in the model test in 2020 or 2021 (or both). Participating POs were Blue Cross & Blue Shield of Rhode Island; Blue Cross Blue Shield of Michigan; Capital District Physicians’ Health Plan; CareOregon Inc.; Commonwealth Care Alliance, Inc.; CVS Health Corporation/Aetna; Hawaii Medical Service Association; HealthFirst, Inc.; Highmark; Humana; Intermountain Health Care, Inc.; Kaiser Foundation Health Plan, Inc.; Medical Card System, Inc.; New York City Health and Hospitals Co.; Presbyterian Healthcare Services; Sentara Healthcare; Summit Master Company LLC/InnovaCare Inc./MMM; Triple-S Management Corporation; UnitedHealth Group, Inc.; UPMC Health System; Visiting Nurse Service of New York; and Centene/WellCare Health Plans, Inc. Four POs continued their participation from the pre-2020 version of VBID, ten entered VBID in 2020 (though three exited the model test in 2021), and eight more POs entered in 2021. In 2020, there was at least one VBID-participating plan in 30 states and Puerto Rico. By 2021, the VBID plans were available in 45 states, the District of Columbia, and Puerto Rico.

Table 1.1 summarizes participation by year. In 2020, 14 POs participated, entering 140 plans into the model test. Several of these plans were consolidated in 2021, so for the purposes of analyses throughout the report, we have crosswalked plans to their 2021 counterparts, which reduced the number of plans that appear to have entered in 2020. More than 1.2 million beneficiaries were enrolled in plans that participated in 2020, although not all interventions targeted all enrollees within a plan (however, all beneficiaries were eligible for WHP services).

In 2021, 19 POs participated, entering 415 plans covering approximately 4.2 million beneficiaries, although—again—not all enrolled beneficiaries were eligible for each plan’s specific intervention (except for those enrollees in plans offering the Cash Rebates). Among 2021 participating POs, 14 offered options from the BDI component (13 offered VBID Flexibilities, seven offered RI, and two offered Cash Rebates), and nine offered Hospice benefits. (Four POs incorporated both BDI and Hospice components into their benefit designs, so the counts of offerings are not mutually exclusive.)

¹ Model test request for applications (RFA) from participating organizations can be found on the Center for Medicare & Medicaid Innovation (CMMI) section of the CMS website (CMS, undated).

Table 1.1. Summary of Participation, by Year

	2020			2021		
	POs	Plans	Beneficiaries	POs	Plans	Beneficiaries
BDI	14	140	1,258,339	14	377	3,749,885
VBID Flexibilities	10	98	770,079	13	302	2,785,002
RI	10	77	729,764	7	252	2,155,395
Cash Rebates	N/A	N/A	N/A	2	4	15,862
Hospice	N/A	N/A	N/A	9	52	608,513
Total	14	140	1,258,339	19	415	4,192,253

SOURCE: RAND analysis of VBID application data and other CMS data. The complete list of data sources and variables is in Table C.5 in Appendix C.

NOTES: N/A = not applicable. Not all beneficiaries within a plan are eligible for a specific intervention. POs could offer more than one intervention component, so the numbers do not sum to the total. Although 145 plans were entered for 2020, we crosswalked these plans to their 2021 counterparts and show only the 140 crosswalked plans.

To encourage candor among those who participated in this evaluation, we have anonymized all primary and secondary data contained in this report. For example, for POs, we have assigned placeholder letter names (PO A, PO B, etc.) to protect their confidentiality. For continuity purposes, we have retained the labeling assignments for POs from previous VBID evaluation reports, where applicable.

Research Questions Addressed

Our evaluation of the VBID model test addresses specific research questions posed by CMS. This evaluation report, the first regarding Phase II of the VBID model test, addresses questions pertaining to several key domains of potential impact—participation, implementation, experiences, enrollment and eligibility, and cost—across the three components of VBID. Other model test outcomes, such as care quality, will be addressed in future evaluation reports. We present a summary of research questions mapped onto impact domains in Table 1.2; see Appendix A for additional details.

Table 1.2. Research Questions Addressed in This Report, by Key Impact

Impact Domains	Research Questions	Chapter
VBID Overall		
Participation	<ul style="list-style-type: none"> • How are VBID plans and participating POs different from nonparticipants? • How do their plan characteristics differ? • Why did POs choose to participate in VBID—or not? • What processes and staff were involved in these decisions? 	2
BDI Component		
Implementation	<ul style="list-style-type: none"> • What BDI interventions did POs implement, and what groups of beneficiaries did they target? • Why did POs choose these interventions? 	3
Experiences	<ul style="list-style-type: none"> • What are POs' and vendors' implementation experiences with the BDI component? • Do these experiences vary by intervention? • How did the coronavirus disease 2019 (COVID-19) pandemic affect the BDI component implementation? 	4
Outcomes	<p>Enrollment and eligibility</p> <ul style="list-style-type: none"> • What proportion of plan enrollees are eligible for the BDI component and receive benefits? How does this change over time? • Are targeted beneficiaries electing to participate in the BDI component interventions? <p>Cost</p> <ul style="list-style-type: none"> • How does the BDI component of the model test affect plan bids for Parts C and D? What variables factor into bid changes? • How does it affect premiums and supplemental benefits? 	5
Hospice Component		
Implementation	<ul style="list-style-type: none"> • What palliative care, TCC, and hospice supplemental benefits do participating POs offer as part of the model test? • How are networks of hospices being built, and what do they look like? How are payment arrangements being handled? • Why did hospices join VBID POs' networks? 	6
Experiences	<ul style="list-style-type: none"> • What did POs need to do to implement the Hospice component into their plans? • How did the COVID-19 pandemic affect the Hospice component implementation? • Do in-network hospices need to operate differently under VBID? • How do in- and out-of-network (OON) hospices perceive the Hospice component of the model test? 	7
Outcomes	<p>Enrollment and eligibility</p> <ul style="list-style-type: none"> • How does enrollment in Hospice-participating plans change over time? Why? <p>Cost</p> <ul style="list-style-type: none"> • How does the Hospice component of the model test affect plan bids for Parts C and D? What variables factor into bid changes? • How does it affect premiums and supplemental benefits? 	8
WHP Component		
Implementation	<ul style="list-style-type: none"> • How did POs implement the WHP requirement? • How did the COVID-19 pandemic affect WHP implementation? 	9

Methods Overview

This evaluation examines Phase II of the VBID model test from multiple vantage points by integrating observations from both primary (qualitative) and secondary (quantitative) data. Our mixed-methods approach incorporates the perspectives of POs, hospices, and vendors with quantitative data on intervention participation, enrollment and eligibility, and cost. We also spoke with participating and nonparticipating POs regarding their experiences with the WHP component. Next, we summarize our methods for gathering and analyzing primary and secondary data for this evaluation. Appendixes B and C provide further description and discussion of these methods.

Primary Data

We solicited the opinions of VBID-participating and nonparticipating POs, vendors, and in-network and OON hospices, which make up the primary data collected for this evaluation, informing context behind and providing nuance for the quantitative analyses. The qualitative data help explain how and why VBID implementation affects key outcomes and therefore allow us to more comprehensively address key research questions.

Parent Organizations

We conducted semistructured small group interviews with representatives of 18 participating and nine nonparticipating POs to explore how POs chose and implemented the model test components (including Hospice), why some POs decided not to participate in VBID or not to implement a certain component, and how the model might affect key outcomes. Including the perspectives of nonparticipants allowed us to probe potential issues related to uptake of the model test. Prior to the participating PO interviews, we asked their representatives to rate their experiences on a pre-interview questionnaire about implementation and expected outcomes and used their answers to help structure the interview. Participating PO interviews will be repeated in future evaluation years to gather longitudinal information.

We interviewed nonparticipating PO representatives in spring 2021; interviews with 2021 model test participants were held in summer 2021. To minimize burden, we held these interviews virtually, at a time convenient to interviewees. Although our interviews with nonparticipating POs lasted for 45 to 60 minutes, interviews with participating POs were twice as long and were often conducted over two sessions.

Vendors

Many POs contracted with vendors to help them implement the VBID model or deliver VBID benefits. Because they played an important role in Phase II of the VBID model test, we interviewed representatives of ten PO-identified vendor organizations in fall 2021 to discuss their experiences with and perspectives on the model test and its expected outcomes.

Hospices

We conducted semistructured small group interviews with representatives of 23 hospices, including those that entered into contracts with POs to be an in-network hospice and those that were OON but in close geographic proximity to model test participants, to explore factors that hospices considered when deciding to participate in PO networks, as well as their experiences negotiating contracts with POs, working with POs to coordinate care for VBID beneficiaries, and delivering Hospice component services. These interviews occurred between September 2021 and January 2022.

Our approach to the analysis of all qualitative data that we collected entailed a series of coding steps to process data from the interviews followed by a thematic analysis. Data coding involved the development of a codebook from an initial set of interview transcripts to identify emerging patterns, and then systematic application of similar codes across subsequent transcripts to pull out common themes. Thematic analysis techniques were used to compare themes, explore variation in implementation experiences by model components and participants, and respond to research questions (Guest, MacQueen, and Namey, 2012). A full description of our primary data collection and analysis methods can be found in Appendix B.

Secondary Data

The core data sets analyzed for this report include MA enrollment data files, data on plan bids, rebates, and the projected costs of supplemental benefits provided by the CMS Office of the Actuary (OACT), plan premium data from the CMS Health Plan Management System (HPMS), and data from CMS's Reusable Framework (RF) and VBID Hospice Web Portal, through which POs report information on beneficiaries' participation in the model test. The timing of data release for several key sources affects which outcomes can be reported in each annual evaluation report. Key outcome data sets, such as the MA encounter data, for instance, are not finalized until 18 to 24 months after the close of the calendar year. In addition, some data collection activities for 2020 and 2021 were postponed or canceled because of the COVID-19 pandemic. As a result, we focused on a limited set of outcomes for this report: beneficiary participation rates, overall plan enrollment, plan premiums, and plan bids. Future evaluation reports will contain a broader set of outcome analyses.

To analyze the data, we compared VBID-participating plans with comparison plans that were eligible for VBID but did not participate.² We used an entropy balancing approach to weight comparison plans so that they closely resembled VBID-participating plans along key dimensions, including pre-VBID trends in each outcome variable. We then used difference-in-differences

² We conducted analysis at the plan level, which reflects the plan benefit package. In some cases, plans are further subdivided into segments. In these cases, we aggregated segment-level information into a single observation for the plan. The 140 plans in our analysis for 2020 reflect 156 segments; the 415 plans in our analysis for 2021 reflect 448 segments (this includes 409 segments from 377 BDI plans, and 39 segments from 38 Hospice-only plans).

(DD) regression models to assess whether trends in outcomes for VBID participants and comparators diverged after the model was implemented. Our models build on an approach documented by Callaway and Sant’Anna (2021) to address the fact that VBID implementation occurred at different time periods for different plans. Briefly, we used this method to create separate estimates for plans that participated in 2020 only, plans that participated in 2021 only, and plans that participated in both years. We then combined these estimates to calculate the association between VBID and outcomes in each calendar year (2020 and 2021). A full description of our statistical methods can be found in Appendix C.

Report Structure

This report describes the experiences of participating and nonparticipating POs, vendors, and hospices with the first two years of Phase II of the VBID model test. It also analyzes the association of outcomes of POs’ interventions with changes in plan enrollment, bids, premiums, and cost. The report is divided into five parts, structured as follows:

- Part I consists of this introductory chapter and Chapter 2, which describes the characteristics of participating and eligible but nonparticipating POs, their perceptions of the model test, reasons for choosing to participate (or not) in the model test, and thoughts about future participation.
- Part II covers the BDI component. The chapters in this section describe the BDI interventions implemented by participating POs (Chapter 3); POs’ and vendors’ implementation experiences, including their thoughts on the impact of the COVID-19 pandemic (Chapter 4); and the outcomes from the BDI interventions (Chapter 5).
- Part III discusses the VBID Hospice component. The chapters in this section describe POs’ hospice networks and interventions and the contract negotiations between POs and their in-network hospices (Chapter 6); the implementation experiences of POs and hospices, including the perceived impact of the COVID-19 pandemic (Chapter 7); and the early outcomes of the Hospice component interventions (Chapter 8).
- Part IV consists of one chapter (Chapter 9) that describes perceptions of the WHP component and its implementation among participating POs.
- Part V contains one chapter (Chapter 10) that offers concluding thoughts about the early stages of Phase II of the model test, including the implementation and outcomes of BDI and Hospice components. It also draws comparisons with Phase I of the model test.

In addition, several appendixes provide additional detail on qualitative methods; statistical approaches and entropy balancing; VBID eligibility and participation; summaries of POs’ interventions; reasons for not implementing certain model test components; the impact of the COVID-19 pandemic on model outcomes; and analyses regarding enrollment, plan bids, premiums, and supplemental benefits.

Chapter 2. Parent Organization Participation in and Perspectives on Model Test

A decision to join such model tests as VBID is a multistep process that requires interdepartmental collaboration and leadership support. POs must determine the extent to which model participation aligns with their organizational priorities and beneficiary needs, identify alternative ways of offering similar benefits outside of the model test, analyze what benefits their competitors are likely to offer, and prepare and submit a model test application, among other things. As a result, not all eligible POs participate in the model test, and not all participating POs enter all of their eligible plans into the model test.

This chapter compares the characteristics of VBID-participating and nonparticipating POs and plans, both quantitatively and qualitatively. First, we present the results of a descriptive quantitative analysis that shows whether and how participating POs and nonparticipating POs (NPPOs) and plans differ from each other. We then describe how participation in other model tests and similar initiatives affected VBID participation. Finally, we summarize the results of our interviews with participating POs and NPPOs conducted in 2021.

As detailed in Appendix B, we interviewed 18 VBID-participating POs (one PO did not respond to our interview invitation) and 12 NPPOs about their participation decisions and thoughts about the VBID model test (representatives of nine NPPOs were interviewed and three shared feedback via email). These interview data were used to describe the decisionmaking processes that POs used to determine whether to participate in model tests, reasons for joining or not joining the VBID model test specifically, and thoughts about joining or leaving the model test in the future.

Key Findings

- Compared with model nonparticipants, participating POs were more likely to be national and for-profit POs with higher enrollment that serve beneficiaries in counties with higher average MA penetration rates.
- Plans in the BDI component were more likely to be Dual-Eligible Special Needs Plans (D-SNPs), had a higher percentage of dual and LIS-eligible enrollees, and had lower premiums but higher OOP maximums, compared with nonparticipants.
- Plans in the Hospice component were also more likely to be D-SNPs, with no monthly premiums and lower OOP maximums.
- Compared with eligible nonparticipating plans, BDI-participating plans had a somewhat lower proportion of males and non-Hispanic White beneficiaries, and Hospice-participating plans had a substantially lower proportion of non-Hispanic White enrollees.
- Almost all plans in BDI and the vast majority of plans in Hospice offered a prescription drug benefit.
- POs evaluate whether to participate in such model tests as VBID in a methodical manner that involves engaging multiple stakeholders internally and sometimes reaching out to external organizations as well.

- Participating POs found that the goals of the model test aligned with their business priorities and that VBID offered POs a chance to expand their benefit offerings while improving quality and health outcomes. The main reasons for joining VBID did not vary by the model test components that POs implemented.
 - Representatives of POs that decided against joining the model test in 2021 cited competing priorities that made VBID less attractive; limited financial and staffing resources; burdens of participation, such as model reporting requirements; perceived lack of a clear return on investment (ROI); and concerns about confusing beneficiaries. Competing priorities included other CMS models and initiatives, some of which enabled POs to offer VBID-like benefits.
 - Representatives of six NPPOs indicated that their organizations were likely to join the model test in the future.
 - Two POs that participated in the model test in 2021 left VBID in 2022, primarily because of concerns that the ROI was insufficient.
-

Characteristics of Participating and Nonparticipating Parent Organizations

Fourteen POs participated in the VBID model test in 2020 and 19 POs did so in 2021. Fourteen POs offered BDI interventions in either 2020 or 2021, although the mix of POs offering VBID changed over time because of entry into and exit from the model test (three exited and three entered in 2021). Nine POs implemented the Hospice component in 2021: Four POs implemented both the BDI and Hospice components, and five implemented the Hospice component only. There were 103 POs eligible to participate in VBID in either year that did not enter any of their plans into the model test. Next, we discuss characteristics of POs that participated in the model test and POs that did not participate. Appendix Table D.2 provides additional details.

Benefit Design Innovations Component

In 2020, BDI component–participating and nonparticipating POs were equally likely to be Blue Cross Blue Shield (BCBS) affiliates. National companies made up 28.6 percent of the participating POs versus 3.88 percent of the NPPOs ($p < 0.01$). Because enrollment in the large, national POs tends to be higher, PO-level enrollment was significantly higher in the participant group compared with eligible NPPOs (835,093 versus 63,279, $p < 0.01$). Similarly, there were more for-profit POs among participants than among nonparticipants (50.0 percent versus 37.9 percent, difference not statistically significant). The weighted-average MA penetration in counties served by participating POs (the percentage of beneficiaries in a county in an MA plan) was higher than the MA penetration rate in counties served by NPPOs (52.1 versus 42.9 percent, $p < 0.01$).

For 2021, the participating and nonparticipating PO characteristics were broadly similar to those for 2020. However, more state-based POs joined the model test (from 64.3 percent in 2020 to 71.4 percent in 2021), decreasing the share of participants that were national POs.

Hospice Component

Slightly more than one-fifth of Hospice component–participating POs were BCBS affiliates, similar to the proportion of BCBS affiliates among NPPOs. POs in the Hospice component were

more likely to be national POs (22.2 percent versus 3.88 percent, $p = 0.02$) and less likely to be state-based POs (66.7 percent versus 89.3 percent, $p = 0.05$) compared with NPPOs. More Hospice-participating POs were for-profit, but this difference was not statistically significant. The average enrollment in eligible plans was higher among participating POs than NPPOs, also reflecting the higher levels of participation among national POs (643,822 versus 62,068, $p < 0.01$). Finally, the MA penetration rate was higher in counties served by Hospice component-participating POs than in counties served by NPPOs (54.1 percent versus 45.9 percent, $p = 0.04$). This might be because of the very high MA penetration rate in Puerto Rico, where two Hospice-participating POs operated.

Characteristics of Participating and Nonparticipating Plans

There was variation across POs in terms of the number of plans they entered into the model test, with some POs entering only a single plan and others entering as many as 200 plans. Three POs (M, O, and X) reported that they entered all of their eligible plans into the model test in 2021. Three other POs (W, L, and V) entered only their smaller plans. “We decided to start small,” said a PO V representative, “to get some experience under our belts, particularly given [that] this is a new model, and we launched it during the pandemic.” We briefly compare characteristics of plans entered into the BDI and Hospice components with eligible plans that were not entered, separately for 2020 and 2021. Appendix Table D.3 provides further details.

Benefit Design Innovations Component

In 2020, there were 140 participating plans in the BDI component. In total, 27.1 percent of participating plans were D-SNPs, as compared with only 10.0 percent of nonparticipating plans ($p < 0.01$). Total premiums were higher in nonparticipating than in participating plans (\$30.41 versus \$23.39 per month, respectively), although this difference was only marginally statistically significant ($p = 0.08$). The average OOP maximum was significantly higher in participating than in nonparticipating plans (\$5,338 versus \$4,995, $p = 0.01$). Participating plans had significantly higher percentages of dual and LIS enrollees (37.6 percent dual and 37.9 percent LIS in participating plans compared with 22.8 percent and 27.4 percent in comparison plans; $p < 0.01$ in both cases), which could be partly attributed to a higher percentage of participating D-SNPs. Participating plans also had a somewhat lower proportion of males (43.0 percent versus 46.2 percent, $p < 0.01$) and non-Hispanic White enrollees (63.8 percent versus 68.2 percent, $p = 0.05$) than nonparticipating plans. The average age of beneficiaries in participating plans was slightly lower than in nonparticipating plans (70.1 versus 71.0, $p = 0.01$). The vast majority of participating and nonparticipating plans offered Part D (97.9 percent versus 91.9 percent, $p = 0.01$).

The number of plans implementing the BDI component more than doubled in 2021 ($N = 377$). Fourteen of these plans implemented both the BDI and Hospice components of the model

test. Plan characteristics of 2021 participants and nonparticipants were similar to those in 2020. The main difference between 2020 and 2021 was an increase in the percentage of D-SNPs, which increased from 27.1 percent in 2020 to 38.2 percent in 2021. The vast majority (99.2 percent) of participating plans offered prescription drug benefits, which was significantly higher than 92 percent of eligible nonparticipants ($p < 0.01$).

Hospice Component

POs participating in the Hospice component entered 52 plans, which were more likely to be D-SNPs than eligible nonparticipating plans (28.9 versus 10.0 percent, $p < 0.01$). Average monthly premiums were lower among hospice-participating plans, although this difference was not statistically significant. Hospice-participating plans were more likely to have no premium than nonparticipating plans (69.2 percent versus 48.9 percent, $p < 0.01$), and average OOP maximums were about \$825 lower in the participating plans ($p < 0.01$). The majority of counties in participating plans' service areas were in urban areas (81.1 percent) versus 75.2 percent for the nonparticipating group ($p = 0.05$). A higher percentage of beneficiaries in Hospice component-participating plans were dual eligibles (33.5 versus 22.6 percent, $p < 0.01$), but participating plans overall had a lower percentage of beneficiaries eligible for LIS than nonparticipating plans because a large number of the Hospice component-participating plans are in Puerto Rico, where there is no LIS (12.3 versus 26.4 percent, $p < 0.01$). Although the proportion of males in participating and nonparticipating plans was the same (roughly 45 percent), the proportion of non-Hispanic White beneficiaries was substantially lower in participating than in eligible nonparticipating plans (33.1 percent versus 68.6 percent, $p < 0.01$), which could be explained by several Puerto Rico plans implementing the Hospice component. Nearly all Hospice-participating and nonparticipating plans offered Part D coverage.

Benefit Design Innovations Outside of the Model Test

In choosing which plans to enter into the VBID model test, some POs specifically considered whether plans were entered into other CMMI model tests. Although POs C and U enrolled the same plans into different model tests, POs G and P, among others, chose specific plans to enter only into VBID. One representative from PO P explained that “keeping them separate allows us to isolate the impact and assess the impact internally of the individual interventions and provide more meaningful and directional information for future iterations.”

Moreover, five of the nine POs that implemented the Hospice component did not implement the BDI component. Representatives of these POs cited their ability to offer flexible benefits outside of the model test as a reason for not implementing BDI interventions. A representative from PO V stated, “I think we could do most of what we would want to do in terms of flexibilities with benefits not through VBID, through the regulatory flexibilities.” PO V representatives also noted that competitors' offerings in their local markets also influenced

whether to expand specific benefits under one of these flexibilities: “So we certainly are exploring those types of opportunities, and certainly we are seeing our competitors launch benefits. So we’re closely monitoring.” Although PO M representatives noted that offering BDI-like benefits outside of the model test presented less administrative hassle for small plans, they considered the Hospice component to be a natural extension of the palliative care program they have been offering as part of New Primarily Health-Related Supplemental Benefits (PHRSBs): “We have a palliative care program that is a nonhospice palliative care program . . . and we’ve had that for a few years on our Medicare Advantage plans, and we actually have it across multiple lines of business.”

A key factor in determining which plans to include in the model test or whether to participate in VBID at all was POs’ ability to implement VBID-like benefits outside of the model test. Since 2019, CMS has implemented a variety of initiatives designed to vary the benefits and cost sharing within a given MA plan (Table 2.1). VBID participants can choose to participate in multiple initiatives at the same time. A correlation between VBID participation and participation in other initiatives could affect our results—for example, if the evaluation wrongly attributed effects stemming from participation in other initiatives to VBID. As a result, we control for participation in these other initiatives in our quantitative analyses.

Table 2.1. Initiatives That Provide Parent Organizations Additional Benefit Design Flexibilities in 2021

Benefit Design Options	VBID	UF	SSBCI	New PHRSB	PDSS
Reduced cost sharing for selected Part C benefits for targeted beneficiaries	Yes	Yes	Yes	No	No
Reduced cost sharing for selected Part D drugs for targeted beneficiaries	Yes	No	No	No	Yes
Additional supplemental benefits for targeted beneficiaries	Yes	Yes	Yes	Yes	No
Non-PHRSBs for targeted beneficiaries	Yes	No	Yes	No	No
Expanded coverage for new and existing technologies or FDA-approved medical devices	Yes	No	No	No	No
Expanded Part C RI program rewards based on the health benefit of the service, up to an annual maximum of \$600	Yes	No	No	No	No
Offer Part D RI programs	Yes	No	No	No	Yes
Offer Cash Rebates to beneficiaries	Yes	No	No	No	No
Offer hospice benefit	Yes	No	No	No	No
Offer expanded palliative care	Yes	No	No	Yes ^a	No
Offer TCC services	Yes	No	No	No	No
Offer hospice supplemental benefits	Yes	No	No	No	No
Ability to offer certain plan benefits based on beneficiary chronic conditions	Yes	No	Yes ^b	No	No
Ability to offer certain plan benefits based on beneficiary SES	Yes	No	No	No	No
Ability to offer certain plan benefits based on beneficiary completion of CM requirements or using a high-value provider	Yes	Yes	Yes	No	No

SOURCE: RAND review of CMS program materials.

NOTE: UF = Uniformity Flexibility; PDSS = Part D Senior Savings; SSBCI = Special Supplemental Benefits for the Chronically Ill.

^a Focused on home-based palliative care services.

^b The definition of chronically ill in SSBCI requires (1) one or more comorbid and medically complex, life-threatening illnesses, (2) high risk of hospitalization or adverse health outcomes, and (3) a need for intensive care coordination. These are stricter criteria than required for VBID.

In 2020, all MA plans could implement VBID-style benefits as part of the following:

- **UF:** In 2018, CMS reinterpreted the uniformity requirement in MA regulations (42 C.F.R. Section 422.100). Previously, this regulation had been interpreted to preclude plans from offering reduced cost sharing or other benefit differences to beneficiaries based on chronic disease status. Beginning in 2019, such differences became allowable, as long as plans “provide for equal treatment of enrollees with the same health status or disease state” (Coleman, 2018b). The reinterpretation allows plans to offer VBID-like approaches that reduce cost sharing for high-value services or providers to beneficiaries with chronic disease. POs can also make the receipt of these targeted benefits conditional

on participation in CM/DM. However, these flexibilities only apply to Part C (medical services) but not Part D (outpatient prescription drugs) benefits.

- **SSBCI:** This provides an opportunity for MA plans to offer additional supplemental benefits to beneficiaries who are chronically ill (therefore, unlike most supplemental benefits, SSBCI is not available to all enrollees). Receipt of these additional supplemental benefits could be further conditioned on CM/DM participation or using high-value providers (Coleman, 2019).
- **New PHRSBs:** This is an expansion in the definition of supplemental benefits that allows additional PHRSBs to be offered to beneficiaries. These expanded benefits include adult day care services, home-based palliative care, in-home support services, support for caregivers of enrollees, and home and bathroom safety devices and modifications, among others (Coleman, 2018a).

Beginning in 2021, MA plans with an enhanced Part D benefit were also able to participate in the *PDSS model*. This model test offers beneficiaries with diabetes who take insulin and who are enrolled in a participating plan a fixed, maximum \$35 co-payment for a one-month supply of insulin in the deductible, initial coverage, and gap phases of the Part D benefit. Participating plans also have the option of offering a Part D RI program to beneficiaries with prediabetes or diabetes.

Table 2.2 shows the number of plans participating in different initiatives in 2020 and 2021, separated by participation in BDI, participation in Hospice, and nonparticipation in VBID (i.e., eligible but nonparticipating plans). Among plans that implemented the BDI component, participation in other initiatives increased from 2020 to 2021, partly because of the addition of the PDSS model test, in which many POs participated. In both years, more than 90 percent of BDI component-participating plans also offered new PHRSBs, while relatively few (20 percent or less) participated in UF or SSBCI. Fewer eligible nonparticipating plans (76 percent in 2020 and 82 percent in 2021) offered new PHRSBs. Eligible nonparticipating plans were more likely to offer UF than BDI participants in both years, although Hospice-participating plans had the highest rate of UF offering in 2021. Similar proportions of participating and eligible nonparticipating plans (about 30 percent) participated in PDSS in 2021.

All but one plan implementing the Hospice component participated in at least one other initiative in 2021, with 48 plans offering at least one new PHRSB and about half (52 percent) participating in PDSS, UF, or both. Compared with plans offering the Hospice component, a smaller proportion of eligible nonparticipating plans participated in at least one other initiative.

Table 2.2. Participation in Other Initiatives, 2020 and 2021

Initiative	2020	2020	2021	2021	2021
	BDI- Participating Plans (N = 140)	Eligible Nonparticipating Plans (N = 2,436)	BDI- Participating Plans (N = 377)	Hospice- Participating Plans (N = 52)	Eligible Nonparticipating Plans (N = 2,436)
Participation in at least one other initiative:	130 (93%)	1,911 (78%)	369 (98%)	51 (98%)	2,181 (90%)
PDSS	N/A	N/A	120 (32%)	27 (52%)	740 (30%)
SSBCI	13 (9%)	177 (7%)	74 (20%)	18 (35%)	442 (18%)
UF	7 (5%)	136 (6%)	11 (3%)	27 (52%)	251 (10%)
New PHRSB	130 (93%)	1,856 (76%)	366 (97%)	48 (92%)	2,000 (82%)
No participation in other initiatives	10 (7%)	525 (22%)	8 (2%)	1 (2%)	255 (10%)

SOURCE: RAND analysis of publicly available PBP benefits data, MA VBID participation data, and the PDSS landscape file.

NOTES: N/A = not applicable. Numbers do not sum to the number of participating and eligible nonparticipating plans because plans can participate in multiple initiatives. Plans were assigned a 2021 identifier to facilitate analysis across years, and data for plans that consolidated or split across years were rolled up to the 2021 identifier. Eligible but nonparticipating plans include all plans that were eligible in either 2020 or 2021 but did not join the model test.

Participation Decisionmaking Processes

Representatives of both participating and nonparticipating POs described similar processes for deciding whether to join a model test, such as VBID, and participation discussions starting as soon as the RFA is released. This decisionmaking process typically involved a review of the application materials, followed by discussion within relevant teams (e.g., those involved in the implementation or those whose functions would be affected). Actuaries would then be tasked to evaluate the costs and benefits of participation, and the results of the evaluation would be discussed among actuarial, compliance, product development, marketing, and clinical teams to determine the pros and cons of participation and nonparticipation.

A representative from one NPPO described a multidisciplinary decisionmaking process:

We’re coming up with some kind of a high-level proposal. And then as a team we sit down together, we talk about it from [a] data and reporting perspective, network building perspective, actuarial perspective, also from a clinical/medical/social perspective. It’s truly a very multidisciplinary team that then says, “Yes, based on our discussion maybe later” or “Maybe not.” Come to kind of a decision . . . and close the loop with [the CEO]. (NPPO H)

In addition to internally evaluating model tests, a few NPPOs noted having conversations with both participating and nonparticipating POs to better understand the pros and cons of model test participation. Some NPPO representatives also reported considering contextual factors, such as market competitiveness.

Once leadership approves the decision to join the model test, representatives reported that a cross-functional design and implementation team would be assembled to design the intervention and submit a model test application. Representatives of two participating POs stated that their organizations engaged an outside consultant for input on their intervention designs, including the choice of the chronic conditions and beneficiary eligibility criteria.

Reasons for Participating

Our interviews with 2021 VBID-participating POs revealed three main reasons for joining the model test. In general, the reasons for joining the model test did not change by which model test components were implemented. Next, we describe these rationales for joining.

Consistent Goals

Representatives of seven POs mentioned that the model test aligned with their corporate goals and priorities. One PO representative stated, “I think VBID fell in well with our goals and values as a company on what we want to pursue, especially when there’s an opportunity to remove barriers to receiving care” (PO O).

For POs that implemented the Hospice component, VBID participation allowed them to enhance their services while aligning with organizational goals and commitments to improving end-of-life care. Some noted that VBID resonated with their corporate goals related to transitioning beneficiaries to hospice care:

I can’t emphasize enough that this program really aligned with our mission; [it is] a great idea allowing us to keep the members with whom we’ve had wonderful relationships and trust and rapport, to keep them with us while they transition to hospice and allow them to have end of life [care], knowing that they were supported by the folks who have been supporting them for years before. It really, really resonated. (PO T)

Opportunity to Offer Additional Benefits

Representatives of ten POs stated that the VBID model test allowed their organizations to expand benefit offerings and to provide non–primarily health-related benefits to their non–chronically ill beneficiaries, especially those with limited incomes. Therefore, they viewed VBID as a vehicle for helping beneficiaries address such social determinants of health (SDOH) as food or economic insecurity and for increasing POs’ competitive advantage in the market. According to representatives from PO P:

We wanted to offer something more broadly to a population that we knew was experiencing food insecurity despite their non-chronically ill status. The VBID model allowed us to offer a healthy foods card as a non–primarily health-related benefit to members who qualify for low-income subsidy and really tackle or adjust food insecurity for both currently chronically ill members and members

who are at risk of becoming chronically ill due to their ongoing or persistent food insecurity.

Moreover, PO R representatives stated that they joined the VBID model test because they wanted to address SDOH by providing a direct cash benefit to beneficiaries:

It was a great opportunity for us in terms of how competitive we will look in the market for our members, and we were so looking forward to helping our members in social determinants of health. And in [our service area], poverty levels are really, really high, and offering our members a more direct benefit, a cash benefit, it looked great for us and for our membership predictions.

Representatives of POs that implemented the Hospice component also noted that the opportunity to offer additional benefits and alternatives to provide better care to patients with serious illness aligned with their philosophy of care delivery. Representatives of PO V and PO X that serve as insurers and care providers noted that hospice carve-in represents the way end-of-life care should be delivered to beneficiaries. As PO V representative put it:

The idea that it should not be carved out, that the hospice benefit and the end-of-life, and providing that end-to-end care was really consistent with the way we provide care. So just sort of philosophically [it] made sense.

Opportunity to Improve Care Quality and Health Outcomes

Seven PO representatives noted that VBID made sense clinically given its focus on improving care quality and health outcomes, which was a major reason for their organization's participation in VBID:

Outcomes for our members is a really important body of our work. It encompasses a lot of our decisionmaking including how we design the product and the discussions we have in our bid [and] our quality improvement initiatives. We saw VBID as an opportunity to improve medication adherence to see if those outcomes improve and [as] important to Star performance [quality rating system]. (PO N)

Several PO representatives also noted that by improving care quality and health outcomes, they anticipate reductions in costs. The representatives of PO G stated, “[We] wanted to see how we could leverage the models to improve care for our members [and ultimately] help drive down medical costs.”

Representatives of POs that implemented the Hospice component felt that participating in the model test allowed an opportunity to improve quality of end-of-life care, particularly through developing closer relationships with their beneficiaries and helping to better coordinate their care at the end of life. A PO X representative described challenges with the “hospice carve-out” and the potential for VBID hospice:

The fee-for-service and the carve-out that currently exists in the Medicare Program is very cumbersome, confusing, and fragmented for members. We strongly believe that [VBID] is the right path to go down and that this will simplify the experience and really allow health plans to work closely, develop

closer relationships, with those members over time and make sure that they're getting the care that they need and improving the quality of life at end of life.

Reasons for Not Participating

Representatives of 12 NPPOs that have yet to join the VBID model test described five main reasons for not participating. Most cited more than one barrier to their participation.

Competing Corporate Priorities

Nine NPPO representatives reported the need to manage competing corporate priorities, such as participating in other initiatives, including UF, SSBCI, or the PDSS model test, and offering new types of plans, such as D-SNPs. All were seen as directly competing with VBID for POs' resources, which might have reduced NPPOs' awareness of VBID or its attractiveness.

Representatives of seven NPPOs reported offering benefits under UF or SSBCI. For example, NPPO I representatives explained that they could more easily offer benefits through these channels without the added challenges of VBID's application and reporting processes, which they perceived to be potentially burdensome:

We had so many other competing priorities at the time, we didn't dig in, and felt like we didn't want to take on an additional one not knowing what the reporting [would involve] and all of the various tasks it might include. And we kind of just stayed with our current offering for a second year for supplemental benefits since they were working very nicely, and we had great uptick in utilization.

Representatives of five NPPOs reported participating in PDSS, three of which cited their participation in PDSS as a reason for not participating in VBID. NPPO representatives felt that unlike VBID, PDSS was simple and straightforward. VBID requires POs to design an intervention first and then implement it, which is more resource-intensive than PDSS:

VBID, as beautiful and sort of lovely as it is in theory, would be very difficult in practice. It's confusing. . . . The Part D Senior Savings model to me made a lot of sense. It was very, very clear exactly what it was going to do, how it was going to benefit our beneficiaries. (NPPO D)

PDSS also resonated with some NPPOs because of its focus on insulin to increase adherence and reduce OOP costs for beneficiaries.

Representatives of five NPPOs reported that they recently started D-SNP plans or intend to start offering one in 2022. Three NPPO representatives stated that their organizations did not wish to take on VBID at this time because they were comfortable with their existing approach, focusing on the benefits they already offer.

Finally, representatives of four NPPOs stated that their organizations were undergoing transitions and merging with other organizations, which limited their capacity to take on VBID.

Financial and Staffing Resources

Representatives of eight NPPOs cited limited resources—including financial, staffing, and operational resources required to design and implement the intervention—as a barrier for participating in VBID. Smaller NPPOs, in particular, raised concerns about their staff bandwidth, both for the application process and for implementation of VBID. One representative from a smaller NPPO described their organization’s comfort with its existing approach and stated that it is cautious about “sudden movement” that might require additional resources:

We’re a very lean ship as far as resources and timelines. We cut things down to kind of like seconds to make sure that we’re maximizing our time on working through it. And so, implementing a whole new kind of model and pivoting at that point in time was just not going to fly for us. (NPPO B)

Burden of Participating in VBID

Representatives of six NPPOs cited the VBID application and reporting requirements as the reasons for not participating in the model test, noting that they can now offer similar types of benefits under UF without additional administrative burden. Four NPPO representatives mentioned that the annual VBID RFAs are not always clear and that the timeline for application submission is not optimal. One NPPO representative described the model test RFA as “ambiguous.” With other competing priorities, some NPPOs considered the timeline of the application process for VBID to be too tight to develop a well-designed intervention:

There was not a lot of time to make decisions on [VBID]. You’re in the middle of doing bids and then suddenly it’s like, oh, let me throw you this new opportunity that you can do. And your strategy may be fairly well-baked at that point and now you’re trying to shoehorn something additional into the space. (NPPO F)

Representatives of six NPPOs raised concerns around the reporting and administrative requirements of participating in VBID, suggesting that reporting and tracking might be resource-intensive and burdensome. Education and outreach efforts to make beneficiaries aware of VBID benefits and participation requirements might be needed, which would require additional resources. In terms of the Hospice component, a representative from one NPPO felt that, despite interest in this offering, their organization would have to use a disproportionate amount of resources for their small population of hospice-eligible beneficiaries:

[The] administrative burden around reporting, given the scope of what we were going to do, seemed very onerous because we were looking at a geography where we had 2,000 members. We thought even if one percent or one and a half percent went into the hospice model that would be a lot of reporting and data analytics we’ll have to share on an ongoing basis. (NPPO H)

Return on Investment Concerns

Uncertainty around the effectiveness of VBID, the perception of high implementation and reporting costs, and the increased likelihood of additional monitoring and audits were key reasons for not joining the model test for seven NPPOs. Although some recognized that VBID might result in savings over time and that such savings could theoretically cover VBID's design and implementation costs, several NPPO representatives considered the financial risk of participating in VBID to be too great for their organization at the time: "I would say we don't deny that there would be savings. But again, there's also a cost to get it up and running" (NPPO C). Others stated that their organizations did not have time to conduct a cost-benefit analysis or were unclear as to whether the outcomes of participation in VBID and ROI would be worth the additional work, especially given that there is no consensus in the literature on whether VBID leads to cost savings for the plans:

As we've looked at the model, we're struggling to understand what the value proposition for us [would be] and the additional work for what we'd have to do as a plan would deliver. It wasn't exactly easy to understand the positives of the program and what we would gain out of it. (NPPO E)

Similarly, NPPO J representatives noted that based on their understanding of VBID's impact, the model has not resulted in significant cost savings to date, rather "only care coordination improved in Star Ratings, while other measures remained flat."

Concerns About Beneficiary Confusion

Three NPPO representatives also worried about potential beneficiary confusion around their eligibility status. As an NPPO C representative stated:

Behind the scenes, you are reaching out to ask them if they want to participate. And beneficiaries are already confused. Health care is confusing for them. Medicare is confusing. They don't understand it. We do our best to do things that are easy for the member to understand because we know it's complicated . . . we [felt like we would have] to do a special outreach, felt like it wasn't necessary if we could just do essentially what we wanted to do within the Flexibility and Uniformity. (NPPO C)

Future Participation in VBID

Because POs can join and leave the model test every year, we asked NPPOs to offer their perspectives on future participation in VBID. We also discussed the reasons for leaving the model test with the two POs that decided to stop their participation after 2021.

Joining at a Later Time

Representatives of six NPPOs reported that they will likely participate in VBID in the future, with one additional NPPO representative noting that our interview piqued their interest in VBID.

Representatives of two other NPPOs stated that they appreciated the opportunity to discuss VBID and will continue to evaluate potential future participation for their organization.

Of the six NPPOs that may join VBID at a later time, four stated that their future participation in VBID is “highly likely” or that they are “actively considering participation in the VBID model.”

Regardless of the willingness to participate, one NPPO representative described some of the complexities behind their organization’s decision regarding future participation:

It’s easy enough to say, “Yeah, we’re going to participate in this,” check the box on the bid application form, and then move on. There’s a lot of work to do from a regulatory compliance standpoint to just respond to CMS and give them the information, and our program and our plan, and our data, and our statistics, and all that type of stuff, let alone to operationalize this. So it is not as easy as one would assume it should be. (NPPO D)

Leaving the Model Test

Among participating POs, representatives of two 2021 model test participants (POs C and T) reported that their organizations will not continue their participation in 2022. Citing concerns similar to those raised by NPPOs, representatives from these two organizations noted that the lack of ROI from participation in VBID was a primary reason for leaving the model test.

For PO C, the savings achieved were insufficient to justify the cost of continued participation, which its representatives partially attributed to a small number of eligible and participating beneficiaries. From the very beginning of the model test, PO C representatives stated that their organization deliberately offered VBID benefits to a smaller population of beneficiaries in an attempt to minimize any potential financial losses. However, some implementation costs, including submitting the annual model test application, designing the benefits, and developing a system of identifying and tracking eligible beneficiaries, are fixed and hence can outweigh any ROI if the number of participating beneficiaries is low. PO C representatives described their decision as follows:

One of the definite considerations was the difficulty of measuring financial performance accurately and being able to justify a savings in the program to confidently say that what we were doing is really cheaper than doing nothing at all. And that was getting harder for us to justify in the actuarial side. While we thought the program provided value and that members appreciated everything that we were doing, it was difficult to continue under the VBID framework for that reason.

It is important to note that PO C has embraced the ability to offer VBID-style benefits outside of the model test and that the organization determined it did not need financial incentives to increase CM/DM engagement rates. In addition, because PO C owns some of its provider network, it would be easier to implement interventions that providers can offer to all patients, not just a subset of patients based on chronic disease status, LIS status, or plan enrollment.

Representatives from PO T described similar challenges with identifying sufficient ROI, which they also attributed to a small number of hospice-eligible VBID beneficiaries in their plans. They also stated that their organization had no beneficiaries participate in TCC, a key feature of the Hospice component. In discussing low patient volume, a representative commented that although their largest hospice partner has the capacity to provide care to 1,000 patients, it saw only about ten VBID patients. Therefore, it was burdensome to ask hospices to change the way they deliver and bill for care they provide to only 1 percent of their patients.

For the smaller hospices, we were asking them, we actually ended up placing a larger burden upon them to carry out some of the requirements, often duplicative, requiring different steps, different interoperability means in order to satisfy things. So, yes, the number of folks that we had transitioning to hospice was low in general, and, on top of that, we just didn't have the bandwidth to do what we discovered, to do what CMS had wanted as part of its proposal, which is to integrate with the hospice interdisciplinary team to be part of the care plan discussion for our members. (PO T)

Representatives from this PO also reported that it was difficult for their organization to adjust to new requirements from CMS. These concerns around reporting and administrative requirements were consistent with concerns raised by other POs that chose not to participate in the VBID model test in 2021. PO T reported not having enough bandwidth to automate claims processing and to submit Notices of Election (NOEs) to CMS. Although they thought the organization could create these systems as part of the model, they were unable to do so, which substantially increased the implementation burden. As a result, some for-profit OON hospices were dissatisfied with the time it took the PO to issue payments. In addition, working with OON hospices and asking hospices to provide care plans for all beneficiaries in the PO was time-consuming, especially given the variation in how hospices approach care plan development.

Summary

Fourteen POs participated in the model in 2020 and 19 in 2021. Of the 2021 participants, ten POs implemented only the BDI component, five implemented only the Hospice component, and four implemented both components. Model participants were more likely to be national and for-profit POs with higher enrollment that serve beneficiaries in counties with higher average MA penetration rates than nonparticipants.

The number of plans participating in the BDI component increased from 140 in 2020 to 377 in 2021; 52 plans offered the Hospice component in 2021. BDI-participating plans were more likely to be D-SNPs, had a higher percentage of dual and LIS-eligible enrollees, and had lower total premiums but higher OOP maximums, compared with nonparticipants. Hospice-participating plans were more likely to be D-SNPs with no monthly premiums and had lower OOP maximums. Compared with eligible nonparticipating plans, BDI-participating plans had a somewhat lower proportion of males and non-Hispanic White enrollees, and Hospice-

participating plans had a substantially lower proportion of non-Hispanic White beneficiaries. Almost all BDI participants and the vast majority of Hospice participants offered a prescription drug benefit.

The decision to join such model tests as VBID is made at the PO level. Both participating and nonparticipating PO representatives indicated that they typically have an internal system by which they evaluate the pros and cons of a model test opportunity. Through this system, teams of staff with various expertise, such as actuaries, clinicians, and compliance and marketing professionals, confer with each other to analyze what would be best for the organization and for beneficiaries. Some also consult with other POs that have experience with the model test (in this case, prior or existing VBID-participating POs). With this information, PO leadership decides whether to apply and, if so, also makes design decisions.

In the course of running through this process, some organizations decided to pursue VBID participation. Representatives of model test participants viewed VBID as well aligned with their organization's mission and priorities. POs embraced the opportunity to provide additional benefits to address SDOH among non-chronically ill beneficiaries or to address the needs of those with serious illness through the Hospice component. PO representatives also saw VBID as a chance to positively influence quality of care and health outcomes for their enrollees. POs could do this by targeting benefits to improve medication adherence or by providing continuity of care through end of life with the Hospice component.

In contrast, NPPO representatives cited several factors as contributing to their decision, including the availability of other mechanisms to offer additional benefits, such as PDSS and SSBCI, which competed for corporate attention and financial resources. Organizations heavily considered whether they would have sufficient resources for implementation and whether the administrative and reporting requirements of the VBID model test would prove too onerous. Relatedly, some were unclear whether the effort and investment in implementing VBID would yield sufficient savings and improvements in outcomes. A few were also concerned about the level of communication needed to avoid potential beneficiary confusion over VBID offerings.

Two POs that participated in the model test during 2021 decided not to continue their participation in 2022. Representatives of both POs cited difficulties demonstrating sufficient evidence that the returns—improvements in outcomes and financial savings—were worth the investment in terms of resources to set up and maintain their interventions, especially in light of relatively few enrollees being a part of the VBID interventions. In contrast, representatives of six NPPOs revealed that their organizations were seriously considering joining the model test in subsequent years.

PART II: VBID BENEFIT DESIGN INNOVATIONS

Chapter 3. BDI Interventions Implemented

This chapter describes the BDI interventions implemented by participating POs and the beneficiary groups those interventions targeted in 2020 or 2021. It also offers explanations of the reasons behind POs' decisions to choose a particular BDI subcomponent or beneficiary group to target. This chapter is based on the review of 2020 and 2021 model test applications, as well as 2021 interviews with 14 POs that implemented BDI subcomponents. We provide more-detailed descriptions of each PO's BDI interventions in Appendix E and explain reasons for *not* implementing different BDI subcomponents in Appendix F.

Key Findings

- The majority of VBID-participating POs and plans in 2020 and 2021 targeted beneficiaries based on their chronic conditions rather than SES. They chose chronic conditions that are most prevalent among their beneficiaries and those that are costly to manage.
 - Representatives from POs that focused on low-income beneficiaries stated that doing so simplified beneficiary identification and offered an opportunity to tackle more expensive downstream utilization of health services by addressing SDOH.
 - VBID Flexibilities was the most commonly implemented BDI subcomponent in both years, as measured by the number of plans implementing it.
 - Reduced cost sharing for medical services and outpatient drugs was the most commonly implemented category of VBID Flexibilities. POs offered non-PHRSBs more often than PHRSBs.
 - Although the number of POs offering RI programs decreased between 2020 and 2021, the number of plans offering them more than tripled during this period.
 - Only two POs implemented Cash Rebates; key reasons for offering this new benefit included a desire to help beneficiaries address their SDOH and increase plan enrollment.
-

Targeted Beneficiaries

For the VBID Flexibilities and RI subcomponents of the BDI component of the model test, POs could target their interventions to specific groups of beneficiaries, such as those with chronic conditions, those with low SES (defined as those eligible for LIS or for both Medicare and Medicaid in territories where LIS is not available), or both. Beneficiary targeting was not allowed for the Cash Rebates subcomponent because POs were required to offer them to all beneficiaries in a participating plan. Table 3.1 summarizes the number of POs and plans that included one or more targeted BDI interventions in their benefit design.

Table 3.1. Number of Parent Organizations and Plans with BDI Interventions Targeting Specific Beneficiary Groups

Target Group	2020	2020	2021	2021
	POs	Plans	POs	Plans
SES only	2	10	3	114
Health conditions only	8	107	7	229
Both	4	23	3	30
Total	14	140	13	373

SOURCE: RAND analysis of VBID model test application materials.

NOTE: One PO with a BDI intervention in 2021 offered the Cash Rebate subcomponent where there was no targeting; therefore, only 13 POs and only 373 plans are listed.

About half of POs and more than three-fifths of plans only targeted beneficiaries with chronic conditions or those who might benefit from such services as medication therapy management (MTM). POs designing interventions for beneficiaries with chronic conditions generally targeted high-prevalence conditions in their plans:

When we looked at the chronic conditions that our members had, 25 percent of our population is diabetic . . . at that time, our organization was focusing on improving diabetic measure adherence, preventive screening and HbA1c control, and so choosing diabetes as the chronic condition the first year just made sense.
(PO N)

POs also often picked conditions that were costly to manage because of frequent hospitalizations or other complications. “By the time a patient with diabetes reaches Medicare age,” said a PO W representative, “most probably that patient has been surviving with diabetes for a very long time. So there is a higher incidence and risk of complications being experienced at this stage of life.”

While two POs and ten plans in 2020 and three POs and 114 plans in 2021 focused solely on low-income beneficiaries, four POs and 23 plans in 2020 and three POs and 30 plans in 2021 focused on both low-income beneficiaries and beneficiaries with chronic conditions.¹ We identified beneficiaries with low SES through their eligibility for the Part D LIS or dual eligibility for Medicare and Medicaid in territories where LIS is not available. Although POs could target beneficiaries eligible for any LIS level, most targeted all LIS-eligible beneficiaries as a group (see “Levels of LIS Eligibility” text box below).

¹ POs could also target beneficiaries with chronic conditions in a D-SNP, where, effectively, the PO would also be targeting beneficiaries with LIS. However, we classified targeted groups according to how the PO described them, not whether the targeted group also happened to be a D-SNP.

PO representatives cited two main reasons for targeting low-income beneficiaries. The first one is related to the ease of implementation: CMS and the Social Security Administration track which beneficiaries are LIS eligible, and CMS communicates this information to plans, making it very easy for plans to identify these beneficiaries for intervention targeting. In contrast, beneficiaries with specific chronic conditions need to be identified through diagnosis code information in providers' claims for payment (which subsequently become the MA encounter data). The second reason for targeting beneficiaries with low SES was a desire to reduce expensive downstream utilization of health services by addressing SDOH, including food insecurity. "We know and we hear from our clinical team and from our representatives that our members were having difficulties affording healthy food," said a PO S representative.

Nearly all plans with an SES-based intervention were D-SNPs (91 percent in 2020 and 98 percent in 2021). "It makes it much easier to administer the benefit in a D-SNP when we can make it available to everybody that's enrolled," said a PO L representative. In 2020, 40 D-SNPs participated in the model test, about 7 percent of all D-SNPs nationally. In 2021, the number of participating D-SNPs grew to 157, representing about 26 percent of D-SNPs nationwide.

Interventions by Subcomponent

Although the same number of POs ($N = 10$) implemented VBID Flexibilities and RI programs in 2020, in 2021 that changed such that roughly twice as many implemented VBID Flexibilities ($N = 13$) as they did RI ($N = 7$) (Table 3.2). Only two POs (R and W) chose to implement Cash Rebates, a new BDI subcomponent for 2021. The proportion of POs that implemented more than one BDI subcomponent increased from 43 percent in 2020 to 50 percent in 2021.

The number of plans implementing each BDI subcomponent increased between 2020 and 2021. Two POs drove the large increase in the number of plans offering VBID Flexibilities: PO P increased its participation from 70 to 208 plans, and PO L increased from one to 65 plans. Although the number of POs offering RI decreased between the two years, from ten in 2020 to seven in 2021, the number of plans with RI interventions more than tripled from 77 in 2020 to

Levels of LIS Eligibility

There are four levels of LIS eligibility, each of which has standard premium and cost-sharing amounts (updated annually):

1. institutionalized beneficiaries or those receiving home and community-based services (no premiums or cost sharing)
2. beneficiaries who are dually eligible for Medicare and Medicaid (no premiums and \$1.30 generic/\$4.00 brand per prescription co-payments in 2021)
3. beneficiaries with incomes between 100 and 134 percent of the federal poverty level and limited resources (no premiums and \$3.70 generic/\$9.20 brand co-payments in 2021)
4. beneficiaries with incomes between 135 and 150 percent of the federal poverty level and limited resources (partial premiums, \$92 deductible, 15 percent coinsurance up to the catastrophic threshold with \$3.70 generic/\$9.20 brand co-payments thereafter for 2021) (Shapiro, 2022).

252 in 2021. This increase was driven by PO P, which offered this benefit in 21 plans in 2020 and 232 plans in 2021.

Table 3.2. Number of Parent Organizations and Plans Implementing BDI Subcomponents, 2020–2021

	2020		2021		
	VBID Flexibilities	RI	VBID Flexibilities	RI	Cash Rebates
PO B	1	0	1	0	0
PO C	6	6	6	6	0
PO G	5	0	5	0	0
PO J	1	0	1	0	0
PO L	1	14	65	0	0
PO N	1	1	1	1	0
PO O	8	8	8	8	0
PO P ^a	70	21	208	232	0
PO Q	1	0	1	0	0
PO R ^a	0	0	0	0	2
PO S	0	0	1	0	0
PO U	0	2	2	2	0
PO W ^a	0	1	1	1	2
PO Y ^a	0	0	2	2	0
PO AA	0	1	0	0	0
PO AB	4	17	0	0	0
PO AQ	0	6	0	0	0
Total POs	10	10	13	7	2
Total plans	98	77	302	252	4

SOURCE: RAND analysis of VBID model test application materials.

NOTE: POs could offer more than one component or subcomponent in a single plan.

^a Also implemented the Hospice component in 2021.

VBID Flexibilities

Ten POs in 2020 and 13 POs in 2021 implemented at least one of the three categories of VBID Flexibilities: supplemental benefits, including PHRSBs and non-PHRSBs; reduced cost sharing for receiving care from high-value providers, meeting participation requirements for engaging with CM/DM programs, or both; or reduced cost sharing for medical services and outpatient prescription drugs. Table 3.3 shows that reduced cost sharing for medical services and outpatient prescription drugs (covered by Part D) was the most popular subcomponent in each year, as measured by the total number of POs or plans implementing it; interventions that focused on use of high-value providers or had participation requirements were the next most popular of the three subcomponents (although more POs implemented supplemental benefits in 2021).

Table 3.3. Parent Organizations Implementing VBID Flexibilities Subcomponents, 2020–2021

	Any Suppl.	Any Suppl.	PHRSB	PHRSB	Non- PHRSB	Non- PHRSB	HVP/PR	HVP/PR	Reduced Cost Share	Reduced Cost Share
	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021
PO B	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes
PO C	No	No	No	No	No	No	No	No	Yes	Yes
PO G	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
PO J	No	No	No	No	No	No	No	No	Yes	Yes
PO L	Yes	Yes	Yes	No	No	Yes	No	No	Yes	Yes
PO N	No	Yes	No	No	No	Yes	No	No	Yes	Yes
PO O	No	No	No	No	No	No	Yes	Yes	Yes	Yes
PO P	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes
PO Q	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes
PO S	No	Yes	No	No	No	Yes	No	No	No	No
PO U	No	Yes	No	Yes	No	No	No	No	No	No
PO W	No	Yes	No	Yes	No	No	No	No	No	No
PO Y	No	No	No	No	No	No	No	Yes	No	Yes
PO AB	Yes	No	No	No	Yes	No	Yes	No	No	No
Total POs	6	9	4	5	2	5	6	6	9	10
Total plans	36	136	8	10	28	128	65	151	70	218

SOURCE: RAND analysis of VBID model test application materials.

NOTES: HVP/PR = high-value provider/participation requirement; Suppl. = supplemental. POs could implement more than one type of supplemental benefits.

Supplemental Benefits

POs participating in the model test can target PHRSBs and non-PHRSBs to subsets of beneficiaries based on chronic condition or LIS status. In 2020, six POs offered supplemental benefits to targeted beneficiaries in 36 plans, with four POs offering PHRSBs in eight plans and two POs offering non-PHRSBs in 28 plans. More POs offered supplemental benefits in 2021: nine POs and 136 plans in total. Five POs and ten plans offered PHRSBs, and five POs and 128 plans offered non-PHRSBs. Next, we describe the types of supplemental benefits that VBID-participating POs offered.

Primarily Health-Related Supplemental Benefits

Transportation: Two POs (B and G) offered transportation services to medical destinations to their targeted beneficiaries in 2020 and 2021. Representatives of these POs stated that they wanted to improve access to regular health care services, such as primary care provider (PCP) or specialist visits by providing the transportation benefit to help beneficiaries “get to the appointments that are necessary so they can follow up with their providers and make sure they’re staying on top of their health” (PO G). This PO representative noted that expanding the transportation benefit in rural areas is still difficult because of the lack of available transportation options.

Primarily Health-Related Supplemental Benefits

PHRSBs are items and services designed to treat or improve a health condition or injury (CMS, 2016a). Examples of these benefits include transportation to medical destinations, fitness benefits, OTC items, dental services, and eye exams. PHRSBs can be offered to all enrollees of a plan but can only be targeted to a specific group of beneficiaries via VBID, UF, or SSBCI.

OTC benefits: OTC health care–related items (e.g., such nonprescription medications as ibuprofen, first aid products, or oral hygiene items) are a common supplemental benefit outside VBID (Kornfield et al., 2021). PO Q has an OTC benefit of approximately \$60–\$75 per month in all of its plans; however, it increased the dollar value for its VBID plans to \$200–\$300 per quarter in 2020 and 2021.

Meal benefits: PO G offered prepared meals as a benefit in 2020 and 2021, which when medically indicated are a health-related supplemental benefit. Meals are available for a two-week period, up to three times each year, with an order from a physician. A representative explained, “Meals and good nutrition are really key to having good outcomes [for patients] with heart failure” (PO G).

Other: POs offered several other types of additional, health-related supplemental benefits, including dental care (PO B), remote monitoring devices (PO G), home health visits not covered by FFS Medicare (PO L), and fall risk assessments (PO U).

Non–Primarily Health-Related Supplemental Benefits

Healthy food: Cash (often delivered via a reloadable card) for healthy food items was the most commonly implemented non-PHRSB in 2021 (offered by POs L, N, P, and S), although

only PO P offered this benefit in 2020. Some POs offered this benefit to low-income beneficiaries in an attempt to reduce adverse medical events:

So third week of the month, fourth week of the month, as the existing assistance benefits start to dwindle, the . . . population starts to have to make difficult choices between paying their utilities, buying their food, covering the cost of their drugs. As those funds start to become tighter, you see higher rates of hypoglycemic-related hospital admissions. (PO P)

The dollar values for the healthy food card benefit varied from \$25 to \$200 per month, depending on such factors as the total value of the PO’s rebate dollars in a given year, other supplemental benefits offered by the PO, or competitiveness of the local market:

There’s always that ongoing tension from a bid perspective around what the plan can afford to invest. The policies are all funded through rebate dollars. We wanted to make the intervention available as broadly as possible recognizing that a significant portion of the D-SNP population is food insecure, and so we offered varying amounts to make it more affordable for plans that might also need to provide enhanced dental benefits or offer something else that was also critical to the health of the population but couldn’t quite afford the \$50 or \$75 card. (PO P)

Although some POs did not allow beneficiaries to retain unspent food benefit funds at the end of the month, others did and even allowed beneficiaries to spend them for a certain period after the benefit year closed. Some POs (N and S) combined the OTC and healthy food benefits so that funds were fungible between OTC and healthy food categories of needs.

POs offering the healthy food benefit generally used a vendor to set up the network of retail stores where groceries could be purchased and to identify the eligible items. Although some POs followed Supplemental Nutrition Assistance Program (SNAP) guidelines in determining eligible food items, others were more actively involved in the selection process:

We want[ed] to be really thoughtful about how we design[ed] the benefit, wanted to make sure that we were limiting members to things that we actually see value. So we removed some of the obvious categories like soda, chips, desserts that we know aren’t adding value and they’re not helping members make healthier choices. (PO L)

In response to the COVID-19 pandemic, some POs temporarily increased funds for the healthy food benefit (PO P) or added alternative delivery mechanisms, including online retail or delivery boxes (PO S). According to a representative from PO S,

We also allow[ed] this card to be used for home delivery and pantry boxes, and so we partnered with two grocery box external vendors that [went] online in between May and June of [2021], and it thus allows our members to go on their

Non-Primarily Health-Related Supplemental Benefits

Non-PHRSBs are items or services that may help maintain function or improve health status. These benefits may include transportation to nonmedical destinations, cooked meals that are not tied to hospitalizations or ordered by a physician, food or groceries, pest control services, portable air purifiers, and air conditioning units (Coleman, 2019). Non-PHRSBs are only available to beneficiaries via the VBID model test or SSBCI.

respective websites and order a grocery or food box and have it delivered directly to their door.

New and existing technologies and devices: Medical devices to help with remote monitoring of a condition were already allowed as supplemental benefits through Medicare. However, the VBID model extended this flexibility to include specific devices or technologies that might not be approved for coverage under Medicare, and to cover previously permitted items in a more expansive way than otherwise allowed. One PO implemented a new device intervention. PO W offered continuous glucose monitoring devices for diabetics and remote monitoring devices for beneficiaries with congestive heart failure (CHF) to help beneficiaries use these devices and manage interactions with clinicians.

Other: PO AB offered transportation to nonmedical destinations in 2020 (it did not participate in 2021). PO AB also offered additional meals that did not need to be ordered by a physician; as a result, these were considered non–primarily health-related.

Reduced Cost Sharing for High-Value Providers and/or Satisfying Care Management/Disease Management Participation Requirements

Two POs (B and Q) targeted reduced cost sharing for specific services provided by high-value providers. PO Q partnered with a provider group that only works with Medicare beneficiaries by offering them primary care, social services, and CM services delivered in the same physical location. PO B intended to use quality data to sort providers within certain specialties as high value but found that there were not enough quality data to be able to implement this approach. In the end, this PO considered all providers of certain specialist categories to be high value.

Six POs in 2020 and 2021 had participation requirements, such as a requirement to participate in a CM/DM program, to receive reduced cost sharing. As PO Y representatives explained, “The overarching goal [of CM/DM] is to find a way to get beneficiaries to interact with the plan and to reward them with lower drug copays.”

Reduced Cost Sharing for Medical Services and Outpatient Prescription Drugs

Reduced cost sharing for medical services and outpatient prescription drugs was the most frequently offered category of VBID Flexibilities, with nine POs implementing it in 2020 and ten POs in 2021. Of these, five POs in both years reduced cost sharing for medical services (Q, G, B, C, and O). PO Q reduced cost sharing for nearly all medical services for LIS-eligible beneficiaries, and representatives stated that their goal was to further reduce cost sharing for medical services because drug co-pays are already low for LIS-eligible beneficiaries. Two POs (Q and G) reduced cost sharing for PCPs. Other POs targeted certain specialists (G, B, and O) or reduced co-payments for durable medical equipment (B and C).

Four POs in 2020 and six POs in 2021 reduced cost sharing for outpatient prescription drugs; representatives of two POs (N and Y) cited improvement of medication adherence, particularly

for conditions that feed into Star Ratings (diabetes, hypertension, and cholesterol), as a motivation for providing this benefit. One representative noted that before VBID, some LIS-eligible beneficiaries still might not be able to afford medications after receiving the LIS, especially if taking multiple medications for more than one condition:

That's been a pain point for a long time [because] these members are obviously low income. They're making \$11,000 a year. Oftentimes we hear stories, and we know members struggle with "how do I pay my rent?"; "how do I afford my food?"; "how do I afford my medications?" To us, it's really kind of taking those social determinants of health and really addressing some of those needs. (PO L)

Rewards and Incentives Programs

RI are, by definition, tied to completing an activity, such as a preventive screening, a medication review, or a CM/DM activity. Ten POs implemented the RI BDI subcomponent in 2020, and seven did so in 2021. POs designed RI interventions to reward beneficiaries for improving the management of their chronic conditions. "At the end of the day, this is about probably transforming lifestyle and understanding of how can they better take care of themselves, so that the interventions are sustainable over time," said a PO W representative. Representatives of three POs noted that the RI programs introduced beneficiaries to CM services early on so that beneficiaries would be more receptive to engaging with a care manager when they have a clinical need to do so (POs C, W, and Y). A PO C representative stated that, ultimately, CM can matter more than direct financial incentives, such as reduced cost sharing or rewards for improving outcomes in this population: "The secret sauce is not always the dollars."

Finally, offering RI programs rather than reduced cost sharing at the point of sale allowed POs to provide what they perceived to be more-valuable incentives to beneficiaries: "You may not ever use your [reduced] cost sharing, but you can definitely use a Visa gift card," said a PO U representative. PO N noted that they had tried reduced cost sharing for prescription drugs in previous years for all members and did not see improvements in adherence, so they decided to try the RI approach instead to engage beneficiaries with medication management consultations.

PO representatives reported experimenting with the incentive amounts. For many, the dollar values were determined according to what the plan could afford, ranging from \$10 for completing a wellness activity to \$100 for completing a tailored health activity. Beneficiaries in some plans could accrue several rewards throughout the year for finishing regular health and wellness activities (including medication adherence consultations), completing screenings for specific conditions, or participating in check-ins with CM staff, up to a \$600 maximum. Other POs noted that the effectiveness of a reward might depend on the beneficiary population. PO C representatives reported targeting a very sick population (those with CHF, chronic obstructive pulmonary disease, or both) with a \$200 incentive for completing CM/DM activities. They also noted that the engagement rates were not as high as they had hoped and that the \$200 in total rewards for completing several health and wellness activities might not have been enough for this population.

Cash Rebates

Only two POs (R and W) selected the Cash Rebate BDI subcomponent. Depending on the PO and the plan, rebate values ranged from \$50 to \$160 per month. Both POs delivered the rebates electronically on a monthly basis to debit cards, which could be used for goods and services wherever credit cards could be used for payment. PO R took an extra step to make the plan identification card into a debit card so that beneficiaries needed only one card. Unspent amounts could be rolled over from month to month.

PO W representatives explained that the Cash Rebate allowed them to “give the member the power to use the benefit [of an additional financial resource] as they need to.” A PO R representative stated that this benefit helps address SDOH more effectively than supplemental benefits:

[W]e wanted to make this benefit available for other things that [beneficiaries] may have. Again, we are trying to attend [to] the social determinants of health as specific on economic relief and how it is not necessarily directly linked to health, but the implications of not being able to pay for essential things have a direct effect on health.

Finally, representatives of both POs felt that offering Cash Rebates could encourage enrollment in their plans, noting that beneficiaries often do not perceive supplemental benefits as valuable. “We already have the member Part B buy-down, but many members don’t see that benefit as tangible as the cash rebate,” said a PO R representative.

Summary

In both years of the model test, more than half of all POs participating in the BDI component implemented interventions that targeted beneficiaries with chronic conditions. The remaining POs (more than 40 percent in each year) targeted beneficiaries either based on LIS status alone or in combination with chronic conditions. Targeting LIS-eligible beneficiaries made beneficiary identification easy for POs and offered them an opportunity to proactively address more expensive downstream utilization of health services by addressing SDOH such as food insecurity.

POs implemented a variety of BDI subcomponents in their participating plans. The most commonly implemented BDI subcomponent in both years was the VBID Flexibilities, of which reduced cost sharing for medical services and outpatient prescription drugs was offered by the most plans. Roughly half of participating POs offered this category of benefits to beneficiaries with low SES. Among supplemental benefit options, more plans implemented non-PHRSBs than PHRSBs; cash assistance for healthy food items was the most frequently offered benefit in this category.

Although the number of POs offering RI programs decreased between 2020 and 2021, the number of plans offering RI interventions more than tripled. This increase was driven by one PO

that increased the number of plans offering this benefit from 21 to 232. Beneficiaries received between \$10 and \$100 for completing a preventive screening, a medication review, or a CM/DM activity. POs generally offered beneficiaries an opportunity to complete more than one RI activity each year to encourage beneficiaries to learn how to better manage their health and to experience the benefit of being continuously engaged with a care manager.

Cash Rebates were a new option for 2021, and only two POs implemented this intervention. POs offered rebate amounts that ranged from \$50 to \$160 per month in an effort to help beneficiaries address SDOH. PO representatives expressed feeling that Cash Rebates could be more effective than supplemental benefits for addressing economic issues that underpin poor health by giving beneficiaries agency in how the money is spent. Both POs considered rebates as a valued strategy for increasing their plan enrollment.

Chapter 4. BDI: Implementation Experiences, Challenges, and Facilitators

To design and implement many of the BDI interventions, POs had to develop an approach to identify eligible beneficiaries, track beneficiary eligibility and utilization of model test benefits over time, and issue rewards for completing certain CM/DM activities, as well as monthly cash rebates. They also had to comply with the model test requirements, including submitting marketing materials for CMS review and participating in model test monitoring activities, which required periodic data submission. In addition, they needed to develop or renew contractual relationships and agree on service delivery protocols with vendors to facilitate the provision of VBID benefits to eligible beneficiaries, among other activities.

It is worth noting that vendors played a key role in helping POs deliver their VBID benefits. POs reported outsourcing the delivery of transportation, healthy food, WHP, and fall risk assessments, among other services.

To better explain BDI implementation experiences, we elicited the perspectives of all 14 POs that implemented the BDI component in 2021 and ten vendors that helped them deliver model test benefits. Both stakeholders participated in a semistructured interview in fall 2021; PO representatives also answered a series of closed-ended questions about their implementation experiences prior to the interview. This chapter synthesizes POs' and vendors' BDI implementation experiences, focusing specifically on implementation challenges and facilitators, and concludes with their observations on the effect of the COVID-19 pandemic on BDI implementation.

Key Findings

- POs generally did not perceive BDI implementation to be too burdensome. Some specifically designed their interventions to be easy to implement, such as by offering VBID benefits to all enrollees of a D-SNP plan or targeting beneficiaries based on LIS eligibility.
- Compliance with model test reporting requirements, working with vendors for intervention delivery, communicating about VBID to providers and beneficiaries, and incorporating CMS review of marketing materials into communication processes were among the most challenging aspects of BDI implementation; however, they were typically rated only as “moderately” or “slightly” challenging.
- PO representatives frequently cited leadership support, cross-team functionality, and financial investments as the main facilitators of successful implementation of BDI interventions. POs stated that having a continuous quality improvement mindset was also helpful.
- Most vendors had preexisting relationships with the participating POs and viewed model test participation as a natural extension of those relationships.
- Vendors reported not fully understanding the model test at first, needing to update their data systems, and finding that participation involved more time than expected, but generally viewed the model test positively and considered their participation a strong business opportunity for their organizations.

- PO and vendor views on whether the COVID-19 pandemic affected their VBID interventions varied substantially, with some seeing no apparent impact on implementation. Although in-person service delivery was most affected by the pandemic, POs and vendors were often able to modify some of these interventions to allow for virtual or contactless service delivery or succeeded in replacing contractors not able to maintain their operations during the pandemic.
 - POs and vendors also observed some positive impacts from the restrictions on in-person interactions, including greater interaction between care managers and beneficiaries who had more free time, increased use of telehealth services, and increased demand for farmers markets and mail-order pharmacy benefits.
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Implementation Experiences

Slightly more than half of POs that implemented BDI interventions did not find implementation to be very challenging or burdensome, indicating that most POs thought BDI implementation went smoothly. They often tried to design BDI interventions with ease of implementation in mind, such as by offering VBID within a D-SNP, targeting LIS-eligible beneficiaries to facilitate the process of identifying eligible beneficiaries, or both. For example, PO S representatives referenced that CMS creates flags for LIS-eligible beneficiaries on a monthly basis, which made identifying eligible beneficiaries a nonissue; moreover, the vast majority of D-SNP members are LIS eligible, which also simplifies the process of beneficiary identification. PO Y representatives stated that they reduced beneficiary cost sharing for certain outpatient medications as part of the VBID model test and considered all beneficiaries in their VBID-participating plans who fill a prescription for these medications to be VBID eligible. PO L combined the two approaches, which helped with beneficiary identification:

We are applying [a Part D VBID benefit] to everyone with LIS. We specifically chose to do it on D-SNPs only so that we're doing it consistently for all members of the PBP, which was what we heard from our pharmacy claims people at the PBM was the only way they'd be able to administer it where they'd be confident it would be done correctly. So because we're applying it to all members of the PBP, they had a way to set it up . . . so that zero co-pay is what the pharmacy sees when the member picks up the prescription, so they shouldn't be charged at all or have to get in the middle of that.

Moreover, PO P representatives said their organization added an RI component as part of the VBID benefit to the existing MTM program to facilitate the administration of VBID benefits. Other approaches included working closely with vendors (PO O) or not changing VBID interventions from year to year (PO J).

Five PO representatives felt that the implementation has been somewhat challenging, noting that many of these challenges have been overcome with time. PO P representatives stated that the first year of their model test participation was “a pretty heavy lift” that required collaboration across multiple teams, information technology (IT) infrastructure changes to be able to track multiple benefits within the same plan, and modifications to normal business procedures, but noted that in “following years, it's not quite as heavy a lift . . . because we have our roles and responsibilities a lot more understood at this point.” Other POs that continued their VBID

participation in 2021 considered the model test a “learning process” and “an interesting journey” (PO C) that gave them “a little bit of a leg up” (PO G) in thinking about UF and SSBCI.

Implementation Challenges

Regardless of whether POs viewed implementation as burdensome or relatively easy, responses to our pre-interview questionnaire (Table 4.1) and interview data show that most POs thought that at least some aspects of their model test participation were “slightly” or “moderately” challenging.

Table 4.1. Parent Organization Questionnaire Ratings of BDI Implementation Challenges

Challenge	Not at All	Slightly	Moderately	Considerably	A Great Deal	Median
Reporting data as part of model participation activities	2	3	7	1	1	Moderately
Working with vendors or subcontractors for components of your VBID intervention(s)	1	4	5	0	1	Moderately
Communicating VBID benefits information to providers	4	2	4	2	0	Slightly/moderately
Communicating VBID benefits information to beneficiaries	5	4	2	1	1	Slightly
CMS review of marketing materials	5	5	2	0	2	Slightly
Administering multiple sets of benefits within one PBP	6	1	4	0	1	Not at all/slightly
Identifying eligible beneficiaries	9	4	0	0	1	Not at all
Tracking beneficiary VBID eligibility over time	8	2	2	2	0	Not at all

SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.

Questionnaire results show that seven POs rated VBID reporting requirements as being “moderately” challenging. During the interview, representatives of POs B, C, N, O, and Y noted that the meaning of some data fields was not clear and changed over time, which required some back-and-forth communication with CMS and the monitoring contractor. Representatives from PO B described their experiences with data reporting as follows:

One of the things that we struggled with in the beginning . . . and we’ve now sort of normalized, is the reporting, and especially over the past two years, making sure that the reporting meets with what CMS and [VBID Implementation and Monitoring Contractor] expect . . . I think really understanding what the expectations are in terms of data to make sure that your program aligns with how the data is going to be reported [has been challenging]. In the past year-and-a-half that was something that we just had a bunch of back and forth with CMS . . .

trying to make sure that we were reporting the data in a way that made sense to them when we stood up the program completely differently.

PO C and P representatives found the time and staff effort needed to submit all required data in a CMS-specified format to be “moderately” challenging. PO P representatives also found it difficult to track and submit data about new beneficiaries to their gift card vendor throughout the year. Finally, some representatives felt that keeping track of and reporting the reasons for beneficiary opt-outs using CMS-specified categories required much effort and coordination with their CM/DM vendor:

On the reporting side, [our CM/DM vendor has] different opt-out reasons, and I think they kind of bucket them under the term “opt-out,” and there could be what they’re using, some of the definitions that they’re using, they want to see people who have told, “Hey, listen, I’m not interested. Don’t ever call me again,” people who have either passed away, have become ineligible, or left the plan and gone to another carrier. . . . [We worked] with our [CM/DM vendor] to figure out: “Hey, what exactly happened with this member?” . . . I think tracking that kind of, the reporting piece, we’ve had to work a little harder with [the vendor] to get the definitions lined up with what the folks at CMMI are expecting to see in the data. (PO O)

The questionnaires also revealed that POs found working with vendors or subcontractors to deliver VBID interventions “moderately” challenging. Representatives of only one PO did not agree, indicating it did not pose any challenges. Other PO representatives, however, indicated they experienced at least some challenges trying to establish the right infrastructure to ensure smooth delivery of VBID benefits. Although most vendors involved in the delivery of VBID benefits were not new partners of VBID-participating POs, new protocols and processes still needed to be established. Representatives from four POs (C, P, N, and U) said they needed to build infrastructure to share and receive data with vendors, coordinate between IT departments, and ensure compliance with CMS requirements. One representative explained, “Challenges for us, like others, would be reporting once members change plans, ensuring that we pick them up with the new eligibility run, really establishing that gift card vendor relationship . . . and making sure the vendor has the right information at the right time” (PO P).

Several POs noted that working with vendors that provide gift cards and food card benefits in particular required additional time and effort because these benefits were new to POs. Of particular note were challenges related to the type of card usage data that can be reported to POs:

Getting what we wanted for reporting versus what they could provide [was an issue]. For example, for the Visa debit card, sometimes case management is not able to help the member as much as they would like because . . . there are security reasons why they can’t tell us what transactions were used on the Visa debit card. They have to call the Visa vendor, and I think that sometimes that’s been a little bit of a challenge. And even though they can tell us how much money was used on the Visa cards and give us a high-level overview whether it was spent at a grocery store, a retail store, they don’t give us the membership data due to the security reasons. (PO C)

When it came to healthy food cards, the expansion of retail networks accepting the card and the integration of the food card with point-of-sale systems to determine eligible items was a challenge:

[G]etting integrated with a grocer's point of sale system has been pretty tricky, and most of the grocery stores in [our area] are independents, even the chains are fairly small chains with maybe ten stores. . . . It's been hard on both fronts, kind of getting an independent to invest in allowing us to change, to modify their technology so that our card will work is challenging, because you can only do one at a time. Then getting a big chain to prioritize this change and among all of their technology changes is also challenging. (PO S)

Communicating VBID benefits information to providers was a slight-to-moderate challenge from the perspective of participating POs. Many POs designed their VBID interventions to operate without active provider awareness and therefore did not conduct active provider outreach. Two Phase II model participants reported not actively communicating with providers about participation in the model test, even though some of their VBID benefits include \$0 co-pays and rewards for medication adherence. According to PO L representatives:

Providers have a lot of different plans that they're serving. The concern is providers aren't going to be able to differentiate [VBID and non-VBID members], and it's going to be more difficult for them to explain how this works if they're not sure at the time of the visit. They're focused on the member's care. They're not focused on the member's other benefits. So that's been our biggest challenge and why we haven't really used the provider avenue, because we think there's better opportunities where we're getting directly in front of the member to kind of promote these benefits.

Representatives of POs that did conduct outreach to providers noted that providers could be an important avenue for disseminating information about VBID benefits, but the small size of the VBID population makes provider engagement challenging:

We have provided some provider education in the form of documents on our provider resource center, some provider-specific communication, leveraging our colleagues that support providers. But what we found is it's difficult on the provider side to know even what insurance a member has, yet alone knowing that they have a specific product that offers specific benefits. Because of the small size of this population, because it's like a subproduct of a product, having that provider knowledge and provider awareness has been challenging. (PO B)

Questionnaire results also indicated that communicating VBID benefits information to beneficiaries was considered "slightly" challenging. The nature of the BDI interventions and the associated participation requirements were the most difficult aspects to explain to beneficiaries. Some POs focused their interventions on beneficiaries with cognitive impairments, which further complicated beneficiary communication and engagement activities. PO L, for example, targeted individuals with dementia. Others offering the new Cash Rebates, such as PO R and PO W, had to develop ways to explain these benefits to their beneficiaries and counteract a negative

marketing campaign initiated by their competitors (see a quotation from a PO W representative that follows).

Some POs modified their standard care delivery approaches—for example, by requiring beneficiaries to see a pharmacist at one of their clinics for medication reconciliation before receiving a gift card. A PO W representative reported experiencing challenges with explaining their VBID program to beneficiaries:

[Our beneficiaries are] used to those programs over the phone where they call and get educated. . . . Understanding that it's a different model [was challenging]. When they come in, one thing that people are not used to is a pharmacist . . . I think that the biggest barrier was to get them to come in and really get that on-boarding process [required for ongoing engagement].

Others reported that “getting ahold of our members telephonically” (PO N) or “getting the patients to come on site for the initial visit” (PO W) was challenging and that “some members don't believe that [VBID benefits would be] helpful to them” (PO N).

Several POs that used gift or OTC cards to encourage continuous engagement in CM/DM-type activities stated that the communication around the issuance of new cards and when additional funds would become available after successful completion of participation requirements caused some challenges. A PO Y representative said that the “biggest issue is that they didn't tell members when they would expect to get the cards. We wanted to do it on a quarterly basis, but didn't communicate that [clearly] to members.” A PO N representative stated that many beneficiaries did not understand that the rewards would be loaded automatically a month after each CM session.

Another requirement related to PO participation in the model test, CMS review of marketing materials, was also considered a “slight” challenge. PO representatives felt there were discrepancies between VBID-specific and CMS-wide marketing guidance, which made VBID implementation more complicated:

Some of the areas where we had hiccups, which get in the way of us doing things timely or as good as we'd like, would be things like guidance around marketing communications, evidence of coverage, and annual notice of change. . . . There's a lot of detail wrapped around that, but we very early on recognized that some of this hadn't fully been worked through. So we found ourselves working with the broader team at CMMI to make sure that we're all on the same page. (PO Q)

The POs that offered Cash Rebates (R and W) experienced some additional challenges related to the development of marketing materials because they had to specify the total rebate amount by year and by month, add a description of potential tax consequences associated with the provision of this benefit, and incorporate an additional ten-day period for CMS review. Furthermore, these POs had to work with the Department of Treasury to receive a ruling that the cash benefit would not be considered taxable income. Unfortunately, that ruling came after the CMS review process was completed, and POs had already mailed out documents mentioning potential tax implications. Their competitor leveraged this hiccup to their advantage:

When members received their ANOCs [Annual Notice of Change] and their EOCs [Evidence of Coverage], what they were seeing is that they were going to be receiving this amount of money, and this could have tax implications. As you can imagine, in [our highly competitive market], some competitors went ahead and used images of our ANOCs in their propaganda stating that [PO R] was providing benefits that will affect them in their eligibility for Medicaid. (PO R)

Administering multiple sets of benefits within one plan, identifying eligible beneficiaries, and tracking beneficiary eligibility over time were not considered major challenges by POs. The questionnaire results show that at least half of PO representatives reported that they did not experience these challenges. As a PO B representative said,

[C]ontinuing to operate the same way with the same sort of structure that we have for so long, I think that some of those types of implementation issues have sort of resolved themselves, whether it's how to keep track of the data, how to operationalize things. I think one of the benefits is that now some things are kind of [business as usual] in this sphere.

Those that reported experiencing some of these challenges stated that figuring out how to track beneficiary reasons for opting out (PO O) and setting up the IT systems (PO P) were challenging only early on:

IT is the biggest challenge . . . IT in every organization is time consuming and requires a lot of notice. Where we were with year one in knowing the needs that it would take to get the pipes built to support the service coverage appropriately for flagging the members and supporting them was very much a fast feat to implement for our IT organization. We pulled it off, but it was the biggest challenge by far. (PO P)

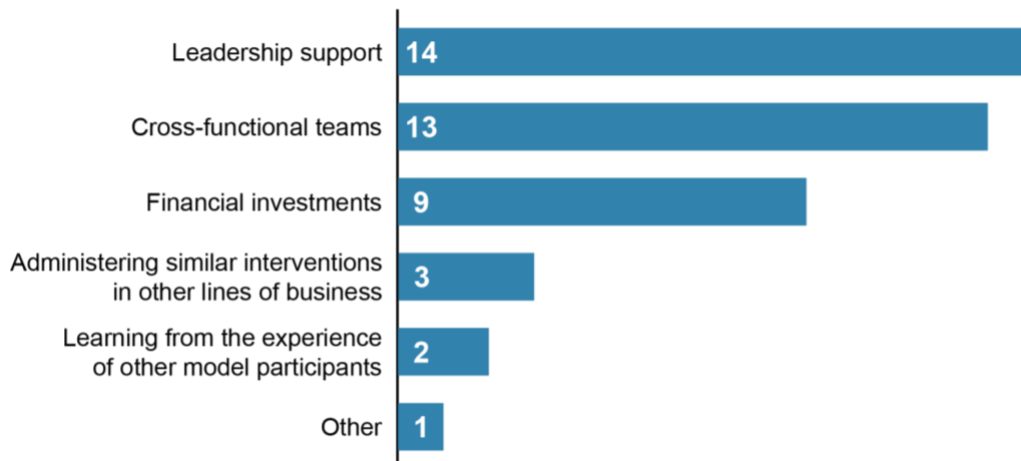
Implementation Facilitators

The top three implementation facilitators mentioned most frequently in the questionnaire by the representatives of 14 POs implementing the BDI component were leadership support ($N = 14$), cross-functional teams ($N = 13$), and financial investments ($N = 9$) (Figure 4.1). A PO G representative illustrated the importance of all three factors as follows:

[Y]ou need financial investments because you're setting up new systems. You might need to hire new resources. You need additional data analytic capabilities. And you need time, right? . . . As a large plan with a lot of different diverse needs from our members and a lot of different programs and things that we're trying to do . . . we [need to] have the leadership support. I would just emphasize that having a cross-functional team to really help work through issues is extremely helpful.

Figure 4.1. BDI Implementation Facilitators Endorsed by Parent Organizations (N = 14)

SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.



Experience administering similar interventions in other lines of business and learning from the experience of other model test participants were considered implementation facilitators only by three and two POs, respectively. Representatives of one PO noted that reliance on existing research and clinical studies helped them design and implement their BDI interventions.

Our interviews revealed another important implementation facilitator, reliance on a continuous quality improvement mindset, which helped POs increase beneficiary awareness of the VBID benefits. For instance, one PO developed a multimodal communications strategy:

Now that we've got five months of understanding of people's utilization patterns, what they're buying, and who's using it, and who's not using it, how do we start to do outreach? So we've got our marketing [department working on it]. Our member experience team is really talking about how [to] change some of our call center scripts when members call in to remind them [of the benefit]. We've talked about . . . how [to] do member notifications, member mailers, postcards, whatever it is [differently]. (PO L)

This continuous quality improvement mindset also helped POs work with vendors to ensure that they “have a really strong Medicare partnership on design and testing and checking on the integrity of the[ir] work” (PO N). By quickly applying lessons learned, POs were able to make needed adjustments either to their marketing strategies throughout a given model year or to their future VBID intervention designs and vendor relationships as they prepared for the next model year. Several POs reported changing their vendors for 2021, particularly those involved in the delivery of OTC card benefits. Continuous quality improvement also helped some POs make adjustments to their BDI intervention design and implementation strategies during the COVID-19 pandemic, discussed next.

To facilitate the implementation of BDI interventions, 11 of the 14 POs reported making at least some additional investments. Of these, all invested in new marketing activities and

materials; nine invested in efforts designed to ensure compliance with VBID reporting and auditing requirements; six hired new staff and worked with a new vendor; five upgraded their existing IT and claims processing systems, and one additional PO stated that they had to purchase new equipment to be able to implement VBID; three established new call centers; and one created a new provider training program.

Vendor Intervention Experiences

During our interviews with POs, we learned that many POs contracted with vendors to ensure smooth implementation of their VBID interventions, including the provision of primarily health-related and non–primarily health-related services and benefits. We interviewed ten vendors regarding their experiences, both with the model test and with POs working to implement their VBID interventions. Five vendors offered primarily health-related services and benefits, such as fall risk assessments, and five offered non–primarily health-related services, such as nonemergency medical transportation. Table 4.2 lists vendors we interviewed (the vendor ID associates them with their respective POs) and describes their services.

Table 4.2. VBID Vendors (N = 10)

Vendor ID	Description of Services
PO G V1	Medically tailored cooked meals
PO G V2	Nonemergency medical transportation broker
PO J V1	ACP tool
PO N V1	Medication adherence program
PO N V2	OTC card implementation
PO Q V1	High-value provider
PO Q V2	OTC card implementation
PO S V1	Farmers markets, farm stands, and fresh food boxes
PO U V1	Fall risk assessment provider
PO X V1	Hospice claims processing assistance

SOURCE: RAND analysis of 2021 vendor interview data.

Contractual and Payment Arrangements with Vendors

Payment methods for vendor services varied considerably. Among those that provided such information during the interviews, some received payments on a per member, per month (PMPM) basis (PO X V1 and PO Q V2) and others on a per service, per member basis (PO N V1 and PO G V1). A vendor providing ACP services (PO J V1) stated that they have an at-risk contract with the PO: “Our contractual relationship basically said that if we don’t cover our costs with return on investment, we essentially have to give all the money back. So we put 100 percent

of our fees at risk.” Other vendors (such as PO Q V2) noted that although they do not have an at-risk contract, they would be interested in signing one.

Reasons for Participation

Eight vendors had preexisting relationships with their respective POs and viewed VBID as an extension of services they already offered to their PO. According to one vendor representative:

It’s just sort of how our partnership has always evolved. We started with them quite some time ago. We started as a pilot and when that pilot was successful, we expanded to their other lines of business. And VBID really was just a natural extension of that. (PO J V1)

The two vendors (PO S V1 and PO U V1) that did not have existing relationships with their respective POs felt that their services could help POs address important beneficiary needs. A fall risk assessment vendor (PO U V1) described an introductory meeting with PO U to discuss a provision of the new supplemental benefit for the model test as one where “everyone got very excited very quickly, and we could see the potential of what we could do going forward.”

Our interviewees generally viewed their participation in the VBID model as a business expansion opportunity. “VBID helped,” said representatives of PO J V1, because “we got an opportunity to demonstrate that we’re a good partner.” A few other vendors noted that they hoped their participation would lead to the opportunity to expand into new POs or new markets. For example, a representative for a cooked meals vendor (PO G V1) stated, “[I]t’s a great fit for us as an organization and helps expand what we do across the country, not only for [PO G] but other plans [as well].”

Implementation Experiences

Almost all vendors felt that their VBID participation was relatively easy and not burdensome, regardless of whether they had an existing relationship with the PO. For instance, a healthy food card vendor with an existing relationship with its PO stated,

I would say it’s been very easy. Again, we already had that relationship with [PO N] in place. They were already familiar with our processes and procedures so [it was] really just a matter of kind of adding to what was already existing, so [it was] very straightforward. (PO N V2)

A vendor newly contracting with its PO cited the PO’s willingness to work with the vendor’s existing systems as reducing implementation burden:

And what really, I think, allowed this program to be possible, too, was [PO S’s] willingness to work with the point-of-sale system that we were already using at our retail sites. (PO S V1)

Implementation Challenges

Although vendors generally felt that their participation in the model test was not too burdensome, many encountered three main implementation challenges early on but have been able to overcome or develop plans to address them since.

First, some vendors noted that, early on, they did not fully understand the model test or its requirements and had to develop new business processes to accommodate the model test requirements. Representatives from one vendor stated that they had

a rocky start, just because there was a little bit of a lack of information that was available to us at the onset. Obviously, the client looks to us as subject-matter experts, but this was a new demonstration that we previously had no experience from an end-to-end hospice member process. . . . Part of the struggle was that PO X does have a lot of custom process[es] that are non-standard for us. We had to “peel back the onion” to see some of the other downstream impacts as we made these configuration updates. (PO X V1)

Developing new business processes was particularly burdensome given that the number of VBID-eligible beneficiaries was low during the first year. PO G V2 representatives noted that they expect to see an increased volume of VBID beneficiaries as the model is expanded to other plans within PO G.

Second, several vendors discussed the need to update their data systems, and some noted that doing so required additional investments. For example, a vendor serving as a nonemergency medical transportation broker (PO G V2) recognized that when beneficiaries call them, they need to differentiate between their use of the core transportation benefit and the VBID transportation benefit to provide the correct information about the number of trips remaining. Another vendor (PO Q V2) also reported working on making their data systems more integrated and automated (e.g., incorporating beneficiary health information from the PO to reduce the burden on beneficiaries for creating a personal health profile, ensuring data reports meet the needs of their PO and are presented in an actionable manner).

Finally, a couple of vendors mentioned that they had incurred unexpected time costs, including discussions explaining the differences between core benefits and VBID benefits to beneficiaries. A vendor operating farmers markets stated,

We didn't want to promote this program too broadly in the same way that we do for SNAP where we broadcast it on social media channels just because the eligibility for the program is limited to a couple of specific plans under the [PO S]. And we do get questions from customers [about why only some beneficiaries with the PO's plans could use their OTC cards at the farmers market and which OTC cards, generally, are accepted]. (PO S V1)

Another vendor (PO N V1) whose pharmacists support the implementation of a medication adherence program stated that it takes “20 minutes usually on the phone with a patient, whereas VBID interviews and even the follow-ups are taking significantly longer than what we projected for.” The vendor also noted that PO N's VBID intervention required them to work with another

vendor to distribute blood pressure cuffs to beneficiaries, which was challenging and required additional staff time to ensure that the equipment was delivered to beneficiaries in a timely fashion. To account for unexpected time costs, this vendor reported increasing its service fees for 2022.

Implementation Facilitators

Vendor representatives reported having positive working relationships and open communication channels with their respective POs as key to implementing VBID, and many met with PO representatives weekly or biweekly. A representative from one vendor stated,

For us the communication—first let me start with the PO G team. We have calls every couple of weeks with a team meeting of what’s going on and what’s taking place. We go through the reports. We go through any issues or concerns that may have come up. . . . So we’re in constant communication with the team that runs this part of the program with us. And they’re very good at their management of what we do. (PO G V1)

Impact of the COVID-19 Pandemic

During PO and vendor interviews conducted in 2021, we asked questions about their perspective on the impact that the COVID-19 pandemic had on the implementation and outcomes of the VBID model test. This section covers our interviewees’ perspectives on the pandemic’s impact on the BDI component in both 2020 and 2021. We note that because some POs left the model test after 2020, we could not capture the impact of the COVID-19 pandemic on their BDI implementation experiences.

There was no consensus among PO and vendor representatives on the impact of the COVID-19 pandemic on their BDI component implementation and outcomes. Representatives of five POs (L, N, O, R, and S) stated that the COVID-19 pandemic affected some aspects of their BDI implementation. For instance, beneficiary identification was affected at one PO because beneficiaries were not seeing providers as frequently; thus, there were fewer opportunities for them to be coded with a given condition (PO N). Because many PO employees could not come to the office, mailroom operations were also affected, which slowed down the distribution of VBID-related materials to eligible beneficiaries (PO R). One PO shifted operationalization of CM/DM participation requirements by replacing a requirement for face-to-face visits with telephonic engagement with care managers (PO O). Food vendor network expansion was affected for one PO because it required “a vendor representative going door-to-door” to grocery stores to sign them up (PO S). One intervention even had to be discontinued because it provided at-home care for dementia beneficiaries who did not want to let anyone come to their homes (PO L). Similarly, representatives from at least six POs reported that the COVID-19 pandemic negatively affected utilization of all BDI benefits requiring in-person interactions, such as

preventive care (PO Q and PO W), fall risk assessments (PO U), in-home care (PO L and PO O), and the use of healthy food cards (PO P).

For vendors, in-person delivery of goods and services was particularly difficult. Some prepared meals delivered to homes had to be left at the curbside, which meant that they might not have been noticed by beneficiaries for an extended period of time. Some health care services, such as primary care visits, had to be delivered virtually. One vendor (PO Q V1) found that only 40 percent of the beneficiaries they served could access video telehealth services, making telehealth a challenging treatment modality.

The COVID-19 pandemic also affected vendors' staffing and availability to deliver services. A nonemergency medical transportation broker (PO G V2) had to expand its contractor network when its previously contracted drivers exited the market because of decreased demand for services.

In contrast, representatives of two POs (J and U) did not view the COVID-19 pandemic as having had a major impact on the implementation of their BDI interventions. PO U representatives reported that in-person MTM sessions had started to be delivered by telephone, whereas PO J representatives stated that reducing cost sharing for medications at the point of sale did not require any COVID-19–related modifications.

Representatives of at least seven POs reported some positive unintended consequences of the COVID-19 pandemic. For example, some felt that CM/DM engagement rates increased, which they attributed to beneficiaries having more free time and becoming more willing to speak with care managers (PO G and PO P). One representative described their interpretation of why engagement rates increased during the pandemic:

There was some isolation, some loneliness that was detected throughout those [CM/DM] discussions and those conversations. So being engaged with care management and being able to refer [beneficiaries to] . . . some behavioral health coaching or some education around that, I think because of COVID, we had a good participation. (PO C)

Others felt that conversations with care managers were helpful to beneficiaries on multiple fronts. For example, according to representatives of POs C and G, they helped beneficiaries deal “with social isolation, with access to community resources, access to PCPs, how to get online to do tele-visits” (PO G). PO B representatives reported that this increased level of CM/DM engagement helped them “discuss any concerns or things [beneficiaries had] been hearing about COVID . . . give member[s] firsthand information on [COVID-19 vaccines],” thereby creating an opportunity to address COVID-19 misinformation.

In terms of utilization of VBID services, PO S representatives noted that they generally saw a reduction in outpatient care costs attributable to the reduction in primary care and specialty visits, increased use of virtual care, reduction in inpatient care not related to COVID-19, and high inpatient costs related to COVID-19 hospitalization. Others noted an increase in the use of

mail-order pharmacy (PO N and PO S), home delivery services (PO S), and telehealth services (PO G and PO L), which they attributed to COVID-19–related restrictions.

Two vendors also reported an increased demand for their services because of the pandemic. A representative of PO S V1 that runs a network of farmers markets said, “We heard from customers that they felt safer shopping outdoors, and so they have this motivation [from] the pandemic, just being in an open-air setting where it was more possible to socially distance.” Similarly, a representative of a PO Q V2 vendor, which provides an OTC benefit, noted an increase in the volume of mail-order items.

Because utilization patterns changed from prior years, representatives from several POs (including B, C, and G) raised concerns about using 2020 and 2021 data for the purposes of evaluating VBID or interpreting any evaluation findings during the pandemic:

From our initial evaluations of VBID . . . we were seeing what we view as positive reductions in . . . acute in-patient admissions, medical costs, and things of that nature. But with COVID and the depression of people seeking services, in a lot of cases, that might actually be necessary. We may see on paper a greater cost savings, but I’m not sure that that’s the level of cost savings we want to see. So I think it’s going to be hard to parse out the impact of the program from just general reduction in utilization. (PO G)

Summary

A little more than half of POs did not consider BDI intervention implementation to be challenging, noting that they were able to overcome challenges they experienced early on during the implementation. Out of a wide variety of BDI designs implemented in 2021, the ones that focused on LIS-eligible beneficiaries in D-SNPs and those reducing beneficiary cost sharing for certain Part D outpatient medications might have been the simplest to implement because it was relatively easy for POs to correctly identify eligible beneficiaries and co-pays.

Most challenges explored through the questionnaires were rated, on average, as moderately to slightly challenging, with a few rated as nonissues for most POs. The highest-rated challenges were data reporting, working with vendors, and, to some extent, communicating about VBID with providers and beneficiaries. In interviews on these topics, PO representatives cited difficulties with supplying the correct data to CMS, from deciphering the meaning of some data fields to applying the appropriate formatting to data submissions. Most POs reported having to spend time setting up infrastructure to appropriately manage vendor relationships and care delivery, although vendors cited few challenges of this nature. Generally, only new Phase II VBID participants experienced difficulties with tracking beneficiaries and their eligibility or with managing multiple VBID offerings within a given plan.

POs identified three factors that helped them implement BDI interventions: support from leadership, teams that can function across departments, and sufficient financial investment in VBID. A few POs also found it helpful to learn about similar interventions in other lines of

business or about the experiences of other model test participants. Additional financial investments were required to develop VBID-specific communication and marketing materials, comply with model reporting and auditing requirements, and hire additional staff, vendors, or both to help with implementation.

Most vendors we interviewed did not always feel that they had a strong understanding of VBID or its requirements, but they did have preexisting relationships with their respective POs, which made their experiences relatively free of burden. Vendor representatives noted that participation in VBID felt like a natural extension of these relationships, although some cited the need to update their data systems to keep up with new process requirements in the model test. Several vendors also mentioned that participation incurred some additional time costs that they were not expecting, which might affect their rates going forward.

Although the BDI implementation took place during the COVID-19 pandemic, most interventions were able to proceed either with small adjustments to allow for social distancing or remote service delivery or with no changes at all. The interventions most affected by the pandemic required in-person visits or service use, but where appropriate those requirements were adjusted to allow for virtual visits (e.g., primary care visits or CM/DM touchpoints) or contactless delivery (e.g., meal delivery). Positive consequences of the pandemic included care managers having more access to and time with beneficiaries to talk about VBID benefits and address concerns related to COVID-19 vaccines, for example, and to help with the social isolation many beneficiaries were experiencing. POs reported lower outpatient care costs, which they attributed to the reduction in primary and specialty care visits because of COVID-19 and the increased use of telehealth services, but also high costs of care related to COVID-19 hospitalization and increased use of mail-order pharmacy and home delivery services. Vendors also cited an increase in demand for some services because of social distancing.

Chapter 5. BDI: Intervention Outcomes

In this chapter, we consider how the BDI subcomponents of the VBID model test influenced beneficiary- and plan-level outcomes in 2020 and, for most outcomes, 2021. We focus on three broad outcomes of interest: beneficiary participation in the model test; total enrollment in participating plans; and the relationship between BDI subcomponents and plan-level cost outcomes, including plan bids, premiums, and provision of supplemental benefits.

We analyzed the data both descriptively and, where appropriate, using DD regression techniques to answer research questions related to the association of BDI with the three broad outcomes of interest. We supplemented these analyses with insights from the pre-interview questionnaire completed by representatives of 14 POs participating in the BDI component and with subsequent interviews with the representatives from these organizations. This chapter highlights POs' perspectives on how BDI might influence additional outcomes, including care quality, clinical outcomes, beneficiary OOP costs, and care experiences. We will quantitatively identify the impact on these outcomes in future reports.

Key Findings

- The percentage of targeted beneficiaries in plans with participation requirements who became eligible to receive BDI benefits varied dramatically, from less than 2 percent to nearly 98 percent across plans and years.
 - PO representatives' views on beneficiary participation rates were mixed; representatives attributed low participation rates to such factors as COVID-19, administrative implementation challenges, and difficulty with provider engagement for small numbers of targeted beneficiaries.
 - Most PO representatives thought that BDI participation could lead to increased enrollment over time. Our analysis tentatively confirmed this insight—plan implementation of BDI interventions was associated with a marginally significant increase in enrollment of 6.2 percent in 2021 ($p = 0.06$; 95% confidence interval [CI] [–0.2 percent, 12.9 percent]). This change represents roughly 660 new enrollees per plan.
 - BDI implementation was associated with a decrease of \$5.97 PMPM ($p = 0.09$, 95% CI [–12.39, \$0.81]) in MA-PD bids in 2020 and \$5.37 PMPM ($p = 0.01$, 95% CI [–\$9.30, –\$1.44]) in 2021. This finding might reflect POs' expectations that the model test will improve chronic disease management, or POs' assumptions about which beneficiaries will choose to enroll given VBID-related changes in benefit design. However, the decline was very small—less than 1 percent of the average monthly bid.
 - Total monthly MAPD premiums rose by \$1.93 PMPM ($p < 0.01$, 95% CI [\$0.89, \$2.97]) among plans that implemented BDI interventions, relative to comparators, in 2021. Although this change represents a small dollar value, the increase was nearly 8 percent of beneficiaries' average monthly premium.
 - The projected cost of mandatory supplemental benefits increased by \$3.06 in BDI-participating plans in 2020 ($p = 0.09$, 95% CI [–\$0.44, \$6.57]), and by \$11.35 in 2021 ($p < 0.01$, 95% CI [\$8.34, \$14.36]), relative to comparators. The increases were particularly steep in 2021, raising the average projected costs of mandatory supplemental benefits by almost 25 percent.
 - Most PO representatives expected the model test to increase care quality, OOP costs, care experiences, and clinical outcomes; opinions on the model test's effects on plan costs were mixed.
-

Beneficiary Participation

Because most BDI interventions were targeted to specific beneficiaries (e.g., based on SES or chronic disease status), not all of a plan's enrollees were eligible to receive benefits through the VBID model test. In addition, some plans had participation requirements, meaning that targeted beneficiaries needed to complete activities, such as meeting with a care manager, before becoming eligible to receive benefits. Targeted beneficiaries were also permitted to opt out of the model test if they did not want to participate. As a result, beneficiary participation rates might vary across POs and might depend on such factors as the characteristics of the targeted beneficiary group, the intervention offered, the persistence and quality of plans' outreach to targeted beneficiaries, and whether the intervention had participation requirements.

Next, we describe participation rates for BDI interventions for 2020 and 2021. We do this separately for VBID Flexibilities and RI interventions, and by whether the PO did or did not include participation requirements. We do not include Cash Rebates interventions in the participation analysis below because, by definition, such rebates had to be offered to all beneficiaries. We report statistics at the PO level. Outcome variables used to describe participation are defined as follows:

- **total beneficiaries:** all beneficiaries in participating plans, regardless of whether those beneficiaries were targeted to participate in VBID
- **total targeted beneficiaries:** all beneficiaries who met targeting criteria for the plan's VBID Flexibilities or RI intervention based on chronic disease, SES, or both
- **total eligible to receive BDI benefits:** all beneficiaries who were eligible to receive BDI benefits; for plans without participation requirements, the number eligible to receive benefits equals the number targeted, unless beneficiaries proactively opted out of the model test; for plans with participation requirements, targeted beneficiaries were eligible to receive benefits only if they completed those requirements
- **benefit eligibility rate:** the share of beneficiaries who were eligible to receive benefits, out of all beneficiaries who were targeted for the intervention.

Participating POs reported these data to CMS through a portal known as the RF. The data reflect participation status reported at the end of each year (2020 and 2021), and the data do not include beneficiaries who died, disenrolled, or became ineligible for VBID during the year.

VBID Flexibilities

Plans Without Participation Requirements

Table 5.1 shows the number of targeted beneficiaries in VBID Flexibilities plans that did not have participation requirements for 2020 and 2021. Among these plans, 112,465 beneficiaries were targeted and eligible to participate in BDI in 2020. The number of targeted beneficiaries grew substantially in 2021, to 1,660,701. However, 244 beneficiaries from PO U opted out of the

model test,¹ resulting in a slight difference between the total number of targeted beneficiaries and the total eligible to receive benefits (1,660,457). The large growth in targeted beneficiaries was driven predominantly by an increase in the number of plans entered by participating POs. For example, PO L entered only one plan into the model in 2020 but entered 61 plans in 2021, adding over 900,000 targeted beneficiaries to the model test. PO P also added a substantial number of plans, and therefore beneficiaries, in 2021. In addition, POs S and U newly entered the model test in 2021, bringing over 130,000 new beneficiaries into the model.

All targeted beneficiaries in POs without participation requirements who did not opt out of the model test were eligible to receive benefits. However, we do not know whether beneficiaries actually used their benefits. It is possible that not all beneficiaries responded to inducements, such as reduced cost sharing for high-value services, despite being eligible to receive these benefits. Further, for most POs, the data indicate that no targeted individuals opted out of the model test. Although it seems unlikely that a large share of beneficiaries would proactively opt out of the model test when not subject to participation requirements, the finding that there was zero opt-outs among most plans raises questions about whether this information was correctly reported. As described in Chapter 4, several POs noted that data reporting was among their key implementation challenges.

¹ PO U's intervention involved \$0 cost sharing for a fall risk assessment conducted by a specific provider.

Table 5.1. Number of Targeted Beneficiaries in Plans With VBID Flexibilities Interventions, Without Participation Requirements, 2020 and 2021

PO	Total Plans Entered, 2020	Total Beneficiaries (includes ineligible), 2020	Total Targeted Beneficiaries, 2020	Total Eligible to Receive BDI Benefits, 2020^a	Total Plans Entered, 2021	Total Beneficiaries (includes ineligible), 2021	Total Targeted Beneficiaries, 2021	Total Eligible to Receive BDI Benefits, 2021^a
PO C	6	138,702	15,900	15,900	6	119,320	13,415	13,415
PO J	1	2,075	397	397	1	2,010	375	375
PO L	1	7,074	154	154	61	1,827,545	987,975	987,975
PO N	1	17,543	1,714	1,714	1	21,038	15,768	15,768
PO P	26	134,789	94,300	94,300	74	986,598	511,245	511,245
PO S	NA	NA	NA	NA	1	318,752	130,945	130,945
PO U	NA	NA	NA	NA	2	8,806	978	734
TOTAL	35	300,183	112,465	112,465	146	3,285,069	1,660,701	1,660,457

SOURCE: RAND analysis of RF data.

^a The total eligible to receive benefits equals the total number of targeted beneficiaries minus those who opt out of the model test. Beneficiary opt-out is rarely reported in the data, affecting only PO U in 2021. In all other cases, the total eligible to receive benefits is equal to the total targeted population.

Plans with Participation Requirements

The number of targeted beneficiaries, the number of beneficiaries eligible to receive benefits, and the benefit eligibility rate for VBID Flexibilities plans that had participation requirements in 2020 and 2021 are shown in Tables 5.2 and 5.3, respectively.

Table 5.2. Beneficiary Participation in Plans with VBID Flexibilities Interventions, with Participation Requirements, 2020

PO	Total Plans	Total Beneficiaries (includes ineligible)	Total Targeted Beneficiaries	Total Eligible to Receive Benefits	Benefit Eligibility Rate (%)
PO B	1	21,921	3,958	3,872	97.8
PO G	5	58,617	5,237	1,958	37.4
PO O	8	41,150	5,726	2,846	49.7
PO P	48	592,604	101,247	3,532	3.5
PO Q	1	41,225	4,787	721	15.1
PO AB	4	13,695	8,754	129	1.5
TOTAL	67	769,212	129,709	13,058	10.1

SOURCE: RAND Analysis of RF data.

Table 5.3. Beneficiary Participation in Plans with VBID Flexibilities Interventions, with Participation Requirements, 2021

PO	Total Plans	Total Beneficiaries (includes ineligible)	Total Targeted Beneficiaries	Total Eligible to Receive Benefits	Benefit Eligibility Rate (%)
PO B	1	19,938	2,902	2,820	97.2
PO G	5	65,348	6,610	2,374	35.9
PO O	8	47,157	5,187	3,231	62.3
PO P	134	1,302,239	141,091	5,717	4.1
PO Q	1	46,219	4,989	1,269	25.4
PO Y	2	37,148	5,281	4,062	76.9
TOTAL	151	1,518,049	166,060	19,473	11.7

SOURCE: RAND analysis of RF data.

Five POs (B, G, O, P, and Q) offered VBID Flexibilities benefits with participation requirements in both years, while PO AB offered such benefits only in 2020, and PO Y offered such benefits only in 2021. In both years, the percentage of targeted beneficiaries eligible to

receive benefits was highly variable across POs, ranging from 1.5 percent in PO AB to 97.8 percent in PO B in 2020, and 4.1 percent in PO P to 97.2 percent in PO B in 2021. Across all POs that offered VBID Flexibilities with participation requirements, there were 129,709 targeted beneficiaries in 2020 and 166,060 in 2021. Of those beneficiaries, 10.1 percent (13,058 individuals) completed participation requirements and became eligible to receive benefits in 2020, and 11.7 percent (19,473 individuals) did so in 2021. In addition to the plans listed in Table 5.3, PO W included one plan that offered a new technology intervention that enabled beneficiaries with diabetes or CHF to receive monitoring devices. Our analysis found that, among 843 beneficiaries targeted to receive these devices, 18 beneficiaries (2.1 percent) took the benefit in 2021.

In sensitivity analyses, we calculated eligibility rates for VBID Flexibilities among the six plans with participation requirements that participated in the model test in 2020 only, compared with the 61 plans that participated in the model test in both 2020 and 2021 (we did not include plans that participated only in 2021). Rates of participation were substantially higher in the group that participated in both years, with mean rates of 1.9 percent (95% CI [1.1 percent, 2.7 percent]) among the six plans with one year of participation compared with 13.0 percent (95% CI [8.2 percent, 17.8 percent]) among the 61 plans with two years of participation. Although this difference was statistically significant ($p < 0.01$), we caution against drawing strong conclusions from this analysis because of the small number of plans participating in 2020 only.

In 2020, participation rates were also lower in the five POs offering VBID Flexibilities with participation requirements that targeted beneficiaries based on SES status (4.2 percent, 95% CI [0, 1.7 percent]) compared with the 62 plans that targeted beneficiaries based on chronic conditions (12.6 percent, 95% CI [7.8 percent, 17.4 percent]). In 2021, only one plan with participation requirements targeted beneficiaries based on SES.

In 2020, participation rates were higher among the seven plans that offered VBID Flexibilities with both reduced cost sharing and supplemental benefits (43.1 percent, 95% CI [31.9 percent, 54.3 percent]), compared with the 56 plans that offered only cost-sharing reductions (8.8 percent, 95% CI [4.9 percent, 12.8 percent]), or the four plans that offered only additional supplemental benefits (1.5 percent, 95% CI [0, 16.3 percent]). Similarly, in 2021, participation rates were higher among the seven plans that offered both reduced cost-sharing reductions and supplemental benefits (43.8 percent, 95% CI [21.6 percent, 66.0 percent]) than among the 144 plans that offered only cost-sharing reductions (8.5 percent, 95% CI [5.8 percent, 11.2 percent]). However, all of these results should be interpreted cautiously because of the small sample sizes in some categories.

Rewards and Incentives

Some participating plans offered RI interventions either by themselves or in combination with other interventions. Tables 5.4 and 5.5 provide statistics on the number of plans that included RI interventions and the number of beneficiaries who earned these benefits in 2020 and

2021, respectively. Six POs (C, N, O, P, U, and W) offered RI in both years, while four POs (L, AA, AB, and AQ) offered RI only in 2020, and one (PO Y) offered RI only in 2021.

In both years, the percentages of targeted beneficiaries who completed requirements and became eligible to earn rewards ranged widely across plans. In 2020, PO AB had the lowest share of targeted beneficiaries who completed RI requirements (1.8 percent); this PO required beneficiaries with certain chronic conditions to complete medication adherence and medication reconciliation activities to earn rewards. PO AQ, in contrast, required beneficiaries to have a telephonic education consultation regarding their medication regimens and had the highest rate of requirements completion (96.5 percent). In 2021, PO P had the lowest participation rate, at 5.2 percent, while PO U had the highest participation rate, at 78.0 percent. Of the 158,548 beneficiaries targeted for RI in 2020, 12.5 percent (19,897 individuals) completed requirements and earned rewards, while 10.6 percent of the 185,425 beneficiaries targeted for RI in 2021 (19,731 individuals) earned rewards in 2021.

Table 5.4. Beneficiary Participation in Plans with Rewards and Incentives Interventions, 2020

PO	Total Plans	Total Beneficiaries (includes ineligible)	Total Targeted Beneficiaries	Total Beneficiaries Earning RI	Share of Targeted Beneficiaries Earning RI (%)
PO C	6	139,587	15,179	3,307	21.8
PO L	14	406,159	18,350	4,199	22.9
PO N	1	17,483	3,106	1,971	63.5
PO O	8	41,200	3,115	913	29.3
PO P	23	231,242	1,523	738	48.5
PO U	2	7,326	5,138	2,319	45.1
PO W	1	12,013	8,892	302	3.4
PO AA	1	12,450	78	47	60.3
PO AB	18	107,540	98,643	1,734	1.8
PO AQ	6	121,651	4,524	4,367	96.5
TOTAL	80	1,096,651	158,548	19,897	12.5

SOURCE: RAND analysis of RF data.

Table 5.5. Beneficiary Participation in Plans with Rewards and Incentives Interventions, 2021

PO	Total Plans	Total Beneficiaries (includes ineligible)	Total Targeted Beneficiaries	Total Beneficiaries Earning RI	Share of Targeted Beneficiaries Earning RI (%)
PO C	6	119,320	13,617	3,125	22.9
PO N	1	21,038	3,326	2,101	63.2
PO O	7	47,022	2,845	915	32.2
PO P	229	3,075,775	150,802	7,831	5.2
PO U	2	8,806	1,517	1,183	78.0
PO W	1	22,638	8,020	500	6.2
PO Y	2	37,148	5,298	4,076	76.9
TOTAL	248	3,331,747	185,425	19,731	10.6

SOURCE: RAND analysis of RF data.

As with the BDI plans analyzed earlier, we found that the 37 plans that offered RI only in 2020 had lower RI uptake (26.1 percent, 95% CI [14.6 percent, 37.6 percent]) than plans that offered RI in both years (40.8 percent, 95% CI [34.7 percent, 47.0 percent]). These differences, which are statistically significant ($p = 0.03$), suggest that low uptake could have been a factor in plans' decisions to exit the model test in 2021. Because only one RI plan targeted beneficiaries based on SES, we could not estimate differences in participation by targeting approach among RI plans.

Participation Summary

Among both POs that offered RI and POs that required beneficiaries to complete participation requirements as part of their VBID Flexibilities interventions, eligibility rates varied substantially across interventions. These differences might reflect a variety of factors, including the types of beneficiaries targeted; the nature of the intervention; and the magnitude and type of the rewards, incentives, and additional benefits offered. In interviews, PO representatives offered a range of opinions regarding whether interventions led to the expected response from beneficiaries. Although PO G and PO B representatives said that participation exceeded expectations, representatives of three POs (C, Q, and W) said that participation was lower than expected, and PO U representatives said that participation was about as expected.

Across all plans with participation requirements, the share of beneficiaries who completed those requirements and became eligible to receive benefits was low for both 2020 and 2021, at 10.1–11.7 percent for VBID Flexibilities interventions and 10.6–12.5 percent for RI. POs attributed low participation to such factors as the COVID-19 pandemic; administrative challenges associated with implementing the model; and difficulties engaging providers,

particularly when the eligible population was small. One representative said, “When we divide and subdivide and then further divide the populations, providers don’t remember it. . . . Telling them to remember that subset and then remembering that intervention is really challenging” (PO C).

Impact on Enrollment

Because the VBID model test enables MA plans to offer a variety of benefits typically not available to Medicare beneficiaries, participation in the model could influence enrollment levels. On the one hand, BDI interventions, such as reduced cost sharing for high-value services, supplemental benefits, and RI programs, could attract beneficiaries, leading to increased enrollment in participating plans. On the other hand, to the extent that the costs of BDI lead to increases in plan premiums, some beneficiaries might prefer not to enroll in VBID-participating plans.

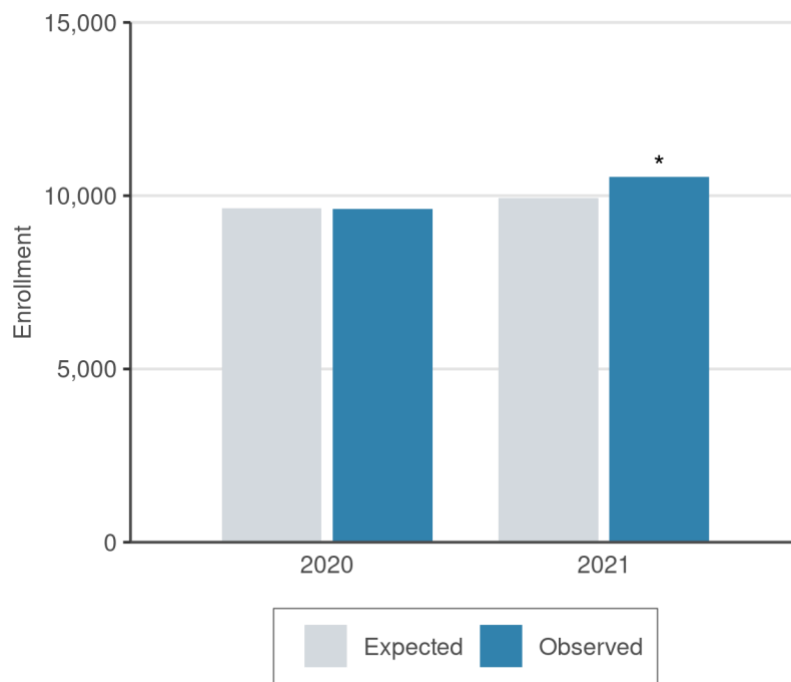
To assess the relationship between BDI and enrollment in VBID-participating plans for 2020 and 2021, we used data from the MA enrollment files. We defined our enrollment variable based on plan-level enrollment on July 1 of each year. Average enrollment in 2019 (the year before the model test started) among plans that offered BDI interventions was 9,320 (standard deviation [SD] = 13,415), which increased to 10,343 (SD = 14,757) by 2021.

For our DD models, we grouped plans implementing BDI interventions according to their participation status in 2020 and 2021: plans that participated in both 2020 and 2021, plans that participated only in 2020, and plans that participated only in 2021. We compared these plans with eligible nonparticipating plans; details on how we applied eligibility criteria are discussed in Appendix D. We estimated BDI intervention impacts separately for each of these three groups of plans, including calculating separate entropy-balancing weights for each group. As shown in more detail in Appendix C, the entropy-balancing weights improve similarity between participating plans and the VBID-eligible nonparticipating plans on selected plan characteristics and preintervention outcome trends.

We analyzed enrollment on a logarithmic scale because enrollment levels vary greatly across plans, but we converted the results back to the original enrollment scale for the presentation of the result. These analyses indicate that participation in BDI was associated with a marginally significant 6.2 percent increase in enrollment in 2021 ($p = 0.06$, 95% CI [-0.2 percent, 12.9 percent]) (Figure 5.1).² This effect was driven both by increases in 2021 enrollment among plans that participated in both years and by increases in enrollment among plans that joined the model test in 2021.

² Marginally significant results are statistically significant at the 10-percent confidence level but not at the 5-percent level. Throughout this evaluation, we report 95-percent CIs for all estimates. As a result, the CIs for marginally significant results cross zero.

Figure 5.1. Estimated Association Between BDI Interventions and Enrollment, by Plan Year and Year After Implementation



SOURCE: RAND analysis of CMS enrollment and other data. The complete list of data sources and variables is in Table C.5 in Appendix C.

NOTES: ***, **, and * represent statistical significance at the 1-, 5-, and 10-percent levels, respectively, from the DD models comparing VBID-participating plans with comparison plans. See Appendix H for full results. The number of participating plans included in the analyses was 417, and the number of comparison plans was 2,233. For a detailed breakdown of sample sizes, including the effective number of comparison plans after entropy balancing, see Appendixes C, H, and I.

The marginally significant enrollment increase of 6.2 percent (CI: -0.02 to 12.9 percent) is nearly as large as the average annual increase in enrollment in participating plans (6.8–7.7 percent between 2017 and 2019) and represents an average of about 660 additional beneficiaries in each plan in each year (nearly 250,000 beneficiaries total across the 377 BDI-participating plans).

We ran sensitivity analyses controlling for the intensity of the COVID-19 pandemic in plans’ service areas during 2020 (as proxied by cumulative 2020 COVID-19 case rates per 10,000 adults ages 60 and above). These results showed a 7-percent increase in enrollment, which was statistically significant at conventional levels ($p = 0.04$, 95% CI [0 to 13 percent]). Please refer to appendix G for more detail.

Our interview data show that representatives of most POs (8 out of 14) anticipated that VBID participation could increase or help retain enrollment over time. However, at the time of our interviews, some respondents had not yet observed such changes or were hesitant to attribute changes to VBID. “So, we’ve picked up market share this year,” said a PO S representative, “but

we are kind of fairly on the market leading edge in terms of benefits overall, so it's hard to attribute it specifically to this.”

Five PO representatives interviewed felt that BDI interventions would not have a major impact on enrollment or beneficiary retention, because many factors affect enrollment decisions:

Just thinking about . . . major drivers of enrollment, it's not often going to be a particular care management program for a particular chronic condition. It's possible, on the margins, that we might see that, but I don't know that there are that many members who have CHF who are making an entire decision around which plan to enroll in based on a care management program. (PO G)

A PO C representative said that very ill beneficiaries tend not to switch plans often, so large changes in enrollment would not be expected with an intervention targeting beneficiaries with chronic diseases. The two POs that implemented Cash Rebate interventions reported experiencing a negative marketing campaign launched by a competitor and incorrectly claiming that Cash Rebates would be taxable income and thus require beneficiaries to pay more in taxes. As a result, representatives from PO R reported that enrollment in their plans decreased after implementing VBID but recovered as the year went on.

Impact on Plan Bids, Premiums, and Supplemental Benefits

We also examined BDI impacts on a limited set of outcomes related to costs for 2020 and 2021: bids submitted to CMS for MA and Part D coverage, beneficiary premiums for MA and Part D coverage, and projected costs of supplemental benefits offered by participating plans to all beneficiaries who enrolled in the plan. As in the analysis of enrollment presented earlier, we estimated the impacts on bids, premiums, and the costs of supplemental benefits resulting from BDI interventions using the weighted DD approach described in Appendix C.

Plan Bids for Medicare Advantage and Part D Coverage

The plan bid represents the projected PMPM cost to plans of providing Medicare coverage to beneficiaries, either for medical services (the MA bid) or for outpatient prescription drugs (the Part D bid) for the upcoming calendar year. One of the goals of the VBID model test is to reduce these costs by increasing the use of high-value services that might avert costly complications among beneficiaries with complex health care needs. However, the relationship between VBID and costs will depend on the costs of implementing the model, the changes in utilization that stem from VBID interventions, and the extent to which interventions are successful in improving beneficiary health. Furthermore, because bids for a given year are submitted before the start of the plan year, changes in the bids depend on actuarial assumptions used by participating POs along with data from previous years' costs and utilization.

We analyzed plan bids for 2017 through 2021, a period covering the pre-period and either one year (for plans implementing BDI in 2021) or up to two years (for plans implementing BDI in 2020) of implementation. Data on MA and Part D bids for BDI and comparison plans were

extracted by the OACT from Bid Pricing Tool spreadsheets submitted for coverage in 2017 through 2021. Bids for MA coverage and Part D coverage are developed separately following program-specific rules and submitted to CMS using two distinct pricing tools. Additional variables reflecting components of the MA and Part D bids were also extracted by OACT and provided to RAND so that we could analyze additional outcomes and study mechanisms contributing to observed changes in bids; these additional variables are discussed and analyzed in Appendix I.

Because BDI interventions could, in theory, affect plan costs for both MA and Part D, we analyzed total plan bids (the sum of MA and Part D bids) for MAPD plans as a summary measure of BDI intervention impacts on plan bidding behavior. MA coverage is generally far more costly than Part D coverage: In 2019, the mean MA bid for MAPD plans that participated in VBID in 2020 or 2021 was \$788, while the mean Part D bid was \$41. Given that MA bids are an order of magnitude higher than Part D bids, changes in the total MAPD bid are likely to be driven primarily by changes in the MA bid. We also analyzed MA and Part D bids separately. Estimates of BDI impacts on MA bids that include MA-only plans were not meaningfully different from estimates for MAPD bids, because there were only three MA-only plans that implemented BDI interventions; these estimates are omitted in the interest of space.

Figure 5.2 depicts the estimated impact of BDI interventions on MAPD bids. BDI interventions were associated with a marginally significant decrease in MAPD bids of \$5.79 PMPM in 2020 ($p = 0.09$, 95% CI [-\$12.39, \$0.81]) and a statistically significant decrease in MAPD bids of \$5.37 PMPM in 2021 ($p = 0.01$, 95% CI [-\$9.30, -\$1.44]).

To provide context for these estimates, we note that MAPD bids among all VBID participants were increasing by an average of \$17 per year between 2017 and 2019; the estimated reductions in MAPD bids associated with BDI interventions were roughly one-third of this magnitude. More generally, a \$5.37 (95% CI: -\$9.30, -\$1.44) decline is less than 1 percent of the average PMPM bid, which was \$804 in the pre-period (2017 to 2019).

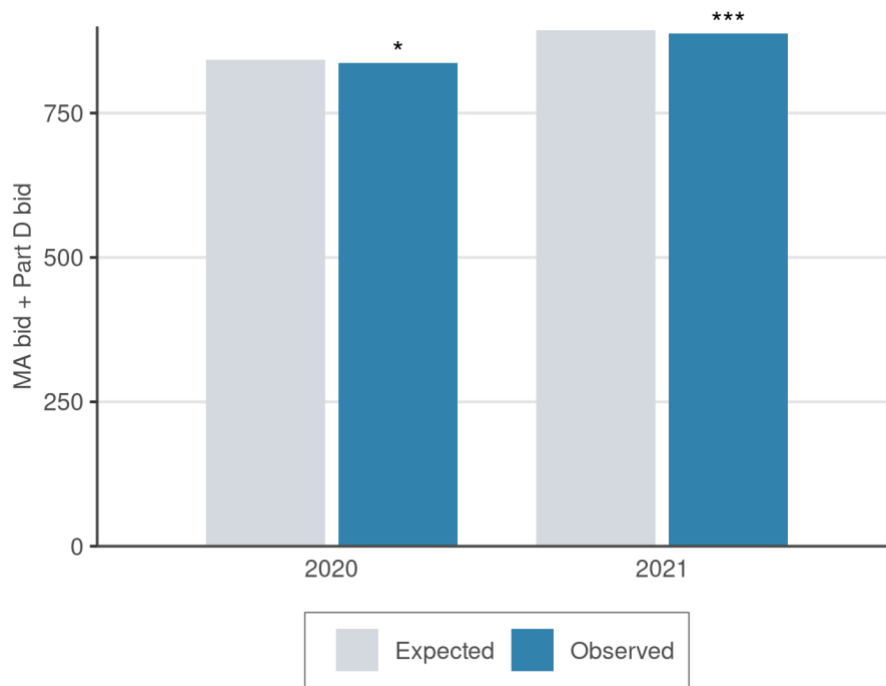
We also examined BDI impacts on MA and Part D bids separately. Our key finding was that the net decrease in MAPD bids was driven by MA bids, not by Part D bids. As noted earlier, this is largely because MA bids are an order of magnitude greater than Part D bids. BDI interventions were associated with a \$7.30 PMPM decrease in the MA bid in 2020 ($p = 0.05$, 95% CI [-\$14.71, \$0.11]) and an \$8.78 decrease in the MA bid in 2021 ($p < 0.01$, 95% CI [-\$12.74, -\$4.81]).

Cost Components

Bids include the following projected cost components:

- **medical or drug spending:** the plan's projected costs for medical services or prescription drug fills for enrollees
- **nonbenefit expenses:** the costs to the plan of administering the benefit
- **gain or loss margin:** the plan's projected profits or losses associated with coverage.

Figure 5.2. Estimated Association Between BDI Interventions and Standardized Medicare Advantage Plan with Part D Coverage Bids, by Plan Year



SOURCE: RAND analysis of 2017–2021 OACT bid data.

NOTES: ***, **, and * represent statistical significance at the 1-, 5-, and 10-percent levels, respectively, from the DD models comparing VBID-participating plans with comparison plans. See Appendix I for full results. The number of participating plans included in the analyses was 417, and the number of comparison plans was 2,233. For a detailed breakdown of sample sizes, including the effective number of comparison plans after entropy balancing, see Appendixes C, H, and I.

In contrast, BDI participation was associated with a \$4.77 PMPM increase in Part D bids in 2021 ($p < 0.01$, 95% CI [\$3.73, \$5.81]). We found no evidence of an association between BDI interventions and Part D bids in 2020. Appendix I presents additional regression results for the bid components that might have contributed to the observed changes in MA and Part D bids.

Representatives from six POs implementing BDI interventions expected no impact on their bids. As a PO N representative stated:

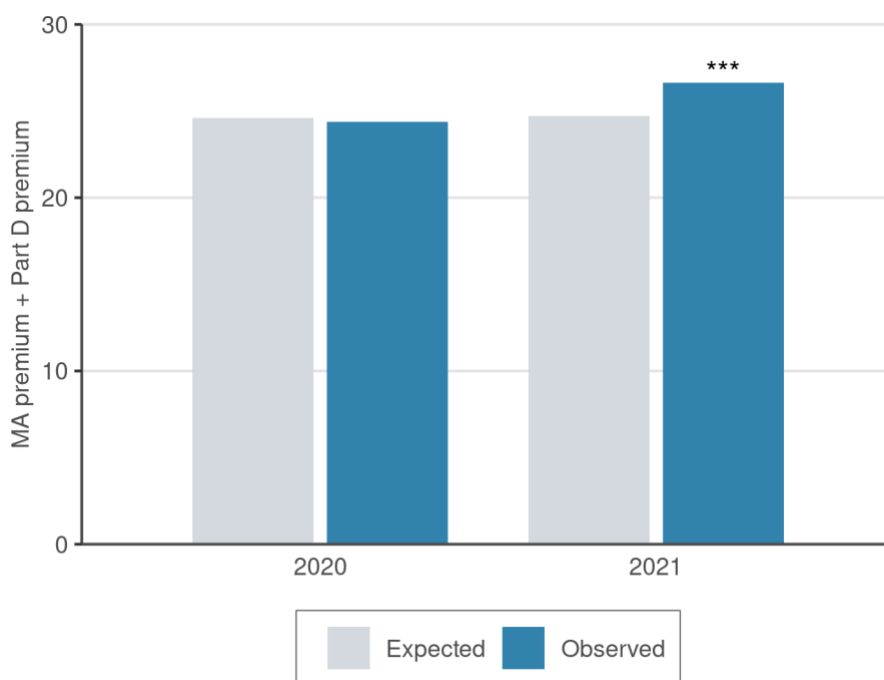
In the current year, while there have been some additional staff or administrative staff added to manage, largely, it’s a quality improvement initiative, and so we feel like it’s a positive towards at least the medical loss activities or medical benefit activities. So we saw it both ways, and in the end we kind of walked away with more of it being a wash.

Among the remaining PO representatives, four felt there would be positive impacts, and four felt there would be negative impacts.

Premiums for Medicare Advantage and Part D Coverage

We used plan benefit package data from the CMS HPMS to construct three premium variables: MA, Part D, and total MAPD premiums for 2020 and 2021. Figure 5.3 depicts the estimated impact of BDI participation on the total monthly premium paid by enrollees in MAPD plans, defined as the sum of premiums for MA and Part D coverage. Participation in BDI was associated with a statistically significant \$1.93 ($p < 0.01$, 95% CI [\$0.89, \$2.97]) increase in monthly total premiums in 2021. We found no evidence of an association between BDI participation and total premiums in 2020 (please refer to Appendix I for details).

Figure 5.3. Estimated Association Between BDI Interventions and Total (Medicare Advantage Plan with Part D Coverage) Beneficiary Premiums, by Plan Year



SOURCE: RAND analysis of 2017–2021 HPMS Approved Plan Information Dataset.

NOTES: ***, **, and * represent statistical significance at the 1-, 5-, and 10-percent levels, respectively, from the DD models comparing VBID-participating plans with comparison plans. See Appendix I for full results. The number of participating plans included in the analyses was 417, and the number of comparison plans was 2,233. For a detailed breakdown of sample sizes, including the effective number of comparison plans after entropy balancing, see Appendixes C, H, and I.

To provide context for these estimates, we note that total premiums among all VBID participants were decreasing by an average of \$2 per year between 2017 and 2019; the estimated increase in total premiums associated with BDI interventions was similar in magnitude to this amount in 2021. Although \$1.93 is a small amount in most contexts, it represents a 7.8-percent increase in enrollees' monthly premium spending.

Increases in the total premiums paid for MA and Part D coverage associated with BDI implementation were driven by the Part D premium. The association between BDI and monthly Part D premiums in 2021 was a statistically significant \$1.53 increase ($p = 0.01$, 95% CI [\$0.62, \$2.43]). We found no statistically significant association between BDI participation and MA premiums (refer to Appendix I for details).

In sensitivity analyses assessing the effects of the COVID-19 pandemic, we found that controlling for differences across plans in their exposure to impacts of the pandemic led to no meaningful changes in our regression estimates of VBID participation's association with bids or premiums. Appendix G provides further details on this analysis.

Supplemental Benefits

The MA VBID model might lead to changes in participating plan offerings of supplemental benefits to all plan enrollees, not just those eligible to participate in VBID interventions. For example, changes to plans' anticipated costs of coverage might lead to increased or decreased rebate dollars, which could prompt changes to benefits, cost sharing, or premiums. For MA plans, increased rebate dollars must be passed through to beneficiaries, and plans could use any such savings to provide additional benefits to all enrollees. POs could also use knowledge gained from participation in the model test to expand some supplemental benefit offerings to all of a plan's enrollees. If costs of coverage increase because of VBID, POs could either cut back on benefits to beneficiaries or absorb the cost through a reduced margin. Conversely, because the model test allows for beneficiary targeting based on chronic conditions or LIS eligibility, participating POs may focus their efforts on designing benefits for eligible beneficiaries and not substantially change their supplemental benefit offerings for all enrollees.

We used two data sources to evaluate the association between the BDI component and supplemental benefit offerings. First, we used the publicly available PBP data to identify a list of mandatory supplemental benefits, which can include non-Medicare-covered services. Non-Medicare-covered services are those that are not covered by FFS Medicare and include such benefits as additional days of inpatient care, home health visits that are not covered by FFS Medicare, and reductions in the number of inpatient days required to be eligible for skilled nursing facility care. Using this list, we identified whether a given plan offered the benefit in the years 2019 through 2021 and then counted the number of benefits offered by each plan in each year. We also calculated the proportion of beneficiaries enrolled in MA plans offering these benefits for BDI-participating plans and eligible nonparticipating plans to gauge whether the proportion of beneficiaries receiving specific supplemental benefits changed over time. Second, we used bid data from

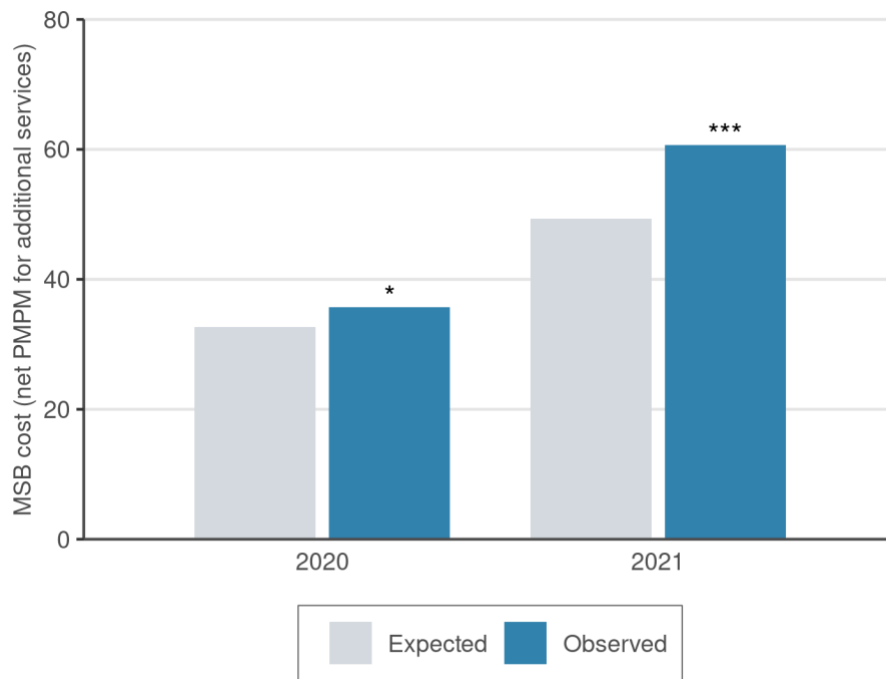
OACT to measure the projected costs associated with mandatory supplemental benefits. We estimated DD regression models to analyze the association between BDI interventions and the projected cost of additional services.

Descriptively, we found that the average number of mandatory supplemental benefits offered by plans implementing BDI interventions and eligible nonparticipating plans increased from 2019 to 2021. Plans that participated in BDI only in 2020 had the lowest average number of supplemental benefits offered, increasing from 14.6 in 2019 to 17.0 in 2021. Those that participated in both 2020 and 2021 increased their offerings from 19.2 to 21.1 across the same time frame. The number of supplemental benefits offered by plans participating only in 2021 also increased, from 18.1 in 2019 to 19.3 in 2021. Finally, eligible nonparticipants increased their supplemental benefits from an average of 15.8 to 18.7. Part of the increase over time might reflect that in 2020, CMS added three additional supplemental benefits as options to the benefits data.

We found that plans implementing BDI interventions increased the projected costs of mandatory supplemental benefits after VBID implementation (Figure 5.4). BDI participation was associated with an increase of \$11.35 PMPM ($p < 0.01$, 95% CI [\$8.34, \$14.36]) in mandatory supplemental benefit costs in 2021. BDI participation was also associated with a marginally significant \$3.06 PMPM increase ($p = 0.09$, 95% CI [-\$0.44, \$6.57]) in mandatory supplemental benefit costs in 2020. To provide context for these estimates, we note that PMPM mandatory supplemental benefit costs among all VBID participants were increasing by an average of \$7 per year between 2017 and 2019; the estimated increase in total premium bids associated with BDI interventions is larger than this amount in 2021. The increase is also substantial compared with mean supplemental benefits spending of \$24 PMPM between 2017 and 2019.

Although the DD results suggest an increase in projected supplemental benefit costs for BDI participants relative to comparators, it is important to note that the RFA for VBID participation required participating plans to submit the costs of VBID Flexibilities benefits within the mandatory supplemental benefits field. Thus, at least a portion of increased mandatory supplemental benefit costs associated with BDI interventions are likely to reflect costs associated with additional benefits for VBID-eligible beneficiaries only rather than expanded availability of supplemental benefits to all enrollees.

Figure 5.4. Estimated Association Between BDI Interventions and Mandatory Supplemental Benefit Costs, by Plan Year



SOURCE: RAND analysis of OACT bid data.

NOTES: MSB = mandatory supplemental benefit. ***, **, and * represent statistical significance at the 1-, 5-, and 10-percent levels, respectively, from the DD models comparing VBID-participating plans with comparison plans. See Appendix I for full results. The number of participating plans included in the analyses was 417, and the number of comparison plans was 2,233. For a detailed breakdown of sample sizes, including the effective number of comparison plans after entropy balancing, see Appendixes C, H, and I.

Other Outcomes

In addition to asking PO representatives about their views on the expected association between BDI interventions and the outcomes discussed earlier, we also asked POs about their expectations on short- and long-term effects of the BDI component of the model test on a variety of other outcomes. These outcomes included care quality, clinical outcomes, and administrative costs. Table 5.6 summarizes POs’ responses for short-term outcomes (i.e., those expected to occur within one to two years). A positive response indicates expected improvements in care quality, satisfaction, and Star Ratings and decreases in cost-related outcomes, such as beneficiary OOP costs and plan administrative costs. Conversely, a negative response indicates the expected effects are in the opposite direction (i.e., decreased quality, satisfaction, and Star Ratings; increased costs at both the beneficiary OOP and plan administrative levels).

Table 5.6. Parent Organization Questionnaire Responses Regarding Expected Model Test Effects on Short-Term Outcomes (N = 14)

Outcome	Positive	No Impact	Negative
Care quality for targeted beneficiaries	13	1	0
Beneficiary out-of-pocket costs	13	1	0
Care experiences/satisfaction among targeted beneficiaries	12	2	0
Clinical outcomes (e.g., changes in health status)	12	2	0
Care utilization	11	3	0
Individual measures that contribute to the overall Star Ratings	10	4	0
Overall Star Ratings	6	8	0
Plan administrative costs	2	5	7

SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.

NOTE: Data come from a pre-interview questionnaire in January 2021 of 2021 participating POs that implemented at least one BDI intervention.

Of the PO representatives completing the questionnaire ($N = 14$), the majority responded that VBID would have a positive short-term impact on most outcomes of interest, including quality of care for targeted beneficiaries ($N = 13$), care experiences/satisfaction ($N = 12$), clinical outcomes ($N = 12$), or utilization measures. One representative observed the following:

[Our VBID intervention] will lead to less hospitalizations which therefore leads to lower medical costs for the plan. And less risk to the member because they're not in the hospital. Yeah, so it's all good for everybody. (PO U)

Not all POs had interventions targeting reduced cost sharing, but the majority of POs offering at least one BDI intervention thought that model participation would reduce beneficiary OOP costs.

POs were mixed on whether BDI implementation would have an effect on overall Star Ratings (eight indicated that they anticipated no effect; six expected a positive effect). Some PO representatives viewed the targeted population as too small to affect Star Ratings. "I think for the Star Rating, we didn't really know that the number of people engaged, being the 2,500 or so, would really move the Star lever at all one way or the other," said a PO O representative in our interview. "There are so many things that really go into [Star Ratings]."

Half of questionnaire respondents expected that the model test would lead to an increase in plan administrative costs ($N = 7$). In interviews, many PO representatives stated that there were start-up costs in the short term that increased administrative costs:

So we are going to have to outsource to a vendor that maybe we didn't use before. We're going to have to produce materials that are a little bit more complex. We're going to have to do additional education. So while it's not significant, it is still additional burden to educate, create all these materials, which is why we are going to see [an increase], but we feel like the positives outweigh the administrative increases. (PO L)

When asked about the effects of the model test over a longer time horizon (three or more years), more POs expected positive outcomes—including for plan administrative costs—even though six POs still felt that long-term administrative costs would increase (Table 5.7).

Table 5.7. Parent Organization Questionnaire Responses Regarding Expected Model Test Effects on Long-Term Outcomes (N = 14)

Outcome	Positive	No Impact	Negative
Care quality for targeted beneficiaries	14	0	0
Beneficiary out-of-pocket costs	13	1	0
Clinical outcomes (e.g., changes in health status)	13	1	0
Care utilization (N = 13)	12	1	0
Beneficiary enrollment and retention	11	3	0
Care experiences/satisfaction among targeted beneficiaries	11	3	0
Individual measures that contribute to the overall Star Ratings	10	4	0
Overall Star Ratings	9	5	0
Plan administrative costs	4	4	6

SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.

One representative explained that their PO expected administrative costs to drop over time:

There are both types of costs. There’s kind of the implementation costs that are more one-time or for a short period, and then there’s ongoing administrative costs, and so over the near term we have both, over the longer term we would just have the long-term administrative cost impact. (PO S)

Notably, we found that nonbenefit expenses allocated to MA-covered services, which capture plans’ administrative costs, declined after BDI implementation, with a reduction of \$5.43 PMPM ($p < 0.01$, 95% CI [−\$8.13, −\$2.73]) in 2021 (Appendix I). However, it could be that the average effect found in our regression models masks PO-specific heterogeneity in administrative costs. Furthermore, because bids are developed prospectively, it is possible that POs’ initial assumptions about changes in nonbenefit expenses will be proved wrong, leading to changes in the bids over time.

Summary

Beneficiaries’ participation in BDI interventions was variable, particularly in POs that required targeted beneficiaries to take actions such as engaging with a care manager to receive benefits. Although some of these POs were successful in enticing beneficiaries to complete requirements (for example, PO B’s benefit eligibility rate was nearly 98 percent), benefit eligibility in some POs remained below 10 percent in both 2020 and 2021. A variety of factors could have influenced beneficiaries’ willingness and ability to participate in the model test, including the nature of POs’ participation requirements, the size of any financial incentives, and

the communication strategies used by POs to engage beneficiaries. The COVID-19 pandemic might have also affected beneficiaries' willingness to participate, particularly in BDI interventions that involved face-to-face interactions with providers.

We estimated that plans that implemented the BDI component experienced a marginally significant increase in enrollment in 2021, relative to comparators. These findings are broadly consistent with POs' expectations because representatives from most POs anticipated that BDI participation could have a positive impact on enrollment over time. It is possible that access to BDI benefits was a selling point for enrollees, making these plans more attractive than comparison plans and increasing enrollment. We were not, however, able to disentangle whether specific subcomponents of plans' BDI interventions had more important implications for enrollment than others.

Plans' participation in the BDI components of the model test was associated with a \$5.79 PMPM reduction in the combined MAPD bid in 2020 and a \$5.37 reduction in 2021, driven by reductions in MA bids among plans that entered the model test. However, the reductions in bids did not translate into reductions in beneficiary premiums, which increased by \$1.93 PMPM in 2021.

The increase in MAPD premiums likely reflects the combination of the increase in Part D premiums, which rose by \$1.53 PMPM, and the increase in the projected costs of mandatory supplemental benefits, which rose by \$11.35 PMPM in 2021 relative to comparators. The costs of mandatory supplemental benefits affect premiums but are included in neither the MA nor the Part D bid, which might explain why the results for premiums and the results for bids trended in opposite directions.

BDI-participating plans were instructed to include the projected costs of VBID Flexibilities benefits in their supplemental benefit costs, which might account for some of the increase that we found. Changes in premiums and supplemental benefit costs affect all plan enrollees, not just those specifically targeted for the BDI intervention. However, it is interesting to note that the change in MAPD premiums of less than \$2 PMPM is substantially lower than the combined increase in the projected costs of supplemental benefits and the increase in the Part D premiums, which—together—rose by more than \$12 PMPM. This result implies that plans found a way to offset most of the projected costs of increased supplemental benefits and VBID-related drug spending or were able to buy down these costs with rebates.

PO representatives generally anticipated a positive association between VBID and outcomes such as quality of care, care utilization, and clinical outcomes, particularly over the long run. The exception was for plan administrative costs, which most POs expected to increase because of model test participation. However, we estimated a statistically significant decline in nonbenefit expenses allocated to MA-covered services, the part of the bid in which plans would record changes in administrative costs.

PART III: VBID HOSPICE

Chapter 6. Hospice Interventions Implemented

This chapter briefly discusses the Hospice component of the VBID model, including the differences with the current Medicare Hospice Benefits, and describes POs' approaches to offering the Hospice interventions as part of the model test. (Appendix E provides additional details about POs' Hospice interventions.) Moreover, this chapter explains how POs approached the process of building their hospice networks. In addition to presenting the POs' perspectives on the model test, we also discuss what in-network and OON hospices thought about the model, including the process of negotiating contracts with VBID-participating POs and their perspectives on future model test participation.

Our analysis of the early stages of Hospice component implementation considered the VBID model test application materials and interviews with eight of the nine POs implementing the Hospice component and 23 hospices that provided care to VBID beneficiaries in 2021 (13 in-network, six OON, and four hospice chains, most of which had both in-network and OON hospices). We used the findings to describe how POs identified eligible beneficiaries; what types of palliative care, TCC, and hospice supplemental benefits they offered; how POs and hospices negotiated with each other; and why hospices joined POs' networks. Throughout this chapter and the next two chapters, we provide a series of boxes that present hospice representatives' perspectives on the future impact of the VBID model.

Key Findings

- Nine POs offered Hospice component interventions in 52 plans; five of the POs had an ownership stake in at least one hospice.
- POs identified beneficiaries who might be eligible for palliative care, TCC, and hospice using provider referrals, proprietary claims-based algorithms, or both approaches.
- Palliative care services, including consults, comprehensive care assessments, 24/7 access to interdisciplinary care teams, ACP, and psychological and spiritual support, were often provided through vendors rather than through in-network hospices.
- PO-covered TCC services included chemotherapy and radiation therapy for cancer patients and dialysis for ESRD patients.
- The most commonly offered hospice supplemental benefits were elimination of cost sharing for hospice drugs and inpatient respite care, and access to additional in-home respite care.
- The majority of hospices providing care to at least one VBID beneficiary in 2021 were OON providers. In-network hospices were, on average, larger and more likely to be not-for-profit and part of a chain than OON hospices.
- Hospices' reasons for joining PO networks included a desire to increase patient choice and offer additional benefits at end of life, to maintain long-term business viability (particularly in markets with high MA penetration), to be an early adopter of a new care delivery model, and to build on existing PO relationships.
- POs varied in their approaches to contracting with hospices: Some established hospice networks with all hospices within a plan's service area and set rates equal to Medicare FFS; others contracted with fewer hospices or offered reimbursement rates 10–12 percent lower than Medicare FFS.

- Hospices receiving the Medicare FFS rate found contract negotiations to be relatively straightforward, whereas others noted a “power imbalance” with POs and felt that rates were offered on a “take it or leave it” basis.
- Most in-network hospices anticipated continuing being a part of PO networks, whereas some OON hospices were not enthusiastic about joining PO networks.

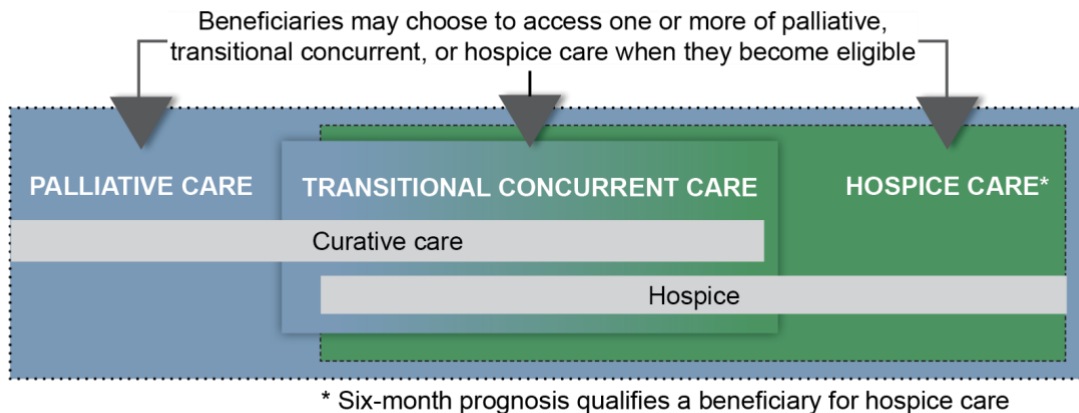
Policy Context

POs participating in the Hospice component must include or *carve-in* the current Medicare Part A hospice benefit into their MA-covered services (CMS, 2020a). In addition, as shown in Figure 6.1, POs are also

- required to provide access to palliative care services for seriously ill enrollees who are not eligible for, or prefer not to receive, hospice services
- required to provide individualized TCC services to hospice-eligible beneficiaries who wish to receive both curative care (i.e., treatment that has the intent of curing illness) and hospice services and who elect to receive hospice from an in-network provider
- permitted to offer hospice supplemental benefits to those receiving hospice care.

Figure 6.1. Beneficiary Choice of Care Services Within the VBID Hospice Component

Before the model test, as described in Chapter 1 and the box below, Medicare payment



policy carved out hospice services from MA. That is, when MA beneficiaries elected hospice, their hospice care was covered by traditional (FFS) Medicare. If beneficiaries chose to stay enrolled in their MA plan, the plan paid for any Part D drugs unrelated to their terminal condition that were covered under the plan formulary and continued to pay for any supplemental benefits included in the benefit package. CMS directly paid hospices providing medical and palliative care services related to the terminal condition and paid other providers offering care unrelated to the terminal condition (Medicare.gov, undated; Pub. L. 105-33).

Hospice Payment Outside and Inside the VBID Model Test, 2021

Outside the Model Test (Status Quo “Carve Out”)

- When MA beneficiaries elect hospice, hospice care is covered by FFS Medicare.
- If beneficiaries stay enrolled in their MA plan, the plan pays for any Part D drugs unrelated to their terminal condition and any supplemental benefits included in the benefit package.
- CMS directly pays hospices for services related to the beneficiary’s terminal condition and related conditions during the hospice stay. CMS also directly pays non-hospice-care providers for services unrelated to the terminal condition.

In the Model Test (“Carve In”)

- Within the VBID model test, CMS pays POs a monthly capitated rate for hospice services that varies according to the length of stay during the first month and then a fixed amount each month for months two and beyond. Monthly rates are adjusted for geography via an area factor.
- The hospice capitation payment is designed to cover the cost of
 - providing hospice services to beneficiaries for their terminal condition (i.e., the reason they are eligible for hospice) and related conditions during the hospice stay
 - other medical care unrelated to the terminal condition provided by non-hospice-care providers during the hospice stay
 - nonhospice care provided after the hospice stay ends (e.g., in the event of live discharge).
- POs may negotiate rates with their in-network hospices but must pay OON hospices at a rate equal to FFS payment for hospice services.

As part of the model test, CMS is testing the impact of incorporating the traditional Medicare hospice benefit into MA-covered benefits in combination with offering palliative care services outside of the hospice benefit and providing individualized TCC services. The payment mechanism being tested represents a significant shift in payment policy for MA plans, which has implications for the design of palliative care and TCC offerings and for the model test implementation process.

Within the VBID model test in 2021, CMS pays MA plans a monthly capitated rate for hospice services that varies according to the length of stay during the first month (ranging from \$1,784 to \$5,353) and then a fixed amount each month for months two and beyond (\$5,248). Monthly rates are adjusted for geography via an area factor. The hospice capitation payment is designed to cover the cost of providing hospice services to beneficiaries for their terminal condition (i.e., the reason they are eligible for hospice) and related conditions during the hospice stay, and other medical care unrelated to the terminal condition delivered by nonhospice providers and other nonhospice care provided after the hospice stay ends (e.g., in the event of a live discharge) through the end of the calendar month. MA plans are paid their regular monthly payment to cover the cost of medical services for the first month in which a beneficiary elects hospice, unless the beneficiary elects hospice care on the first of the month.

MA plans participating in the model test are responsible for creating hospice networks, negotiating payment rates with in-network hospices, paying in-network and OON hospices, and adjudicating claims. Because beneficiaries in hospice services are not expected to need many services unrelated to their terminal illness and related conditions, MA plans must develop

processes to monitor how much unrelated care is being delivered. In addition, plans participating in the Hospice component must offer palliative care and TCC services.

In the course of contracting with hospices to be a part of their hospice networks, POs may negotiate payment rates with hospices, such that hospices may receive a different rate than they would have received from FFS Medicare. POs also have a responsibility to oversee hospice claims for the first time. Specifically, both in-network and OON hospices must submit NOEs and claims to POs for care provided to beneficiaries in VBID-participating plans and must also submit NOEs and informational claims to CMS.

Participating Parent Organizations in 2021

Nine POs implemented the Hospice component in 52 of their plans (Table 6.1). Half of all Hospice-participating plans were from POs R and W; these two, along with PO P, entered plans with the highest total enrollment across all plans participating in the Hospice component of the model test. Five of the nine POs implementing the Hospice component owned one or more hospices (POs P, V, X, Y, and Z).

Table 6.1. Parent Organizations and Plans Implementing the Hospice Component

PO	Number of Participating Plans	Beneficiaries in Participating Plans
PO M	5	25,434
PO P ^a	9	144,496
PO R ^a	14	99,629
PO T	1	12,022
PO V	1	18,268
PO W ^a	12	237,951
PO X	1	3,004
PO Y ^a	3	29,251
PO Z	6	38,458
Total	52	608,513

SOURCE: RAND analysis of VBID model test application materials and CMS enrollment data.

^a Also offering BDI interventions.

Beneficiary Identification

In keeping with eligibility for the Medicare hospice benefit, under the VBID model test, beneficiaries become eligible for hospice when they have an expected prognosis of six months or less. Because TCC is offered to hospice-eligible beneficiaries who want to maintain some curative care, TCC eligibility criteria also include an expected prognosis of six months or less. Although there is no set time frame for eligibility for palliative care, some POs, such as POs X

and V, considered beneficiaries with an expected prognosis of 12 months or less as being eligible for palliative care.

POs relied on a variety of methods to identify beneficiaries who would benefit from palliative care, TCC, and hospice, including provider referrals ($N = 4$), claims-based algorithms developed in-house ($N = 4$) or created by an electronic medical record (EMR) vendor ($N = 1$), or a combination of those approaches ($N = 5$). According to a PO X representative,

[W]e engaged with our business intelligence team to help us create an algorithm, really, to identify members. The algorithm really defines the criteria, which include the complexity of disease, other things [such as] the medications, the trajectory of where they are, inpatient stays, a lot of other things were considered. And with this algorithm, we're now able to identify those members who may fit the criteria for potential referral, both to palliative and hospice [care].

Representatives of another PO, however, noted the limitations of claims data to accurately identify potential beneficiaries, stating that claims data do not capture the level of detail needed to identify deterioration in a beneficiary's condition:

Identifying terminally ill members with poor prognosis using codes and utilization data is challenging. We evaluate the cases and the reports . . . early on to identify the members that could benefit from the model. The deterioration of the disease and the difficulty of maintaining the daily activities of the members, that is the main area [where] we offer palliative and hospice. (PO W)

In contrast, others thought that their algorithmic approach to identifying beneficiaries for palliative care was preferable to a physician-referral-based system, noting that some providers do not have a clear understanding of who is a good fit for palliative care. Moreover, PO T representatives reported being comfortable with self-referrals and provider referrals to identify patients for palliative care:

[Predictive analytics] are a wonderful dyad to the self-referrals or the referrals that come from our care deliverers [because] there still needs to be a significant amount of education in the health care system, [in] my opinion, regarding palliative care and hospice care. . . . When someone is referred to palliative care [but a provider disagrees and] says, "No, no. It's not time for palliative care," they are confusing palliative care with hospice care.

Types of Hospice Services Offered

All POs participating in the Hospice component were required to offer palliative care services as part of the model test. Some POs contracted with hospices or outside vendors, such as programs that provide home-based serious illness care, to provide these services. In their model test applications, all POs indicated that they would be providing consults, comprehensive care assessments from an interdisciplinary care team, 24/7 access to that care team, care planning, ACP, and psychological and spiritual support. All POs stated that they would offer pain management services, access to social and community resources, medication reconciliation, and

caregiver support. Three POs also stated that they would offer some additional services, particularly care transition oversight, care coordination by a physician, bridge prescribing, paramedicine services, and home care collaboration.

POs were also required to offer TCC services to beneficiaries receiving care at in-network hospices. All POs noted that TCC plans would be determined on a case-by-case basis in consultation with the provider and the patient. To qualify for TCC, POs required a beneficiary to have a terminal condition, such as cancer or ESRD. Based on the review of model test applications, TCC services typically included chemotherapy and radiation therapy for cancer patients and dialysis for ESRD patients. Other services offered included infusion therapies, pain management, pulmonary support through continuous positive airway pressure or bilevel positive airway pressure, and rehabilitation services; a few POs covered specialist and emergency department (ED) care that aligned with the plan of care for the patient.

During the interviews, representatives of POs T, V, and X mentioned that medical conditions and services that they covered as part of the TCC benefit included those that historically prevented their beneficiaries from electing hospice because electing hospice would have required them to forgo all curative treatments. According to a PO X representative, “The ones that we came up with just looking at previous data were things like some cancer treatments, radiation for pain or palliative care, diuretics, IV [intravenous] antibiotics and really kind of a case-by-case on respiratory.” Most PO representatives reported creating a set of key TCC services and then tailoring them to the specific needs of a beneficiary. According to a PO W representative, TCC

is based on members’ specific needs that we identify according with the plan of care established with the member and the member goals. We set a group of possible services that can be common in members with terminal illness or conditions. Chemotherapy, dialysis, biological medications, and others. But we go through case by case evaluating the needs of the member and the specific plan of care of the member.

Because the model test did not prescriptively establish a list of services that must be provided under TCC, PO V representatives argued that the lack of such a list created confusion around who was considered a good fit for TCC. The PO’s representatives noted that nonhospice clinicians, such as those providing dialysis or transfusion, were unclear about which services would be covered and who would pay for them for beneficiaries also receiving hospice.

Most POs also offered hospice supplemental benefits. POs most commonly offered the elimination of cost sharing for hospice drugs, biologicals, and inpatient respite care ($N = 6$) and provision of additional in-home services, such as respite care and support for activities of daily living (ADL) ($N = 4$). Some POs capped in-home services at a specific quantity (e.g., 40 hours of in-home respite care) or a weekly maximum (e.g., four hours of in-home support per week) for a set number of days (e.g., 60 days). One PO also offered a readmission prevention program.

Hospice Networks

As part of the model test, POs were responsible for setting up hospice networks. For medical providers, CMS sets explicit MA network adequacy requirements (such as establishing a minimum number of providers per specific type within a county) but has not yet established similar requirements for hospices (CMS, 2017). POs typically negotiate favorable rates with in-network providers and encourage beneficiaries to use these providers by setting less-favorable rules for OON care. For nonhospice services, such rules could include requiring prior authorization or higher beneficiary cost sharing for OON services. While POs could not enforce such rules for OON hospice providers in 2021, TCC was available only to beneficiaries who selected in-network hospices. Starting in 2023, POs in their third year of offering Hospice component interventions will be permitted to use incentives to encourage beneficiaries to use in-network hospice care. CMS also established model-specific hospice network adequacy requirements for 2023 (CMS, 2022a).

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

Across all POs, 596 hospices provided care to at least one VBID beneficiary in 2021 (Table 6.2). Of these hospices, 103 (17.3 percent) were in one or more POs' networks and 493 (82.7 percent) provided care only as OON hospices. Forty-six in-network hospices were a part of the network of PO P, which had the largest service area in the model test. In general, POs worked with a larger number of OON hospices, ranging from seven (PO X) to 227 (PO P), than in-network hospices, ranging from 2 (POs X and R) to 46 (PO P).

Table 6.2. Number of In-Network and Out-of-Network Hospices Delivering Care to at Least One VBID Beneficiary in 2021, by Parent Organization

PO	All Hospices (N)	In-Network Hospices (N, %)	OON Hospices (N, %)
PO M	24	10 (41.7)	14 (58.3)
PO P	273	46 (16.8)	227 (83.2)
PO R	51	2 (3.9)	49 (96.1)
PO T	36	19 (52.8)	17 (47.2)
PO V	71	4 (5.6)	67 (94.4)
PO W	76	4 (5.3)	72 (94.7)
PO X	9	2 (22.2)	7 (77.8)
PO Y	30	13 (43.3)	17 (56.7)
PO Z	88	3 (3.4)	85 (96.6)
Total ^a	596	103 (17.3) ^b	493 (82.7)

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

^a Total reflects the unique number of all hospices, in-network hospices and OON hospices for all POs, respectively, deduplicating hospices that provide care to beneficiaries from more than one PO within each group of hospices.

^b Total includes 11 hospices that were in-network for one PO and also provided OON care for at least one other PO.

In-network hospices tended to be larger than OON hospices (Table 6.3). For example, 47.6 percent of in-network hospices served 500 or more patients every year, while 26.6 percent of OON hospices were that large. Few hospices served VBID-participating beneficiaries in rural areas; however, rural hospices were nearly twice as prevalent among in-network hospices as OON hospices (5.8 percent versus 3.0 percent). Although most hospices were for-profit, a greater proportion of in-network hospices were nonprofit relative to OON hospices (26.2 percent versus 17.7 percent). A substantially higher proportion of in-network hospices were part of a chain, compared with OON hospices (43.7 percent versus 12.5 percent).

Table 6.3. Characteristics of In- and Out-of-Network Hospices Providing Care to at Least One VBID-Participating Beneficiary, 2021

Characteristic	In-Network Hospices ^a (N = 103)	OON Hospices ^a (N = 493)
Size (number of Medicare beneficiaries per year) ^b		
< 100	3 (2.9%)	112 (22.2%)
100–249	21 (20.4%)	144 (28.6%)
250–499	30 (29.1%)	95 (18.8%)
500+	49 (47.6%)	134 (26.6%)
% of hospice decedents in freestanding hospice inpatient unit ^c		
< 1	72 (69.9%)	382 (75.8%)
Hospice provides care in rural area ^d		
Yes	6 (5.8%)	15 (3.0%)
Ownership ^e		
For-profit	67 (65.0%)	350 (69.4%)
Nonprofit	27 (26.2%)	89 (17.7%)
Other	9 (8.7%)	44 (8.7%)
Part of a hospice chain ^f		
Yes	45 (43.7%)	63 (12.5%)
Provides care to beneficiaries from more than one PO		
Yes	11 (10.7%)	60 (11.9%)

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

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

^a Columns reflect the distinct number of in-network and OON hospices, respectively, deduplicating hospices that provide care to beneficiaries from more than one PO within each group of hospices.

^b Hospice size was obtained from the 2020 Medicare hospice claims files and was defined as the number of patients, including decedents, live discharges, and patients still under care.

^c The 2020 Medicare hospice claims files were used to calculate the percentage of patients who die in a freestanding hospice inpatient unit.

^d Hospices were defined as *rural* if more than 80 percent of patients in the 2020 Medicare hospice claims files lived in a rural zip code and the December 2020 Provider of Services file indicated that the hospice was rural.

^e Ownership was obtained from the December 2020 Provider of Services file. “Other” includes government and other profit statuses.

^f Chain status was determined by the research team based on web searches.

Reasons for Becoming an In-Network Hospice Provider

Our hospice interviews revealed four main reasons why hospices became in-network providers, and many hospice representatives cited more than one reason.

First, eight hospice representatives (Hospices E, F, H, M, O, P, R, and W) emphasized the desire to increase patient choice at the end of life, continue to provide high-quality care to their Medicare patients, and offer patients additional benefits. According to a Hospice R representative, VBID allowed them to be “creative for Medicare members . . . and increase their choice, lower cost, all of those things are important.” Representatives of Hospices F and P specifically mentioned their interest in improving the quality of end-of-life care for their patients. A representative from a different hospice described an interest in advancing TCC services:

A lot of literature and webinars that CMS had provided really talked about the benefits of this carve-in. And so we thought that it was important to be part of this project to see how it would evolve through the years and working with the MAO to make sure that we can help facilitate giving this service [transitional concurrent care] to our patients and the population here. (Hospice O)

Second, representatives of at least eight hospices (A, C, F, N, O, U, T, and W) felt that they needed to become an in-network provider with at least one PO to remain in business long term. “[I]n [our locality, which has high MA penetration] you have to [be] part of the network. You have no option. If you are not part of the network, you’re out. You have no future,” said a representative of Hospice N. Not only did hospice representatives say that the VBID model provided them access to MA enrollees, but they also felt that the hospice carve-in is likely to be the future of hospice:

There’s a really good chance that going forward, this is going to be our new world, where we have to participate with these Medicare Advantage plans . . . if [the payment rate is] something reasonable, I think it’s in our best interests to sign these agreements and participate, because say in three or four years, if we have to be in-network with these plans, we need to build that relationship, we need the experience, we need to be in-network. Because there could be [POs] out there in the world that say, well, we already have an established network. (Hospice U)

Third, seven hospice representatives (Hospices F, L, O, P, R, T, and W) reported wanting to be “early adopters” on the “forefront of innovation” (Hospice R). Another hospice representative said,

Hospices’ Expectations

In-network hospice representatives identified four ways in which the Hospice component could ultimately lead to better care quality:

- improved communication between POs and hospices (Hospice E) and hospices and patients (Hospice Q)
- better care coordination (Hospice F)
- POs being “more innovative, more creative, and more nimble” than traditional Medicare (Hospice Q)
- greater hospice attention to quality measures because of PO oversight (Hospice A).

The reason that we wanted to join the VBID hospice is to be thought leaders, to be able to influence the model, and participate for sure. We're very eager to increase access, as [our state] has some of the lowest access in the country. We want to be able to educate other providers about hospice care . . . and also to demonstrate good cost efficiency, quality, and to be good stewards of our financial resources. (Hospice T)

Finally, seven in-network hospices in our sample (Hospices J, K, M, O, P, Q, and R) reported becoming in-network providers to build on their prior relationships with POs. Their representatives attributed their status as a preferred provider to successful prior relationships or a shared ownership arrangement. A representative from one hospice described the decision to become an in-network hospice by saying,

We already had a relationship with that organization . . . if I'm not mistaken, PO V approached us because they picked about three preferred providers to join them in this partnership, and we were one of the three. (Hospice P)

Representatives of hospices with an ownership relationship with a PO stated that they felt that they were expected to participate in VBID. "As the VBID process came about, [PO P] had a significant interest in proceeding with their VBID offering. And since we are associated with [PO P], that led to us participating in that as well," said a Hospice S representative.

Criteria for Establishing Hospice Networks

Most POs reported that their first consideration when establishing a hospice network was ensuring that one or more hospices could provide care across their plan's service area. POs pursued different approaches to achieving this coverage. For example, while PO M contracted with all hospices in its state, PO R limited its network to just two hospices for the first year to develop internal capacity to comply with all CMS oversight requirements. POs X and Z had just two and three hospices in their networks, respectively. In contrast, POs P and V, which own hospice organizations, reported contracting with additional hospices beyond their own to ensure beneficiary choice. PO V representatives also reported aiming to include hospices diverse in both size and ownership status.

In addition, representatives of four POs (L, W, V, and X) described reviewing quality-of-care metrics, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice

Hospices' Expectations

Hospice representatives had mixed predictions regarding the impact of establishing hospice networks. On the one hand, because of the expectation that some OON hospices would close as a result of the model, representatives of Hospices I and N thought that "a lot of [poor quality] hospices will disappear with the VBID model and that's not necessarily a bad thing" (Hospice N) because it "might improve the level of quality that patients receive" (Hospice I).

On the other hand, a representative of Hospice A described how POs might select lower-quality hospices in their attempt to keep costs low: "[I]f in fact the hospices that are really sought after [by POs] are those that keep their costs down, and the way you keep costs down is by limiting visits, by shortchanging people when it comes to the equipment and supplies. There are ways to do it. Any [PO] is going to want to go after a hospice that can keep its cost so low. But is that really the best for the patient?"

Survey scores, when considering hospices for inclusion in their networks to ensure that their in-network hospices provide high-quality care to beneficiaries. While PO X did not exclude any hospices based on their quality measure performance, PO W used CMS data to select high-quality hospices for inclusion in the network. PO M, however, only required hospices to meet the minimum criterion of being Medicare-certified.

Contract Negotiations Between Parent Organizations and Hospices

All POs electing to offer Hospice component interventions had prior relationships with hospice organizations, and these relationships served as the foundation for establishing their hospice networks. Such relationships included ownership of hospice organizations and contracts with hospices for other purposes, such as provision of hospice services for commercial lines of business or for palliative care services under MA.

Parent Organizations' Perspectives

PO representatives cited several factors involved in contract negotiations with hospices. As a PO M representative put it, “[D]epending on the community, they [hospices] might have . . . a higher penetration of our MA members, and so then they would want to contract with us, but they’re all already contracting with us . . . so now the VBID is part of their contract as well.”

Discussions about the Hospice component were sometimes initiated by the POs and sometimes by the hospices. When POs made the initial outreach to hospices about becoming an in-network provider, many hospices were receptive. Nonetheless, representatives of PO X, which owns a hospice, reported facing initial skepticism from outside hospices regarding whether the PO would really refer patients to hospices other than the one they own. PO representatives noted that, at first, some hospices were hesitant about participation because they did not know much about VBID. A PO T representative said, “I felt like I was a salesman . . . I really had to emphasize, ‘We’re not going to interfere with what you do.’” Awareness of the model, its requirements, and potential benefits seemed to improve over time.

In contract negotiations, four POs (M, T, W, and X) reported offering the full FFS hospice payment, whereas others, such as POs V and P, reported offering rates that were lower than FFS on the grounds that the PO would refer more beneficiaries to in-network hospices. According to a representative from PO P,

All in-network providers are taking a rate cut to some degree from the 100 percent fee-for-service rate, [reflecting] the place they [in-network hospices] have in terms of that preferred provider role with the in-network benefits being

Hospices' Expectations

Eight hospice representatives expected that POs will offer lower reimbursement rates in the future (Hospices B, G, K, J, P, R, S, U). Representatives of Hospices B, P, and W pointed out that if POs offer lower-than-FFS rates to their in-network hospices, these hospices will have to make changes to care delivery that might affect care quality. “It’s almost unfathomable to me to think that we can provide the same quality of care at the 15 percent lower rate,” said a Hospice B representative.

available, their potential for growth, and referrals from providers upstream based on that status.

To ensure that beneficiaries are aware of the benefits of choosing an in-network hospice, PO P’s Provider Engagement Team used claims data to identify providers making the largest number of hospice referrals and conducted targeted outreach activities to educate these providers on VBID benefits, including describing the supplemental benefits offered through VBID, and providing them with the in-network provider directory.

Hospices’ Perspectives

Hospice representatives also shared their experiences in negotiating contracts with POs. Representatives of ten hospices reported being contacted by their respective POs about their potential participation in a hospice network for the model test. Hospice representatives indicated that members of their leadership teams were actively involved in the contract negotiation processes, pulling in additional support from clinical or other experts as needed.

Multiple hospice representatives, including those from Hospices B, J, O, S, V, and W, reported feeling that they had no power in the negotiations. A Hospice S representative felt a “major power discrepancy” between smaller hospice providers and POs, whereas representatives from another hospice described the contract negotiation as follows:

There’s a whole host of issues just with the contract. And when we presented it to [the PO] for discussion—and quite honestly, in the hopes to improve the contract so that it was at least compliant with both state and federal regulations—we were instructed that this is the contract. If you’re interested, please sign it. If not, we’ll go to another provider. So again, I don’t think “negotiation” is an operable word. (Hospice W)

Reimbursement rates were often the sticking point in negotiations. Representatives of six hospices (J, K, N, P, R, and W) reported receiving discounts off the FFS rates. As a Hospice W representative put it, “[I]t was a 12 percent across-the-board cut. And so, yeah, again, take it or leave it.” As mentioned earlier, hospices often felt that they had to accept the lower rate because they perceived VBID to be the future of the hospice benefit and did not want to be left out of PO networks.

Levels of reimbursement for palliative and hospice care also varied in comparison with rates that the POs pay the hospices outside the model test or in other lines of business. Hospice N representatives reported that the PO was paying them a discounted reimbursement rate for provision of a palliative care benefit, whereas Hospice K representatives reported receiving a

Hospices’ Expectations

Six hospice representatives explicitly mentioned that hospice network expansion could result in closure of some hospices, potentially limiting beneficiary access and choice (Hospices A, C, I, Q, U, and V).

Some hospice representatives expressed particular concern that smaller, independent hospices would be left out of networks because “no [PO] wants to have 120 contracts just for one metro area if they can keep from it. It’s just a nightmare for administration” (Hospice S), and it will be more efficient for POs to contract with national chains (Hospice I).

reimbursement rate comparable to the rate they were getting under their non-VBID contract for the PO's commercial line of business, which has a small number of hospice-eligible beneficiaries. Some hospice representatives reported that they can accept a discounted rate for a small number of their patients but cannot afford to do so on a larger scale for all their patients who are MA beneficiaries.

For other hospices, however, the contract negotiations processes seemed more straightforward. Eleven hospices reported being offered rates that were the same as or very similar to those of FFS Medicare (Hospices A, B, E, F, M, O, Q, S, T, U, and V). In addition, Hospice T representatives reported that they would be eligible for a bonus if they exceeded certain quality goals (e.g., achieving certain CAHPS Hospice Survey benchmarks). Besides negotiating reimbursement rates, four hospices (E, K, M, and P) appreciated conversations with POs related to establishing a scope of the covered hospice services and provided additional information demonstrating to POs that they provide high-quality care.

Nonetheless, some hospice representatives noted that future contract negotiations might become more difficult because reimbursement rates would be a big consideration. Representatives of two hospices (S and U) had a misconception that POs had to maintain FFS rates for in-network hospices in 2021 but that they were no longer required to do so after the first year of the model test. Others felt that with time, hospices will better understand the responsibilities associated with participating in the VBID model test, including the changes they will need to make to their normal procedures for a small number of their patients; this might make hospices less willing to accept lower reimbursement rates, because they recognize that it is not sustainable to meet model test requirements with less payment.

It is interesting to note that even hospices that are partially or wholly owned by their POs (Hospices E, K, L, S, and T) described needing to negotiate contracts with the POs, although these negotiations generally went smoothly. According to a representative of Hospice L, which is owned by PO V, "I think what this demonstration model has created [is] an opportunity [for us] to explore things that probably, as an integrated care system, we just didn't think to solve."

Representatives of only two hospices (K and N) reported being contracted to provide palliative care under VBID, although some other hospices noted that they have the capability to offer this service and would have preferred to include palliative care in their contracts with POs. In contrast, most of the in-network hospice representatives we interviewed reported that their hospices were contracted to provide TCC. This discrepancy might be explained by the fact that although TCC can only be provided by in-network hospices, POs have flexibility regarding the types of providers that can deliver palliative care. To that end, some POs extended contracts with their previously contracted or owned providers (such as home-based serious illness programs) rather than contracting with hospices to offer palliative care services as part of their newly signed VBID contracts.

Perspectives of Hospices on Future VBID Participation

Representatives of eight in-network hospices (F, J, M, N, O, P, R, and W) shared their intent to continue contracting with POs to be able to provide care to their MA patients. Representatives of two other in-network hospices (K and S), however, indicated that they had mixed feelings about future participation, given challenges that they experienced in 2021. One hospice representative shared concerns regarding the ROI:

[W]hat is the return on the investment for our organization? And at this point, we're struggling to see that . . . I advocated for us to get in it. . . . But I would not be surprised if we step out of the demonstration because we're doing all of this work for less money when we have an alternative for patients that we've been providing to them for years. (Hospice K)

Representatives of five OON hospices (B, C, D, V, and U) were not enthusiastic about participating in the model test; only two hospices (A and B) had specific plans to join a network of a VBID-participating PO. Another one (Hospice I) implied future participation by saying that the field is moving in that direction. Hospice V representatives noted that more information about the model test outcomes is needed for them to make an informed decision. Representatives of a hospice chain expressed reluctance about future participation given other hospices' experiences to date:

So in year one, overall, there was a relatively low appetite for [POs] to participate in the carve-in component. Of the nine [POs] that were participating [in VBID Hospice], [most] owned their own hospice provider. . . . Those providers that were not owned by insurance plans have been rather vocal that their experience in year one was very underwhelming and didn't meet their expectations. . . . Not a single palliative care encounter occurred from their plan that they were participating with, and that the net result was patients accessing the benefit at the same time or even later in the disease trajectory. (Hospice D)

Two OON hospices (D and U) expressly indicated that substantially reduced reimbursement rates would prevent their future participation. One representative stated,

If they're proposing a deep discount to Medicare rates, then most likely we are not going to participate. I can tell you that once you accept a rate that's less than Medicare, it's extremely difficult to renegotiate that rate. So even on the commercial side, if they are proposing five percent or ten percent discounts, there is usually nothing in the budget year one, year two, year three out, to try to negotiate an increase. (Hospice U)

Summary

The first year of implementing the Hospice component required POs to work with hospices in novel ways. Not only did POs have to establish networks of hospices within plans' service areas, but they also had to work closely with OON hospices and issue payment to these hospices for services provided to their VBID enrollees. POs also had to establish (1) payment rates and

processes to pay in-network hospices and adjudicate claims, (2) procedures for identifying which enrollees would benefit from palliative care and TCC services, (3) systems for delivering or contracting for this care, (4) guidelines for provision of TCC, and (5) data reporting systems. Claims-based algorithms were used by many POs to help with palliative care identification, but some PO representatives cited the limitations of identifying enrollees with deteriorating conditions by means other than provider referral.

POs worked with 596 hospices that provided care to their hospice-eligible beneficiaries in VBID-participating plans, approximately 83 percent of which were OON hospices. In-network hospices were more likely to be part of a hospice chain and larger (i.e., serving more than 200 Medicare beneficiaries) than OON hospices. Hospice networks varied in size; some POs included all hospices within a given plan's service area, whereas others included only two or three hospices. POs often used hospices with which they had preexisting relationships as a starting point for building their networks. Some POs factored such quality data as CAHPS Hospice Survey and other measure scores publicly reported by CMS into their network choices, yet others required only CMS certification to operate under Medicare. Most POs decided to offer palliative care services through other providers rather than through their in-network hospices; per model requirements, POs offered TCC and hospice supplemental benefits to beneficiaries receiving care from in-network hospices.

Experiences with contract negotiations varied substantially. Some POs simply set their reimbursement rates the same as Medicare FFS rates, which simplified contract negotiations substantially. Hospices that were partially or fully owned by POs still had to work through negotiations, although one hospice noted that this process was an opportunity to find some efficiencies in their relationship. Hospices receiving the full Medicare FFS rate in their contracts tended to have a more positive view of participation in networks and participation in the model test than hospices working with POs that offered rates lower than FFS. Some representatives from hospices that did not receive the full Medicare FFS rate also noted feeling little negotiating power to set agreeable reimbursement rates.

Although hospice representatives often viewed participation in the model test as an opportunity to increase care quality and patient choice in end-of-life care, most of their reasons for being involved in VBID were business related. Representatives reported seeing the model test as a way to stay in business long term, given their anticipation that the Hospice component will be expanded over time. Some hospices with existing PO relationships reported feeling that they were expected to participate in the model test. OON hospices were less enthusiastic about the model test, specifically noting a lack of involvement in the provision of palliative care services, low hospice referral rates, and low reimbursement rates as their key concerns about model test participation.

Chapter 7. Hospice: Implementation Experiences, Challenges, and Facilitators

This chapter uses the results of a 2021 pre-interview questionnaire and interviews with eight Hospice-participating POs and 23 hospices that provided care to VBID beneficiaries to describe model test experiences during the first year of the Hospice component implementation. These data also afford an early look at the challenges and facilitators POs and hospices encountered as they implemented the Hospice component. As in Chapter 6, we provide a series of boxes that present hospice representatives' perspectives on the future impact of the VBID model. We conclude with PO and hospice representatives' thoughts on how the COVID-19 pandemic affected the model test implementation.

Key Findings

- The majority of participating POs and sampled hospices indicated substantial challenges with Hospice component implementation related to administrative requirements, the process of explaining the model requirements to hospices and providers, and POs' oversight of hospice care delivery, some of which required additional staff and IT modifications to manage.
 - POs found data reporting to CMS and the identification and tracking of eligible beneficiaries especially challenging; other moderate challenges were communicating about benefits, hospice engagement, and claims processing and payment.
 - Hospice representatives saw no difference between the care that they delivered to VBID beneficiaries and the care that they delivered to other patients. Nonetheless, they considered extra layers of processes in terms of reporting, care planning, eligibility approval, and payment to be substantially more burdensome and inefficient than working directly with CMS.
 - Although POs found leadership support, cross-functional teams, and learning from other model participants or similar interventions to be key implementation facilitators, hospices considered education about the model and open lines of communication and active engagement with POs to be helpful during implementation.
 - Hospice representatives suggested that developing model-wide minimum definitions of the palliative care and TCC services, maintaining adequate reimbursement rates, and increasing model awareness among key stakeholders would promote hospices' implementation of the model in future years.
 - PO and hospice representatives noted that dealing with the COVID-19 pandemic was a major competing priority as they began implementing the Hospice component; the pandemic constrained hospices' ability to provide in-person services and limited in-person interactions that could have helped facilitate strong relationships between POs and hospices.
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Implementation Experiences

Representatives of six POs that implemented the Hospice component (M, P, T, V, W, and X) noted that the first year of the model was quite challenging and required substantial investment to ensure that staff within the PO, staff at hospices, and other providers become knowledgeable about the new services offered by the model and who was eligible to receive these services. POs also had to configure new internal processes for identifying VBID-eligible beneficiaries, tracking

NOEs, processing and reconciling claims, overseeing care plans, and reporting required data to CMS. This “heavy lift” (as a representative of PO V described it), however, eased somewhat over time for most POs as they implemented tailored systems to automate their administration of the Hospice component, and as POs and hospices became more familiar with the model test.

Nonetheless, the Hospice component of the model test had a significant impact on the way that both in-network and OON hospices operate when they provide care to VBID beneficiaries. For example, hospices must submit NOEs and claims for VBID beneficiaries to both the PO and CMS. To do so, hospices must be able to distinguish VBID beneficiaries from their other hospice patients. In-network hospices might also be subject to PO-specific requirements, such as contacting beneficiaries that the PO has identified as potentially eligible for hospice benefits, reporting data at specified intervals, or meeting with PO case managers.

Although POs participating in the Hospice component used a variety of strategies to identify beneficiaries who could benefit from palliative care and hospice (refer to Chapter 6), both in-network and OON hospice representatives generally agreed that the Hospice component of the VBID model test did not change how patients were referred to hospice (Hospices E, I, K, M, P, and W) or when hospice referrals occurred in a beneficiary’s care trajectory (Hospices A, E, F, H, and U). One hospice representative described it this way:

We still need to go out there to the hospital to make sure we get new referrals. We need to go into the community to the PCPs to make sure we get new referrals. We keep getting the same referral like we did before in the VBID. So we’re not getting the patient earlier or later because of the VBID. (Hospice E)

There were a few notable exceptions to these experiences. For example, a representative of in-network Hospice T stated that, although the hospice’s volume of patients remained the same in 2021, the type of patients changed. The hospice’s VBID beneficiaries were at higher risk of hospitalization than other patients; the hospice representative noted that their VBID beneficiaries had different “socioeconomics and . . . acuity” because the PO with which the hospice is contracted is a D-SNP, so the VBID beneficiaries are “by definition . . . dual eligible, they have Medicaid and Medicare, low-income, and complex care needs that require long-term services and supports.” A representative of another in-network hospice, which is a part of an integrated health system PO participating in the model, described a substantial increase in patient volume attributable to participation in the model:

I think this model has heightened our awareness and sensitivity to be more proactive. . . . We’ve heightened that awareness in both our inpatient team and our plan hospital teams . . . When we compare our . . . hospice agency to all of [regional area] hospice agencies, our referrals have gone up or our census has gone up almost 13 percent, whereas for [regional area] hospice agencies, that was only at 5 percent. . . . So I believe that [was due to] that proactive screening identification, that really understanding where patients are on their advance care planning journey. (Hospice L)

In-network hospices from two different POs (Hospices K and N) described receiving lists of beneficiaries potentially eligible for palliative or hospice care from the POs, noting that contacting potentially eligible beneficiaries was very labor-intensive but resulted in lower rates of transition to palliative care or hospice than they experienced in other lines of business. One representative described that the PO “just gave us a list of 1,000 pages, and we had to establish contact,” noting that the patients listed on these pages had a very low transition rate to hospice. In contrast, outside of the VBID model, another PO typically sends the hospice a list of beneficiaries that have an almost 100 percent transition rate to palliative care and 38 percent transition rate to hospice: “[They] could send us like five patients per week, but they have already talked to that patient, they have already presented the [palliative care] program” (Hospice N).

Similarly, another hospice representative noted that the hospice is required by its contract with the PO to call potential palliative care patients “six times before we officially say they were unable to be called; that is a heavy lift on the front end . . . especially because we’ve spaced it out to where we’re not calling back-to-back” (Hospice K). The hospice representatives reported that this is a much higher number of calls than they would typically pursue to recruit a patient and that the calls rarely resulted in enrollment in palliative care. On these calls, “a lot of times, we do hear feedback from patients that [PO P]’s always sending me things and they’re always calling me, and I don’t want another program. And so I don’t think that the process that they have us following at the beginning of our intake and referral is as . . . warm as we’d like it to be” (Hospice K).

Representatives of eight in-network hospices (Hospices E, F, H, N, Q, R, S, and T) described greater PO involvement in care management and coordination for VBID beneficiaries than for other lines of business. One representative indicated that prior to a beneficiary’s hospice enrollment, the PO has

a care manager that works with the patient, the family, just in terms of helping them to understand what the hospice benefit is and kind of what that means. . . . But they don’t get involved in terms of the clinical management or clinical oversight. It’s simply more of this patient is assigned to me as a care manager, and I’m trying to help navigate their care. And they’re moving onto hospice, and so I’m helping them understand what the benefit is and what that means and what hospice means. And so, when we are then notified that this patient is going to transition to hospice, some of that prep work has already been done. (Hospice Q)

Once beneficiaries start receiving TCC or hospice care, one hospice representative noted that

something that is new and different for us and kind of cool is now pulling those [VBID] patients out for a separate conversation, identifying them outside of the normal herd, if you will, and having the access to [PO V]’s hospice palliative care physician who oversees this group as part of the team and part of the conversation. (Hospice R)

Another representative described the benefits of collaborating with the PO's pharmacy services team:

We're looking at identifying any inappropriate therapy based on prognosis. We're trying to avoid duplication of therapy, especially if there's two different prescribers, as the hospice physicians are really the experts in symptom management. We just want to make sure that the primary physicians of these patients, under the VBID, are aware of our medications. And we would like also to avoid any wrong dose frequencies, wrong medications to be used, or any drug-drug interaction. . . . One of our goals is also to reduce nonadherence to the medication therapy. So I think this VBID participation is surely giving us more opportunities to collaborate with the pharmacy services team. (Hospice T)

Overall, across both in-network and OON hospices, ten hospice representatives (Hospices C, F, I, J, M, O, S, T, U, and W) reported no differences between how hospice care is delivered to VBID beneficiaries and how it is delivered to other hospice patients. As a representative from an in-network hospice described,

I don't think the delivery of care is different, honestly. I think we continue to provide the same quality care that we always do. I think the care remains the same. I don't think the patient is actually getting or seeing the impact with the VBID program. It's more of hospice, you know, just seeing some additional challenges within the process but it's not impacting the patient directly. (Hospice F)

Implementation Challenges

Representatives of both POs and hospices reported experiencing implementation challenges.

Parent Organization Perspectives

To begin conversations with PO representatives regarding the challenges that they experienced during implementation, we sent them a pre-interview questionnaire as previously described. This questionnaire asked POs to rate potential implementation challenges that we anticipated they would face (Table 7.1).

In this section, we describe the results of their ratings, in tandem with observations from our interviews, organized along three themes: administrative requirements, communication challenges, and oversight of hospice care delivery.

Table 7.1. Parent Organization Questionnaire Ratings of Hospice Implementation Challenges (N = 8)

Challenge	Not at All	Slightly	Moderately	Considerably	A Great Deal	Median
Reporting data as part of model participation activities ^a	0	1	3	3	0	Moderately
Identifying eligible beneficiaries ^a	1	2	3	1	0	Moderately
Tracking beneficiary VBID eligibility over time ^a	1	0	4	1	1	Moderately
Communicating VBID benefits information to providers	2	1	4	1	0	Moderately
Communicating VBID benefits information to beneficiaries	3	4	0	1	0	Slightly
Administering multiple sets of benefits within one PBP	1	4	1	2	0	Slightly
Implementing annual wellness health care planning services to all beneficiaries in a PBP ^a	1	4	2	0	0	Slightly
Working with vendors or subcontractors for components of your VBID intervention(s) ^a	2	3	1	1	0	Slightly
CMS reviews of marketing materials ^a	5	1	1	0	0	Not at all

SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.

^a For this item, one PO answered, “not applicable,” indicating that they did not encounter this challenge at all, bringing the total number of POs answering to seven.

Administrative Requirements

The biggest challenge from the PO perspective was model test data reporting requirements, which include biannual submission of beneficiary-level data and summary information on service use and costs, and triannual submission of lists of hospices within the PO network. Most POs rated these requirements as “moderately” (P, Y, W) or “considerably” challenging (T, V, X). One representative noted that, initially, it was

a lot of work from systems perspectives and to implement required reporting elements, and I would say the challenges in some respects were exacerbated by the fact that we didn’t have a long lead time in all cases to implement. (PO V)

Another representative described “working with multiple systems and processes [that] are not all on a single system” to pull together the required data (PO X). However, for both of these POs, once systems were established, reporting started to go more smoothly. In contrast, representatives of a smaller PO noted that “it was a challenge for us to keep up with what CMS

was asking us to do” with regard to data reporting, highlighting that the lack of definition around “how to organize our data and feed it” was perhaps more problematic for a smaller organization than for larger participating POs (PO T).

Most POs also reported that it was at least “moderately” challenging to identify and track eligible beneficiaries. Representatives of PO W described difficulty identifying beneficiaries for palliative, transitional concurrent, and hospice care, noting that it was challenging to use claims data to determine whether beneficiaries were experiencing a significant deterioration from their disease, were having difficulty maintaining ADL, or had a prognosis of six months or less. On account of this challenge, PO W relied more on health care providers and CM programs to refer patients because providers and programs can assess patients’ needs using their clinical judgment. For PO M, however, identifying beneficiaries eligible for TCC was more challenging than identifying those eligible for palliative or hospice care. As one representative put it,

I would say that [identifying those in need of TCC] is in evolution more so [compared with identifying those in need of palliative or hospice care], from the standpoint that we’re still getting out information about the differences of what we’ve previously provided to what we’re providing now and the intent of broadening the inclusion criteria of providing those benefits. (PO M)

Representatives of other POs, such as POs T and X, did not note this challenge and reported that creating new—or updating and applying existing—claims-data algorithms was an effective approach for identifying eligible beneficiaries.

Our interview data also revealed that claims processing and payment has involved a substantial learning curve and investment in IT during the first year of VBID Hospice implementation. PO V, X, and Y representatives acknowledged explicitly that they did not have prior experience paying hospice claims. In the initial months of implementing the Hospice component, some POs adjudicated claims manually to determine the correct payment amount in a timely manner. In describing the process of increasing claims review automation, one representative said that it was a challenge to determine “the best way to configure the system to automate payments,” and that while system changes were made by the end of the first quarter of 2021, some processes (for example, paying for extended stays or differentiating hospice staff physicians from independent physicians) still remain manual (PO X).

Representatives of POs R and W noted that they frequently needed to coordinate with hospices to reconcile claims, especially with OON hospices. One representative described the process as very challenging: “We have to call [hospices] almost every week or every two weeks . . . because we receive the claims and when we compare with the CMS report, we identify some [beneficiaries listed by the hospices] that CMS do not have in the[ir] report” (PO W). PO R hired a consultant to help with claims processing but is still “in a constant learning process with the hospices for both parties [hospices and PO].”

PO X and R representatives also described needing to learn how to distinguish between claims for services that were related to the beneficiary's terminal condition and those that were not:

Just reading the guidelines, there are certain modifiers and condition codes that [need] to be put on the claim in order to signify whether a non-hospice claim is unrelated to the member's terminal illness and is therefore eligible for payment. And those claims that do not have those qualifiers get denied [inclusion] in the hospice benefit. (PO X)

In its review of claims for related versus unrelated services, this PO found that some were paid incorrectly. The PO is "taking the appropriate steps to not only recoup the funds but to educate the provider and give them the opportunity to submit corrected claims if the service was unrelated to the member's terminal illness" (PO X).

Communication Challenges

Another challenge that received a "moderate" median rating on the PO questionnaires was communicating Hospice component benefits information to hospices and other providers. Representatives from some POs (T, V, and W) reported that hospices, particularly OON hospices, were initially unfamiliar with the model and that they needed to educate hospices about the services, eligibility criteria, and administration requirements available through the model test. A PO T representative noted that earlier communication from CMS to all hospices would have been helpful. Representatives of PO V indicated that the need to educate hospices is decreasing over time, as POs and hospices gain experience with the model test and CMS releases more information.

Interview data also revealed that PO M, T, V, W, and X representatives felt providers needed to better understand "the benefits of receiving palliative care and hospices services in a timely manner" (PO W) and required guidance on when to refer a patient to palliative care versus TCC or hospice. A representative of PO M described getting questions from providers about the distinction between palliative care and TCC as follows: "What are these similarities, what are the differences, and why would somebody choose one over the other?"

PO W and V representatives noted that it was difficult to engage with all hospices in their service area to provide information about the model, in part, because there were so many hospices. One PO described calling every hospice in their large service area to inform them about VBID:

We used the information off—outdated or not—from the website and then chased the rabbit to the extent we had to find the right person and the right organization to make sure people were notified . . . [it] was a big-time commitment. (PO P)

Questionnaire responses also indicated "slight" challenges with communicating VBID benefits information to beneficiaries, administering multiple sets of benefits within one plan,

implementing annual WHP services to all beneficiaries in a plan, and working with vendors or subcontractors. No challenges were reported with regard to CMS review of marketing materials.

Our interviews also identified several additional communication challenges related to administrative processes required by the model test. For example, POs V and Y noted that, in the model, both in-network and OON hospices are required to submit NOEs to both Medicare and the PO for VBID beneficiaries but that many hospices—particularly OON hospices—were confused about where to send the NOEs or simply did not submit them to the PO. Even when the hospice was aware of where to send the NOE, PO V representatives noted that hospices had difficulty knowing which patients were eligible for VBID.

Oversight of Hospice Care Delivery by Parent Organizations

POs reported inconsistent experiences across hospices with regard to their ability and willingness to share care plans. PO R, T, and W representatives described challenges in receiving care plans from hospices for each VBID patient, particularly from OON hospices. PO R representatives noted that some hospices had excellent care plans and promptly shared them with the PO, some had care plans but were slow to share them with the PO, and still others did not update their care plans at the time intervals required by CMS and, therefore, did not share them with the PO. Representatives of PO R added that sharing of care plans allowed for interdisciplinary care team discussions between the PO and both in-network and OON hospices. In contrast, a PO T representative reported not having the “bandwidth” to have these discussions.

Representatives of some POs, including POs R, T, and W, also noted that hospices are not accustomed to sharing care plans with CMS and, therefore, did not understand why they are being asked to provide them to the POs. This was particularly true among OON hospices, although some OON hospices did readily share the plans, as stated by PO R and W representatives. According to a representative of PO R, hospices “don’t feel very comfortable” sharing care plans, but they are increasingly doing so. Receipt of care plans was critical for PO R, which reconciled charges against the hospice’s care plan for the beneficiary to determine whether a charge should be considered related or unrelated to the patient’s terminal condition.

PO R representatives noted that hospices were putting up “resistance” to the PO’s oversight of care:

[I]f I see prescription of pain medication that they are supposed to be giving the member, and I see a prescription after the Notice of Election, we deny those medications. . . . [If they call,] I talk to them and say: “This is unacceptable. You know that you have to supply the medications. It is part of your work,” and that thing never happened with them before. So now they’re putting a lot of resistance . . . some of them continuing resistance; others are starting to work better with us.

Hospice Perspectives

Hospices also reported three main types of challenges to model test implementation, most of which parallel the challenges encountered by POs. The first type, related to burdensome billing

and delayed payment, is similar to the challenges described by POs regarding the administrative burden of identifying VBID hospice beneficiaries and receiving and adjudicating their hospice claims. The second type of challenge—PO oversight of hospice care delivery—was also reported by POs. Nonetheless, the third type—the challenge of providing TCC and hospice supplemental benefits—was specific to hospices, reflecting their direct role in providing services.

Billing Processes and Payments

Representatives from ten hospices described experiencing considerable administrative burden associated with their model test participation, particularly with regard to the requirement that hospices submit NOEs and claims to both Medicare and the PO. As a result, hospices had to develop new processes and systems:

We are required to report into CMS for any hospice patient, even if they're in the VBID program, and then if it is a patient in the VBID program, we've got to figure out how to ensure that those same claims, plans of care, recertifications, everything that we would have submitted to CMS, also goes to that Medicare Advantage organization. . . . The way they [CMS] take in claims, the way they take in claim forms, plans of care, has been very standardized on the hospice end. But as soon as you have a Medicare Advantage organization implementing this type of program, they might be using different systems, they might be using different claims TPAs [third party administrators], and so things often look a little bit different. And so it's not even as simple as clicking a button twice; it's actually more significant to ensure that the actual processes get set up in the right way in the first place. (Hospice B)

Hospice representatives described the high level of staff effort needed to meet the specific claims requirements of VBID. “To help put it in perspective,” reported a representative of Hospice K, “we have two team members who are completely dedicated to all of our Medicare population, right, which is about 90 percent of the patients that we serve. And I have one full-time team member” dedicated solely to supporting claims processing for 50 VBID patients, who compose the remaining 10 percent of the hospice’s total volume.

Representatives of Hospices F, L, T, and U reported challenges in identifying which of their patients were VBID beneficiaries, a prerequisite for (1) determining the beneficiaries for whom they need to submit NOEs and claims to the PO and (2) confirming covered benefits. A representative from another hospice recalled occasional instances, usually on weekends, in which waiting for the PO to confirm VBID eligibility delayed enrollment in hospice care, and there were “times when we wouldn’t be able to tell based on the benefits eligibility that they had a

Hospices’ Expectations

Several hospices anticipated that their costs would increase over time as more POs participate in the Hospice component. Specifically, these hospices were concerned about dealing with what one representative called “a smorgasbord of different prior approval processes and timeframes and procedures with various Medicare Advantage programs” (Hospice G), which could result in hospices needing to hire more billing staff (Hospice T). Representatives of Hospices J and U also expressed concern about the resources it would take to respond to PO claim denials and lost revenue if denials are upheld.

VBID program but then we find out later once we were trying to bill that the claim was denied” (Hospice F).

Representatives of seven hospices (both in-network and OON) reported delays in payment, which, for some hospices, such as Hospice P, created a cash flow problem. One attributed delays to POs’ initial denial of claims (Hospice F), whereas a Hospice I representative indicated that delays were caused by the PO’s insistence that they

submit our claims to Medicare [first]. Medicare has to deny, saying that they’re a VBID, and then we have to submit the bill to the Medicare Advantage plan for payment, and they won’t pay it until it’s been denied because that’s the process. So it’s a lot of work for our billing department.

Another representative attributed the delay to limitation in its PO’s computer systems:

The reason I think their claims were so late is because they still didn’t have a computer system. Their billing processing system couldn’t handle the Medicare type reimbursement model. So we went from getting our Medicare NOEs in such a timely manner that it was amazing, and our reimbursement usually within two weeks of billing . . . I think we still have a couple of NOEs . . . [that] Medicare approved, but we’re still waiting on [PO M] to approve. And then reimbursement went from two weeks to sometimes months. (Hospice J)

Parent Organization Reporting Requirements and Oversight

Representatives of Hospices K, N, R, and T considered POs’ extensive reporting requirements very burdensome. A Hospice N representative described their PO’s reporting and audit requirements, emphasizing that failure to meet these requirements is associated with a reduction in payment:

They [PO R] have the compliance division, they have a quality division, they have a clinical division, and they have a contract administration division. So we have to [submit] . . . so many different reports to each one of these divisions. . . . On top of that, we have audits from those divisions. Like you could have an audit from one division this week and you could have another—and then you have someone for two days going through that audit and someone from your staff. The next week there’s another audit. But then every 15th of the month we have to report KPIs [key performance indicators]. . . . And if you don’t comply with these KPIs, there’s going to be a reduction of 2 percent.

For some hospices, meeting reporting requirements required significant IT investments and staff time:

They had to add, like in the hospice side, preauth[orization] resources to manage that spreadsheet that’s updated every day and sent out to [PO P]. . . . We had to pursue SOC 2 security [information security auditing procedure], and that’s contractually required for [PO P] in the VBID demonstration. So that’s five- to six-figure investment over the time of the demonstration, which requires our IT department and many others to do extra audits and reporting to get that security protection, in addition to all of our vendors that we work with. . . . So that’s been a huge lift. (Hospice K)

The vast majority of hospice representatives interviewed (16 of 23 hospices) indicated that POs were not getting any more involved in overseeing hospice care delivery or payment than Medicare typically does outside the model. However, a concerned minority of hospices (C, K, U, and W), three of which contract with the same PO, found that PO oversight was overly burdensome or that it interfered with their clinical judgment; one hospice representative observed that the oversight “really kind of handcuffs us a little bit in how we treat our patients and how we can improve their quality of life” (Hospice K). Other hospice representatives reported that the PO was conducting prepayment audits on every patient (Hospice U), instructing the hospice to pay for medicines that treat secondary diagnoses (Hospice C), and specifying that certain types of services, such as pain management, should be delivered by other, non-palliative-care providers (Hospice K). A Hospice C representative said, “This is the first time I’ve seen a medical director of a health plan give me direct directions on how to manage my patients.”

Transitional Concurrent Care and Hospice Supplemental Benefits

Representatives from seven in-network hospices reported challenges related to providing TCC and hospice supplemental benefits. Hospice E, H, and W representatives noted that there was some confusion and lack of clarity about which services are covered by TCC and for how long. A Hospice W representative noted that the PO approves TCC “less than half of the time” that the hospice team recommends it. A Hospice E representative noted that TCC has “been a little more difficult to implement because other providers . . . don’t understand [TCC]. There is a misunderstanding there that they’re not going to get paid for their service because the patient elect[ed] hospice.” Hospices H and T noted instances in which they needed to educate TCC patients regarding the number of days that they would receive the TCC benefit.

In addition, representatives of Hospices T and V mentioned the complexity of coordinating care for TCC patients. A Hospice V representative recalled a patient for whom it was

unclear clinically who was managing what. So we’re very used to when a person comes on hospice, hospice is responsible for evaluating the patient’s needs and then making a plan of care and delivering a plan of care. And in this instance, I recall that the patient was calling [the hospice and the PO]. Both organizations were responding and making assessments and recommendations and then, sometimes they would even be in conflict.

Representatives of three hospices (K, S, and W), all of which contract with the same PO, described concerns about the feasibility of implementing a supplemental hospice benefit for in-home respite care in a manner timely enough to comply with their PO contracts:

[T]he member only has to provide us with 24-hour notice. And the in-home respite is provided by [a] CNA [certified nursing assistant]. . . . Anyone got a CNA just sitting around with nothing to do tomorrow? To operationalize that, are you kidding me? . . . I was very concerned about how do I free up a CNA tomorrow for eight hours. They have a schedule. They have patients they’re seeing. How would I meet that need? So I reached out . . . to multiple home health agencies and other providers that had CNAs to establish contracts or

memorandums of understanding between us so that I could contract for those services if we're not fulfilling that need. (Hospice W)

Another representative also indicated that the hospice needed to gain preauthorization before providing supplemental benefits, leading to concerns about delays “in care to patients who already have a short length of stay. . . . And then you have to slow down for there to get approval. You're just delaying access to the benefits for patients that desperately need it” (Hospice K).

Hospices' Expectations

Representatives of six hospices expressed concerns that if POs require preauthorization processes for in-network hospices in the future, care would be less timely (Hospices A, G, I, K, T, and U).

Implementation Facilitators and Required Resources

Parent Organization Perspectives

Using the PO questionnaire responses, we identified two key implementation facilitators: leadership support ($N = 8$) and cross-functional teams ($N = 7$) (Figure 7.1). One representative described both of these facilitators:

I met and became closer to folks in claims and contracting and member services and enrollment and in various different operations departments, our analytics folks, legal, compliance, etc. Everybody worked together in order to be able to present to, and able to make this work once executive leadership said go. Leadership support was crucial. . . . This program is good . . . It highly aligns with our mission. (PO T)

Figure 7.1. Hospice Implementation Facilitators Endorsed by Parent Organizations ($N = 8$)



SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.

Representatives of four POs also considered learning from the experience of other model participants and administering similar interventions in other lines of business as important implementation facilitators. Representatives of one PO described attending calls that CMMI held in 2021 and building on their experience in other lines of business:

I've been on those calls and disseminating what we've learned from those calls to the rest of the cross-functional teams . . . to sort of help us understand internally are we the only ones having this question, how are other people answering this question, that sort of thing. So that's been really helpful. . . . In terms of administering similar interventions in other lines of business, I'm thinking about the fact that we—for instance, the supportive care benefit, which is how we meet the non-hospice palliative care requirement in the model, is not limited to our Medicare Advantage line of business. It's actually present in other lines of business, as well. And so, that gives us kind of more—there's a broader use of the benefit and also internally, there's more understanding of what it does and where it is and how we . . . kind of what our baseline is that we're building off of when we implemented the hospice VBID. (PO M)

In addition to identifying key implementation facilitators, we asked POs to identify any additional investments they had to make to implement the Hospice component. Although only three POs reported making financial investments to facilitate the Hospice component implementation, six of the eight participating POs reported making changes to the claims processing system and working with palliative care providers, TCC providers, or both. Moreover, five of the eight POs reported investing in efforts designed to ensure compliance with VBID reporting and auditing requirements, new marketing activities and materials, new provider training programs, and the process of establishing a hospice network.

Hospice Perspectives

In-network hospice representatives identified three main facilitators that have helped them implement the Hospice component. First, representatives of five hospices (L, O, R, T, and W) highlighted the importance of their efforts to educate the hospice team and nonhospice clinicians about model eligibility and processes, particularly with regard to TCC eligibility criteria and services:

[E]ducating our staff [about] transitional concurrent care [was helpful]. It was definitely a new concept to our hospice team and having that understanding of what's going to happen with the patient. In the beginning, there was definitely confusion of: "Is it a VBID patient? No, what ZIP code do they live in? Wait, what's a TCC?" There was a learning curve there. We overcame it pretty quickly. (Hospice R)

Second, representatives of three hospices (L, P, and Q) described how having prior relationships with their POs opened lines of communication and established processes that could be easily tweaked to allow for participation in the model test. This was especially true for Hospices L and Q, which are part of the same integrated health system as their POs. For example, one representative explained that the transition to VBID billing requirements was seamless for the following reason:

[W]e're providing services for [PO Z] for a number of their products, the billing process obviously transitioned from billing Medicare for those services to simply billing [PO Z] for those services. And there hasn't been any kind of hiccup or

anything that we've navigated there other than just adjusting our billing.
(Hospice Q)

Another representative described how being part of the same integrated health system as its PO facilitated implementation of the model test through joint operations meetings to review workflow and processes and shared records that gave the hospice team “greater insight into where our patients are going and how they are ending up on hospice, when we may not see that in the chart” (Hospice L).

Finally, a representative from a hospice that is part of a large chain described a case management approach that allowed for smooth coordination with its PO:

We've got a set of transitional care specialists. Think kind of a case manager-like person on our side, as well, that helps to facilitate this and acts as a single point of contact in a given area of the country—not exactly state, but think like a state area—to then coordinate which branch would be most involved, get the right people involved and get them hooked up, linked up for the information with a [PO P]-side case manager. (Hospice S)

Ways to Make the Model Test More Attractive for Hospices

In addition to discussing facilitators that helped in-network hospices implement the Hospice component in 2021, interviewees from in-network and OON hospices identified three additional factors that could help hospices implement the model going forward. First, they strongly suggested developing model-wide minimum definitions of services to be provided by hospices as part of VBID, including palliative care (Hospices A, B, D, K, P, S, and W), TCC (Hospices A, H, V, and W), and hospice services (Hospices I and P). One representative said, “[The lack of palliative care definition] allows [PO P] to say they're giving palliative care without always necessarily making sure that full palliative care is being given. That's negatively impacted the quality of the care provided to those patients” (Hospice S). Representatives of two hospices (B, U) suggested that in-network hospices should play a more active role in the provision of upstream care, such as palliative care services that were often provided by third-party vendors, and help POs identify patients who could benefit from hospice services. This stemmed from the belief that POs could benefit from hospices' involvement in identifying beneficiary needs:

The early experience over the last 6–9 months of this program proves that the [POs] aren't, by and large, prepared to really understand and address that serious illness population from the point of view of transitioning them to hospice.
(Hospice B)

Second, because of hospices' concerns about payment rates, they argued that maintaining adequate reimbursement rates for their services would be important to ensure that hospices are willing to join POs' networks (Hospices B, G, H, K, N, P, U, and W). This could be achieved by requiring POs to maintain FFS rates (Hospices B, H, and P), limiting rate reductions (Hospice U), or otherwise establishing minimum pay or regulating profitability margins (Hospices G, N, and W). One representative suggested that “Medicare should just tell [POs] you have to go by

the rates that we already have established here. Or maybe tell them an average, you know, between the highest and the lowest. But not let them just go free” (Hospice H). Other representatives went further to suggest that additional payments might be needed to cover costs of model test administration not previously included in hospice care (Hospices P and K).

Finally, hospice representatives felt that increasing model awareness among key stakeholders, including POs, hospices, and beneficiaries, is going to be important for setting expectations regarding the structure of the model and its rules (Hospice O), appropriate utilization of hospice benefits (Hospice B), and best practices for processing hospice claims and establishing collaboration between POs and hospices (Hospice F). As one representative stated, VBID would be more attractive to hospices with “consistent information, so everybody understands what the role is, what the expectations are, and then what needs to be negotiated” (Hospice V). Some hospice representatives felt that CMS should take a stronger role in monitoring and supporting interactions between POs and hospices (Hospices H, J, S, and M) to “help ensure that everybody is doing their part to promote the success of this program and the intent of the program” (Hospice M). These suggestions included CMS standardization of contracting processes (Hospice S), establishment of “readiness and capacity” of PO administrative systems prior to model implementation (Hospice M), and monitoring of reimbursement timeliness (Hospice H).

Impact of the COVID-19 Pandemic on the Hospice Component

During interviews, we asked both PO and hospice representatives to describe the impact of the COVID-19 pandemic on health care delivery generally and the implementation of the Hospice component of the model test in particular. A Hospice V representative provided this context:

Staffing shortages, supply shortages, the hospitals are discharging people quickly or not admitting them at all. . . . The reality is, was everybody able to spend the time and attention on looking at VBID or are they trying to keep their staff safe and provide care to people who are COVID-positive? So the pandemic . . . has clouded everything.

Half of PO representatives we interviewed (POs W, M, R, and X) noted that COVID-19 led to a reduction in in-home services provided to beneficiaries. In particular, PO representatives noted that beneficiaries did not want staff coming into their homes, because of concerns about COVID-19 spread, and that staff had similar concerns:

I would say that on both sides of the coin, beneficiaries were fearful of new people coming into their home, and the organizations were fearful to go into places and to see people that they didn’t quite know whether or not—to what extent they were going to be risking their own staff of exposure. (PO M)

In addition, a PO M representative stated that hospices had challenges acquiring adequate personal protective equipment, leading to concerns about disease spread between beneficiaries and staff.

Representatives of five hospices (G, L, M, S, and V) expressly indicated that the COVID-19 pandemic was a competing priority with implementation of the Hospice component. One hospice representative mentioned that the pandemic interfered with processes that might have helped the model test work more smoothly:

COVID has not really been very useful in letting us get together. . . . It's been very disruptive to normal process flows. . . . And the way we would like to have it happen is an actual either virtual or an in-person meeting, typically quarterly, to just review generally how things are going. Specifically, what these numbers look like from the [PO P] side, from the [Hospice S] side and just saying if there are best practices we need to help distribute, if there's [stuff] we need to work on, if there are issues that we know we don't want to do it that way, that we can make sure everybody knows not to do it that way and try to address a fix. But that's unfortunately been a little haphazard in 2021. (Hospice S)

Summary

The PO and hospice representatives we interviewed generally considered Hospice component implementation to be challenging and conveyed various difficulties they encountered. Some of these challenges, such as needing to adapt IT systems or managing claims and payment processing, were expressed by both POs and hospices. Identifying and tracking beneficiary eligibility was also a shared challenge that led to some instances of delays in approvals of benefits. Data reporting was also a shared concern, although POs felt that the reporting requirements from CMS were burdensome and hospices viewed POs' requirements as the culprit. Likewise, payment was a shared concern; however, from the PO perspective, this was an issue of developing specialized systems and knowledge to adjudicate claims, whereas some hospices were concerned about delays in receiving payments, which created cash flow problems for some.

Communication also presented challenges in different ways: Some POs found it difficult to communicate with the multitude of hospices in a given area, especially because some hospices would end up caring for only a few VBID-eligible beneficiaries. Both POs and hospices faced difficulties with getting all stakeholders up to speed on what the VBID model test is, particularly with regard to TCC eligibility and benefits. Both PO and hospice representatives cited advantages to having existing relationships with one another. But for some hospices, these relationships did not necessarily help. Hospice representatives discussed duplicative claims processes that required additional staff time to work through, excessive reporting and auditing requirements from POs, and frustrating delays in payment processing.

From the perspective of many POs and some hospices, various challenges, such as the need to update IT systems, appeared to be working themselves out over the course of the first year. PO

and hospice interviewees expected improvements in other areas, such as communication, as the model test continues and becomes more well known among stakeholders and beneficiaries. Hospice representatives noted that the quality and types of care provided to VBID beneficiaries and other patients were the same, but that care for VBID beneficiaries involved more effort on the administrative end.

Chapter 8. Hospice: Intervention Outcomes

In this chapter, we consider how the Hospice component influenced key outcomes, including beneficiaries' enrollment in plans; plan bids, premiums, and provision of supplemental benefits; and utilization of Hospice component services (i.e., hospice services overall, as well as palliative care, TCC, and hospice supplemental benefits). We analyzed 2021 data on these outcomes descriptively and also used DD regressions to answer relevant research questions.

As with the outcome analyses for the BDI component, we supplemented these analyses with data from pre-interview questionnaires of the PO representatives who subsequently participated in semistructured interviews and data from interviews with hospice representatives regarding expected outcomes of the Hospice component. Where possible, we include illustrative quotes from PO and hospice representatives relevant to the quantitative findings in this chapter.

Key Findings

- Participation in the Hospice component was not associated with a statistically significant change in plan-level enrollment, a finding that reflects POs' expectations, at least in the short run.
 - Hospice component implementation was associated with a statistically significant \$22.40 PMPM decrease in MA bids ($p = 0.01$, 95% CI $[-\$38.12, -\$6.68]$), roughly 3 percent of the average monthly MA bid. This finding is consistent with the possibility that POs expected that more beneficiaries would utilize palliative or hospice care and incur fewer acute care costs as a result. However, the estimated change in the combined MAPD bid was not statistically significant.
 - We found no evidence of a relationship between implementation of the Hospice component, MAPD premiums, or projected cost of mandatory supplemental benefits.
 - For most POs, palliative care utilization was lower than they had expected when they applied to participate in the model test. Hospices and POs alike reported low uptake of TCC as well. Across all POs, in 2021, a total of 2,596 beneficiaries received palliative care and a total of 146 beneficiaries received TCC.
 - In the first year of the Hospice component implementation (2021), more VBID beneficiaries received care from OON hospices than from in-network hospices (62.7 percent compared with 37.3 percent). This pattern might change over time as the model begins to allow POs to use tools to steer beneficiaries to in-network hospices.
 - The majority of in-network hospice representatives interviewed reported no difference in the number or types of patients receiving care from their hospices.
 - Across all in-network hospices, the median number of VBID enrollees was 16. The low census created some administrative challenges related to implementing PO-specific requirements for a small share of their total population.
-

Impact on Enrollment

To the extent that beneficiaries consider end-of-life care when making enrollment decisions, the Hospice component could affect beneficiaries' plan choices. We assessed whether implementation of the Hospice component was associated with beneficiaries' enrollment decisions by comparing enrollment trends in Hospice component-participating plans relative to eligible nonparticipating plans. As in Chapter 5, we used a DD regression approach, and we

weighted the comparison group to resemble the participants along key dimensions. We transformed the dependent variable, enrollment as of July 1, using logarithms. Data for the analysis, which came from the MA enrollment files, spanned from 2017 through 2021, the first year that the VBID Hospice benefit was available. Average enrollment in VBID-participating plans was 12,106 in 2020, the year before the Hospice component took effect.

Our regressions, shown in Appendix H, found no statistically significant differences in enrollment in Hospice-participating plans, relative to comparison plans in 2021 ($p = 0.92$). These findings are broadly consistent with our qualitative findings. Questionnaire results show that most POs (five out of eight) thought that in the short term, participation in the Hospice component would have no impact on plan-level enrollment. Over the long term, however, more POs thought that the Hospice component would have a positive impact on enrollment and retention in their plans (Table 8.1).

Table 8.1. Parent Organization Expectations Regarding Beneficiary Enrollment and Retention

Outcome	Positive	No Impact	Negative
Short term (1–2 years)	3	5	0
Long term (3+ years)	5	3	0

SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.

The following quotation from a PO representative illustrates this perspective: “We really do not think that hospice is going to be a reason people choose our plan; certainly, not short term when we have no experience and no community word-of-mouth or anything on whether what we’re doing is good or bad” (PO L).

Impact on Plan Bids, Premiums, and Supplemental Benefits

We analyzed plan bids for 2017 through 2021 to determine the impact of Hospice component implementation. Data sources for studying plan bids are the same as those described in Chapter 5.

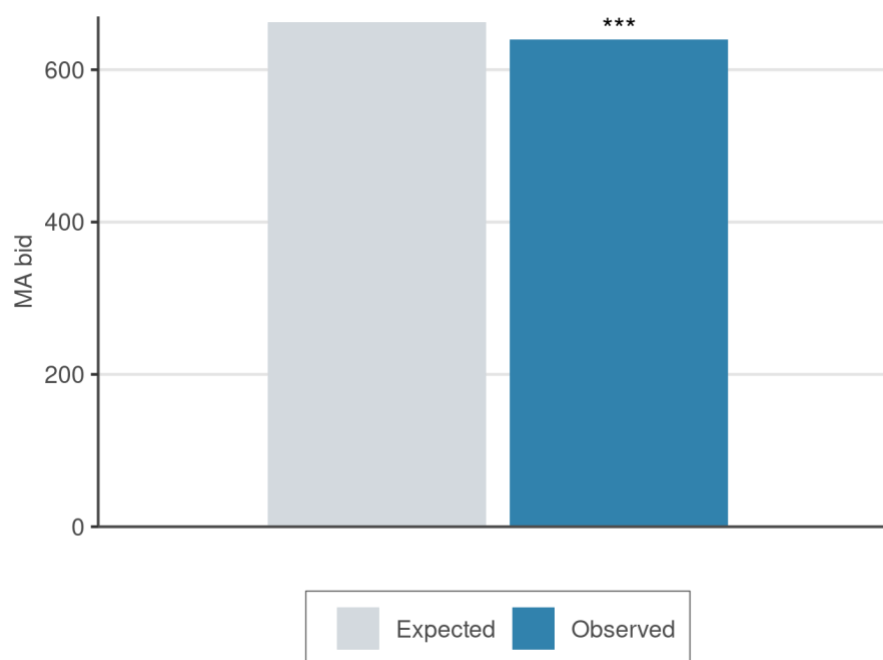
CMS set a capitation payment to plans for hospice care provided under the model test; therefore, MA and Part D bids would not include the cost of hospice care in their projected costs for Medicare-covered services or outpatient prescription drugs. However, to the extent that the Hospice component of the model test changes whether and when beneficiaries elect hospice care or their utilization of high-cost services, there could be implications for projected medical spending on Medicare-covered services or prescription drugs, which would affect bids. The cost of administering the hospice benefit might also affect POs’ bids, although CMS included an administrative loading factor in the calculation for the capitation payment.

Plan Bids for Medicare Advantage and Part D Coverage

In our main models, participation in the Hospice component was associated neither with statistically significant changes in the combined MAPD bid nor with statistically significant changes in Part D bids. However, in sensitivity analyses in which we controlled for 2020 COVID-19 case volume in a plan’s service area, we found that participation in the Hospice component was associated with a \$21.51 PMPM reduction in the MAPD bid ($p = 0.02$, 95% CI [−\$40.29, −\$2.72]). See Appendix G for further discussion.

In our main models, we also estimated that participation in the Hospice component was associated with a statistically significant \$22.40 PMPM decline in MA bids ($p = 0.01$, 95% CI [−\$38.12, −\$6.68]; Figure 8.1).

Figure 8.1. Estimated Association Between Hospice Component Interventions and Medicare Advantage Bids, 2021 Plan Year



SOURCE: RAND analysis of 2017–2020 OACT bid data.

NOTES: ***, **, and * represent statistical significance at the 1-, 5-, and 10-percent levels, respectively, from the DD models comparing VBID-participating plans with comparison plans. See Appendix I for full results. The number of Hospice component-participating plans included in the analyses was 46, and the number of comparison plans was 2,233. For a detailed breakdown of sample sizes, including the effective number of comparison plans after entropy balancing, see Appendixes C, H, and I.

We analyzed MA bid components to explore mechanisms that might have contributed to these findings (Appendix I). Although most changes were imprecisely estimated, Hospice component participation was associated with a marginally significant \$26.79 PMPM reduction in

projected plan spending on MA-covered services ($p = 0.10$, 95% CI [-\$58.76, \$5.19]). This finding is consistent with the estimated decline in MA bids.

Questionnaire results show that the majority of POs expected that participation in the Hospice component would have no impact on bids in the short term (five POs); only one PO expected bids to increase (negative impact), and two POs expected bids to decrease (positive impact) (Table 8.2). In the long term, half of the POs thought that the bids would go down as a result of participation in the Hospice component; the other half did not expect to see any impact on bids.

Table 8.2. Questionnaire Results for Parent Organization Expectations Regarding Bids and Administrative Costs

Outcome	Positive	No Impact	Negative
Short term (1–2 years)			
Bids	2	5	1
Plan administrative costs	1	1	6
Long term (3+ years)			
Bids	4	4	0
Plan administrative costs	3	2	3

SOURCE: RAND analysis of 2021 MA VBID PO questionnaire data.

Administrative costs factor into bids. Most POs (six out of eight) expected to see increases in administrative costs at least in the short term, resulting in negative impacts on bids in some cases. “So offering [VBID Hospice] did come at a little more of a configuration cost. We were able to cover that through the enterprise investment as part of that process, but it does need to factor into our bid accordingly,” said a representative from PO Q. It is interesting to note that POs’ perspectives varied on long-term administrative costs. Three POs hypothesized that these costs would increase, and another three POs projected that they would decrease.

Premiums for Medicare Advantage and Part D Coverage

We used the CMS PBP benefits data files to construct three premium variables—MA, Part D, and total MAPD premium. We found no evidence of a significant association between plans’ participation in the Hospice component and any of these outcomes. Point estimates and 95-percent CIs are presented in Appendix I, along with additional regression estimates. In Appendix G, we reestimated the premium regressions after controlling for COVID-19 case rates for older adults; these sensitivity analyses did not change our conclusions.

Supplemental Benefits

It is not clear a priori how the Hospice component of the VBID model could affect plan decisions regarding mandatory supplemental benefits offered to all plan enrollees. Because the Hospice component is paid for with capitation payments for specific beneficiaries who elect

hospice, MA plans do not have to incorporate coverage for hospice benefits into their projected bids in the same way they do for BDI benefits. Similarly, Hospice-participating plans may not change their supplemental benefit offerings substantially, as the election of hospice is not necessarily associated with utilization of supplemental benefits. One exception might be the provision of palliative care or other supplemental benefits associated with end-of-life or serious illness care. If Hospice-participating plans perceive that the addition of these types of services for all plan enrollees might affect the outcomes associated with the Hospice component implementation, they might or might not choose to add them.

The data sources and approach for studying supplemental benefits are the same as those described in Chapter 5. Descriptively, we find that the average number of supplemental benefits offered by Hospice participants and eligible nonparticipating plans increased from 2019 to 2021. Hospice-participating plans increased their offerings from an average of 16.5 in 2019 to 19.0 in 2021. Eligible nonparticipants increased their supplemental benefits from an average of 15.8 to 18.7, which is very similar. Part of the increase in supplemental benefit offerings might reflect that, starting in 2020, CMS added three additional supplemental benefits as options to the benefits data. Appendix I contains additional details on specific supplemental benefit offerings.

Our regression results indicate that Hospice participants did not significantly change the projected costs of mandatory supplemental benefits after VBID implementation. We found no evidence of an association between Hospice participation and mandatory supplemental benefits costs (refer to Appendix I for full results).

Taken together, these findings suggest that plans' participation in the Hospice component did not lead to increased offering of supplemental benefits to all enrollees in the participating plans, relative to the supplemental benefits offered to nonparticipating plan enrollees.

Utilization of Hospice Component Services

In this section, we report observations from interviewed POs and hospices regarding utilization of Hospice component services in 2021; describe utilization of palliative care, TCC, and hospice supplemental benefits using data reported by POs to CMS as part of model monitoring activities; and describe utilization of in-network and OON hospices across POs using lists of network hospices provided by POs to CMS and preliminary hospice claims data for 2021.

Palliative Care

Enrollment in palliative care in 2021 was lower than POs expected when they applied to the model (Table 8.3). POs reported that a total of 2,596 beneficiaries received palliative care or care from a similar program during this time, ranging from zero (PO Y) to 720 (PO P). Among those beneficiaries who received palliative care, the average number of days in palliative care was 111.4, with a range from 3.0 (PO Z) to 206.8 (PO R). Wide variation in the length of palliative

care use might be related to beneficiary diagnoses and the setting in which the care is delivered (e.g., hospital, outpatient, or home).

Table 8.3. Number of Beneficiaries Receiving Palliative Care and Palliative Care Length of Stay, 2021, by Parent Organization

Hospice POs	Total Number of Beneficiaries Receiving Palliative Care	Average Number of Days in Palliative Care
PO M	178	49.0
PO P	720	128.7
PO R	446	206.8
PO T	308	123.1
PO V	80	53.7
PO W	357	105.5
PO X	82	162.8
PO Y	0	N/A
PO Z	425	3.0
All POs	2,596	111.4

SOURCE: RAND analysis of data submitted by POs as part of the VBID model test.
NOTE: N/A = not applicable; PO reported that no beneficiary received palliative care.

PO questionnaire responses suggest that all POs that implemented the Hospice component expected to see increased utilization of palliative care services in both the short and long term (results not shown). Many POs did not contract with hospice organizations to provide palliative care. Instead, they continued working with palliative care organizations with which they had established contracts before VBID. Therefore, they did not see the Hospice component changing anything in the way they offer palliative care services:

We already have palliative care programs, and we’re actually leveraging our current program and our current palliative care partners to sort of flow into hospice. So we are not doing anything different with palliative care front-end. It’s more how we tie into the hospice program on the back-end, so no impact there.
(PO L)

Of the two hospices interviewed that were contracted to provide palliative care services, Hospice K reported caring for very few VBID beneficiaries, while Hospice N, which operates in a service area with very high MA penetration, reported that participation in VBID doubled its palliative care volume.

The Hospice component is designed to promote smoother and timelier transitions to hospice, in part, by promoting availability and use of palliative care among beneficiaries who are not yet ready for hospice. However, representatives from two in-network hospices (S and T) highlighted that in 2021 they received few referrals from palliative care into hospice and speculated that this might be partly because of incentives for palliative care providers to maintain patients. A representative from Hospice S described it this way:

I think it [VBID] does identify patients that would potentially benefit from hospice/palliative care and it's routing people to palliative care, but that's not in turn always resulting in them going on to hospice. . . . It's sometimes easier for plans to refer to palliative care and let the palliative care folks do the conversation. But if the palliative care folks realize that they're getting paid a set amount per month to do care, they're going to make a little more money if they do four months instead of three. And that translates into not an earlier transition to hospice after all.

Transitional Concurrent Care

Few beneficiaries received TCC in 2021 (Table 8.4). In data submitted to CMS, seven of the nine participating POs indicated that 12 or fewer beneficiaries used TCC. PO M was the notable exception, reporting that 82 beneficiaries received TCC during the year. Across all POs, 1.5 percent of beneficiaries electing hospice received TCC, ranging from zero (POs R and Z) to 12.1 percent (PO M).

Table 8.4. Number of Beneficiaries Receiving Transitional Concurrent Care and Average Length of Stay, 2021, by Parent Organization

VBID POs	Number of Beneficiaries Receiving TCC	% of Beneficiaries Who Elected Hospice Receiving TCC	Average Number of Days in TCC
PO M	82	12.1	3.5
PO P	10	0.3	25.4
PO R	0	0.0	N/A
PO T	1	0.3	17.0
PO V	12	2.9	63.8
PO W	2	0.1	73.5
PO X	1	0.9	21.0
PO Y	38	5.4	38.4
PO Z	0	0.0	N/A
All POs	146	1.5	20.2

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

NOTE: N/A = not applicable; PO reported that no beneficiary received TCC.

Although some POs did not expect high utilization of this new benefit, actual utilization was even lower than expected. At the time of our interview with PO T representatives, they stated that they did not have any TCC patients:

So under the transitional concurrent care model folks could transition to hospice, because they were eligible and they wanted it, and for a period of time they also would have this curative care weaning down. . . . Our members were not going onto hospice not because they . . . wanted to continue curative care aspects, they

didn't want to go on hospice because they thought that they would lose the services at home, the long-term services and supports or home community-based services for which they had become accustomed to. . . . They didn't go on hospice because of the fear that hospice would not continue those services once they transitioned. . . . So over the past seven months, we haven't had, truly, a transitional concurrent care case.

All in-network hospices interviewed also indicated that they cared for very few TCC patients. This might be, in part, because outreach and education regarding TCC are still needed (PO V).

Nonetheless, representatives from some hospices (M, O, R) expressed enthusiasm about the observed early benefits of TCC. A representative of Hospice M described the role of TCC in smoothing the path to hospice for those who might benefit from it by saying, "It's a tool to get them on services when they really need it, and they are reluctant because they feel like putting their loved one on hospice is throwing in the towel. And when you give them that extra tool, they relax a little bit and accept it better." Moreover, a representative from Hospice R noted that TCC

Hospices' Expectations

Several hospice representatives reported that as VBID Hospice expands, they expect to see beneficiaries elect hospice earlier, noting that this could be achieved through PO case management and earlier identification of eligible beneficiaries (Hospice Q), TCC creating a bridge to hospice (Hospice P), and increased societal awareness of the advantages of hospice (Hospice M).

brings the beneficiary into the decisionmaking loop and allows them better access to sort of understanding the options that are available to them . . . I just don't see how a beneficiary doesn't benefit from that and being a more active participant in their outcomes and what's going to happen. They still have the decisionmaking power. They can still say, no, that sounds really nice but I don't want that. No patients' arms are twisted into accepting the program or being part of it. I think those who have participated have felt positive about it.

Representatives of Hospices M and R also noted that TCC helped prevent rehospitalizations. As the representative of Hospice M described it,

What [TCC] really does help with is preventing rehospitalizations for the same thing over and over again. By being part of this VBID program, the benefit is that they still can get treatment, and they can still—they're monitored by a team of professionals who know what they're doing, can triage any of their calls 24 hours a day, 7 days a week, visit them, have a nurse on their bedside if needed. . . . It's reducing hospital admissions and keeping the patient at home. And I think that's a really important piece to take with the VBID program.

A Hospice S representative, however, expressed skepticism about the helpfulness of TCC for most beneficiaries, noting, "Yes, there's going to be an occasional patient that it's definitely helpful for. But for the vast majority of patients who are coming onto hospice . . . that's not why they haven't come onto hospice earlier."

Hospice Supplemental Benefits

Utilization of hospice supplemental benefits was also low (Table 8.5). Of the seven POs offering supplemental benefits, all POs except PO P offered to eliminate cost sharing for hospice drugs and biologicals and inpatient respite care. A total of 239 beneficiaries across two POs, 229 in PO V and 10 in PO Z, received reduced cost sharing. Only four POs offered other types of supplemental benefits; a total of 286 beneficiaries received them. These beneficiaries included 146 from PO P, which offered a \$500 yearly care assistance allowance and in-home respite care, and 138 from PO Y, which offered a readmission prevention program. Other POs offered additional respite care days (PO Z) and an in-home support benefit (PO R), with only one beneficiary receiving these benefits.

Table 8.5. Number of Beneficiaries Receiving Hospice Supplemental Benefits in 2021, by Parent Organization

PO	Number of Beneficiaries Receiving Reduced Cost Sharing	Number of Beneficiaries Receiving Other Types of Supplemental Benefits
PO P	N/A	146
PO R	0	1
PO T	0	N/A
PO V	229	N/A
PO X	0	N/A
PO Y	0	138
PO Z	10	1
All POs	239	286

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

NOTES: N/A = not applicable; PO did not provide supplemental benefits or reduced cost sharing.

POs M and W did not offer hospice supplemental benefits; therefore, they do not appear in the table.

Although our interviews with PO representatives did not cover utilization of hospice supplemental benefits, a few interviewees (Hospices H, I, K) highlighted the perceived usefulness of hospice supplemental benefits in improving quality of care and quality of life. Benefits cited as particularly helpful were in-home modifications and a \$500 allowance to help patients purchase lift chairs, ramps, and other items to promote accessibility that they might not otherwise have been able to afford.

Hospice Care

In 2021, across all POs, 9,630 VBID beneficiaries received hospice care. This corresponds to 1.6 percent of all beneficiaries enrolled in plans participating in the Hospice component. For reference, the total number of beneficiaries from these plans who received hospice care in 2020 was very similar (9,666 corresponding to 1.5 percent of all enrolled beneficiaries).

Of all beneficiaries receiving hospice care, 37.3 percent received care from in-network hospices and 62.7 percent from OON hospices. The proportion of beneficiaries receiving care

from in-network hospices varied greatly, from just 10 percent in a PO that restricted itself to two in-network hospices in 2021 (PO R) to 97.9 percent in a PO that contracted with all hospices in its service area in that year (PO M). POs also varied greatly in terms of the number of beneficiaries who received any hospice care, ranging from 113 in PO X, which operates in a market with low hospice enrollment, to 2,988 in PO P, the largest PO participating in the model test.

In-network hospices delivered care to a larger median number of beneficiaries per hospice than did OON hospices across all POs (Table 8.6). The median number of beneficiaries cared for by in-network hospices ranged from five in PO T’s in-network hospices to 90 in PO W’s in-network hospices, while the median number of beneficiaries cared for by POs’ OON hospices ranged from one in PO M, PO V, and PO X) to eight in PO W.

Table 8.6. Number of Beneficiaries Receiving Hospice Care from In- and Out-of-Network Hospices in 2021, by Parent Organization

PO	All Hospices	In-Network Hospices	OON Hospices	In-Network Hospices	OON Hospices
	Number of Beneficiaries	Number (% of PO’s beneficiaries)	Number (% of PO’s beneficiaries)	Median Number per Hospice (25th %ile, 75th %ile)	Median Number per Hospice (25th %ile, 75th %ile)
PO M	675	661 (97.9)	14 (2.1)	60.5 (28.0, 97.0)	1.0 (1.0, 1.0)
PO P	2,988	1,219 (40.8)	1,769 (59.2)	14.5 (6.0, 32.0)	3.0 (1.0, 8.0)
PO R	923	94 (10.2)	829 (89.8)	47.0 (25.0, 69.0)	7.0 (1.0, 14.0)
PO T	313	191 (61.0)	122 (39.0)	5.0 (2.0, 13.0)	2.0 (1.0, 4.0)
PO V	411	155 (37.7)	256 (62.3)	40.5 (15.0, 62.5)	1.0 (1.0, 3.0)
PO W	2,817	383 (13.6)	2,434 (86.4)	90.0 (65.0, 126.5)	8.0 (1.0, 44.0)
PO X	113	87 (77.0)	26 (23.0)	43.5 (8.0, 79.0)	1.0 (1.0, 7.0)
PO Y	702	611 (87.0)	91 (13.0)	20.0 (9.0, 31.0)	3.0 (1.0, 6.0)
PO Z	688	192 (27.9)	496 (72.1)	9.0 (2.0, 181.0)	4.0 (1.0, 8.0)
All POs	9,630	3,593 (37.3)	6,037 (62.7)	16.0 (6.0, 44.0)	3.0 (1.0, 9.0)

SOURCE: RAND analysis of preliminary CMS hospice claims data, 2021, and data submitted by POs as part of the VBID model test.

Interview and questionnaire data revealed that utilization of Hospice component services in 2021 did not align with POs’ expectations. Some, such as PO T, indicated that they had very few beneficiaries enrolling in hospice in the initial months of 2021 and that the median length of stay for these patients was very short (three days). Others, such as PO V representatives, felt that utilization was higher than expected but attributed it to very low expectations rather than a high number of beneficiaries in hospice:

The number of referrals in the VBID is probably a little bit higher than . . . initially projected, because before, we only had transparency into patients that came through our referral process, but now we can see NOEs from outside

providers, right? So we see people that are on hospice in the VBID model that we might not have known were on hospice previously until they receive[d] services or died on the service.

Nonetheless, there was consensus among PO representatives that hospice utilization will increase in the future. A PO M representative suggested that the expected increase in utilization of the hospice benefit could be explained by increased provider awareness of the model test: “As awareness improves in the hospice provider community, in the physician community who are helping these patients with advanced illness . . . there is more opportunity to have a positive impact on the timing of enrollment and referral into hospice.”

Interviewed hospice representatives agreed with PO representatives that VBID Hospice did not result in a meaningful increase in hospice utilization in 2021. The overwhelming majority of in-network hospice representatives interviewed

reported no difference in the number or types of patients receiving care from their hospices following the introduction of the VBID Hospice component in 2021. As a representative of Hospice W described it, “[W]e started collecting Medicare Advantage data before VBID was initiated, and so we are able to see that we’ve had no increase. So we’re really sort of seeing the same that we’ve seen before.” The representative also noted that the PO is “not identifying this patient base to us; these patients are coming to us through historical referral patterns and channels and we’re having to identify this patient base to [the PO].”

This observation was concerning to some hospice representatives (Hospices C, D, K, and S), who hoped that increased hospice utilization would offset some of the negative financial impacts of the model. One hospice representative explained that the hospice would have made specific case volumes mandatory in the contract with the PO had they known how low the volume would be (Hospice K).

Hospices’ Expectations

Representatives of Hospices A, D, and V noted that an expansion of the Hospice component may introduce incentives for POs to steer higher-cost patients—such as those with short anticipated lengths of stay or costly medications—to OON hospices. Moreover, some thought that both in-network and OON hospices might be reluctant to accept these patients, which could limit beneficiary choice. Similarly, Hospice S representatives speculated that POs that own hospices might direct beneficiaries toward their own hospices or away from hospices owned by competing POs.

Summary

We found no evidence that POs that implemented the Hospice component experienced changes in enrollment in 2021, a finding that is consistent with POs’ short-term expectations about the likely effects of the model test.

Although we found no statistically significant changes in MAPD bids, we estimated a statistically significant \$22.40 PMPM decline in the MA bid. The change in the MA bid represents a roughly 3-percent reduction, on average. Deeper exploration of the bid data suggested that projected medical spending might have fallen in Hospice component–participating plans. These findings are consistent with the possibility that Hospice component–participating

plans anticipated higher utilization of palliative and hospice care and, as a result, reduced their projected utilization of costly inpatient and ED visits. However, in interviews with POs and hospices, some representatives commented that such changes in length of stay had not yet occurred. Because bids are developed prospectively, they are driven by expectations about future effects, which might lead to differences between the assumptions used in developing the bids and POs' experiences in the first year of implementation.

We found no evidence of a relationship between POs' participation in the Hospice component and MAPD premiums, supplemental benefits, or other components of the bid. These findings could indicate that a PO's decision to participate in the model test had no direct impact (positive or negative) for beneficiaries who did not make use of the hospice benefits, at least among the outcomes that we analyzed. It is possible that these results could change over time, particularly as POs enter more plans into the Hospice component.

For most POs, palliative care utilization was lower than expected in 2021. Among the few hospices that provided palliative care to VBID beneficiaries, changes in use were mixed. One hospice reported an increase in utilization and another reported no change.

Both hospices and POs reported very low uptake of TCC, perhaps because the TCC component of the model test was poorly understood. Although many hospices believed that TCC could be helpful in reducing hospitalizations and encouraging beneficiaries to make use of hospice care, at least one felt TCC was unlikely to help many beneficiaries.

More VBID beneficiaries received care from OON hospices than from in-network hospices in 2021. This pattern might change over time as the model begins to allow POs to use tools to steer beneficiaries to in-network hospices. The majority of in-network hospice representatives interviewed reported no difference in the number or types of patients receiving care from their hospices as a result of contracting with a VBID-participating PO. Across all in-network hospices, the median number of VBID participant enrollees was 16. The low census created some administrative challenges related to implementing PO-specific requirements for a small share of their total population.

PART IV: WELLNESS AND HEALTH CARE PLANNING

Chapter 9. Wellness and Health Care Planning: Implementation Strategies and Experiences

POs participating in VBID must offer the WHP component of the model test to all beneficiaries in their model-participating plans, regardless of eligibility for other VBID benefits (CMS, 2022b). Through WHP, beneficiaries can gain timely access to WHP activities and services, including ACP, education and discussions around end-of-life care, and information about or help with completing advance directives and selecting surrogate decisionmakers. Although ACP is a key aspect of WHP, the WHP component more broadly also includes infrastructure to encourage beneficiaries to engage in planning for their future medical care. The WHP component is designed to help POs innovate in the arena of ACP and offer a comprehensive approach to timely ACP. For example, POs can invest in data systems that help them track completion of ACP activities or offer education for providers around ACP, as well as rewards or incentives for beneficiaries and providers who engage in WHP activities. Early engagement in ACP, a process that supports beneficiaries in identifying and sharing their values, preferences, and goals about future care, is a proactive approach to help beneficiaries avoid making medical decisions in haste or receiving unwanted care at the end of life. Including all beneficiaries in the WHP component is expected to improve timeliness of ACP activities, provide an opportunity for beneficiaries to discuss their care preferences with providers and family members, facilitate sharing of ACP documents across places of care, and—ultimately—improve quality and reduce cost of care by aligning the care that beneficiaries receive with their preferences and goals.

In this chapter, we report on our findings from a review of 2021 PO application materials and semistructured interviews with the representatives of VBID-participating POs regarding their WHP implementation strategies and experiences, including implementation barriers they faced. We also explore POs' perceptions of the impact COVID-19 had on the delivery of WHP services.

Key Findings

- PO representatives generally reported positive experiences implementing the WHP component, noting that their VBID WHP activities were similar to their preventive care offerings outside the model test.
- The majority of participating POs offered WHP services through multiple approaches and delivery modes.
- Engaging beneficiaries in guided conversations about their end-of-life care preferences that eventually lead to the creation of a written document available to care providers and family members seems to be a desirable strategy for WHP delivery from the PO perspective.
- About one-third of participating POs offered RI to beneficiaries for using WHP services.

- Challenges to implementation included accurate and timely tracking of WHP use, communication with providers about their delivery of WHP, and reconciliation of emotional and cultural barriers to ACP engagement.
- POs that attributed challenges with WHP delivery to the COVID-19 pandemic tended to rely on in-person service delivery.

Strategies for Implementing the WHP Component

Many PO representatives stated that their organizations are committed to offering WHP, and several reported that their organizations provided ACP services prior to the implementation of VBID. PO representatives generally considered WHP activities as “preventive care” because they help engage all beneficiaries, regardless of their health status, in planning for their future before they become terminally ill. One representative from PO T described ACP as a “value-based initiative” because of its potential to provide high-quality care and reduce spending on unwanted care. In other words, by promoting ACP via WHP early in the disease process or before a beneficiary nears the end of life, POs are moving conversations regarding ACP upstream from the time ACP-related decisions would be needed, while also normalizing the process of engaging in discussions around goals of care.

All nineteen 2021 VBID-participating POs indicated on their model test applications that they planned to use a variety of strategies to operationalize the required WHP component (Table 9.1).

Table 9.1. Strategies Used by Parent Organizations to Implement the WHP Component (N = 19)

Implementation Strategy	N (%)
WHP approaches	
CM program	17 (89.5)
Annual wellness visit	15 (78.9)
In-home assessment	12 (63.2)
Health Risk Assessment	10 (52.6)
Other	7 (36.8)
Delivery mode	
Representative-guided ACP services	19 (100)
Phone	18 (94.7)
In person	18 (94.7)
Self-guided online ACP services	11 (57.9)
Incentives	
WHP rewards for beneficiaries	7 (36.8)
WHP rewards for providers	3 (15.8)

SOURCE: RAND analysis of SOURCE: RAND review of POs' 2021 VBID model test application materials.

WHP Approaches

The majority ($N = 17$; 89.5 percent) offered WHP services through a CM program, which offers an opportunity for beneficiaries to have a conversation about ACP as part of either an initial assessment or an ongoing CM activity. Fifteen POs (78.9 percent) specifically mentioned annual wellness visits as their WHP delivery approach. Twelve POs (63.2 percent) indicated that they offered WHP through an in-home assessment program. Ten POs (52.6 percent) offered WHP through the Medicare Health Risk Assessment, which is used to assess beneficiary general health and identify health risk factors. Finally, seven POs (36.8 percent) offered WHP through some other approach, such as mailing welcome kits to beneficiaries, offering workshops, or using a digital platform for self-guided ACP.

Delivery Mode

In their model test applications, all 19 POs reported offering ACP services guided by a representative, either in person ($N = 18$; 94.7 percent) or by phone ($N = 18$; 94.7 percent). In addition to offering representative-guided ACP services, eleven POs (57.9 percent) reported offering self-guided ACP services (i.e., online or web-based tools; refer to the text box “Advance Care Planning Tool”). A PO P representative noted that “the online tool [is] integrated in our main digital experience [and provides] validated” information, which helps the plan track ACP completion.

Advance Care Planning Tool

PO J uses a vendor to offer an online ACP tool to beneficiaries, in addition to offering ACP services via phone that are guided by a representative. The tool is a six-step online program that guides beneficiaries through a series of questions to help them think about the types of choices they might face in their future medical care by focusing on values and beliefs and preferences for care in a variety of medical scenarios. It ultimately creates personalized documents outlining medical care wishes that beneficiaries can send to family members and health care providers.

In addition to helping beneficiaries complete an advance directive, this tool helps them start conversations around planning for end-of-life care with their health care providers and loved ones. The tool generates personalized documents describing beneficiaries’ preferences under different hypothetical scenarios, which ultimately helps improve concordance of care. On average, beneficiaries spend 42 minutes to complete all program steps. The vendor conducts annual outreach to beneficiaries through mail and email. Although the program is designed to be completed online, it can be offered in a booklet format. The vendor also provides a \$25 gift card incentive for program completion.

Although self-guided services, especially those completed online, might be convenient for some beneficiaries and POs, some PO representatives felt that self-guided approaches might not be as effective as having conversations with a health care professional. Such conversations help engage beneficiaries, their family members, and physicians in ongoing discussions around end-of-life care and enable beneficiaries to share this information by uploading advance directives to the EMR to facilitate coordination of care across providers. One representative explained,

I think [that successful ACP requires] collaboration, working with that member and the family. And in the initial engagement where we make a welcome call to every member, we discuss expectations, setting the standard right there of how often we will be talking. And making it clear upfront has really been helpful. Engaging the family and everyone in their care team that they identify as a significant member of that care team is included often. Every time we do a reassessment, we review that plan with that member or designated representative to ensure that they are still giving us the okay to engage with people that they think are important in their care team. (PO X)

Because WHP is a required model test component, POs must take a “broad” approach to reach all beneficiaries, not just those targeted for VBID, which may include infrastructure investments to benefit all beneficiaries in the plan (CMS, 2022b). Our interviews show that such approaches typically included the distribution of printed educational materials about ACP and its benefits and provided access to a call center for assistance with ACP completion. One representative felt that it is useful to offer WHP services to

a broader population outside of [beneficiaries with a terminal illness] and then increasing the use of advance care planning for the healthy population or the maybe chronically ill but not terminal population [by] increasing the access at the primary care level and in a kind of self-directed approach. (PO S)

Some POs offered provider training on how to initiate ACP discussions and gave them access to digital platforms for uploading advance directive forms to facilitate access to the most up-to-date documents among a beneficiary’s providers.

In addition to their “broad” approach to WHP, some POs implemented a “targeted” WHP strategy designed specifically for their VBID-eligible beneficiaries, such as patients with advanced illness and limited life expectancies who might be at risk for hospitalization. One PO representative spoke of their strategy for identifying beneficiaries for the targeted outreach by care managers:

Every member gets a minimum monthly contact to ensure that we’ve reviewed their care plan and address[ed] any care needs. If we identify a member who is high risk, we will make several contacts, depending on the need, to connect the member to the appropriate level of care. (PO X)

Incentives for WHP Activities

Seven VBID-participating POs (36.8 percent) offered financial incentives for engagement in WHP activities (POs B, C, J, N, O, W, and Z). The reward amounts ranged from \$10 to \$50 per year. Moreover, PO W allowed beneficiaries to redeem RI immediately after engagement in WHP or to accumulate the earned funds as part of other CM activities toward a redemption of a higher value. PO U did not offer RI for WHP for beneficiaries in 2021, although it did offer a \$25 gift card for WHP activities in 2020. PO N did not provide any details on the reward.

Some PO representatives felt that financial incentives “encourage a member in closing some of the gaps in care, encouraging them to really just take control of their care” (PO X), whereas others felt that incentives could be costly and do not necessarily lead to achieving an ROI:

There’s an ROI challenge for us on that to make it meaningful for members. It’d have to be ten or twenty dollars [per year] and then applying that over 120,000 [members] . . . that’s money that could go towards other things for members.
(PO S)

Moreover, one representative raised some discomfort related to plans incentivizing ACP completion when these conversations should be between the beneficiary and the care team:

We try not to pressure them because a lot of times it feels very personal that members want to have that discussion maybe with a family member or just introspecti[on]. They may want to spend time thinking about it themselves, and so we don’t want to come across as an insurance company trying to tell them, “Hey, you need to fill out this ACP form.” (PO L)

Three POs (15.8 percent) offered financial rewards to encourage providers to offer WHP services. PO S offered providers \$20 per beneficiary who engaged in WHP, PO C offered higher rates of reimbursement for WHP, and PO M used a comprehensive primary care quality program in which providers can earn approximately \$1,400 for the ACP quality measure included in a comprehensive primary care quality program.

WHP Tracking

Most POs track the completion of WHP activities using claims and EMR data and the data collected via online digital platforms, such as those used by WHP vendors (see prior text box, “Advance Care Planning Tool”). Representatives from eight POs (B, C, J, L, M, O, P, and Q) noted that although they know if an advance directive or conversation has occurred and been documented, they are unaware of the contents of advance directives or the details of a beneficiary’s preferences and wishes for care. As one representative put it, as a health plan they do not “use [advance directives] at all . . . but want to make sure that the physician has [this information] and that the physician is aware of the member’s wishes” (PO L). Representatives from POs N and T reported that their organizations incorporate beneficiaries’ preferences into their care plans. A PO T representative noted that they share the content of MOLST and POLST forms with relevant providers, thereby “supplementing what the primary care providers are trying to do as well.”

Implementation Challenges

On the survey administered to POs prior to the interviews, PO representatives generally noted that implementing annual WHP services to all beneficiaries in a plan was “slightly” challenging. Our interviews revealed three additional common challenges with delivering WHP

services as part of the VBID model test. First, representatives of seven POs (G, L, N, P, Q, S, and Y) noted challenges around tracking and reporting the delivery of WHP services to their beneficiaries. Because some WHP activities might take place during the annual wellness visit, representatives of four POs (L, P, S, and Y) noted that they are not sure whether providers actually use ACP codes when they submit claims. If such codes are not used or are used incorrectly, plans will not know whether ACP discussions actually took place during the annual wellness visit. This could lead to underreporting of WHP completion. As a representative from PO P stated,

We include in our provider manual the expectation of advanced care planning discussions happening in a timely manner with the annual wellness visit. The claim [code] around advance care planning discussions for providers to use is relatively new. . . . Providers are still adopting the utilization of that claim [code].

Second, representatives from five POs (B, J, Q, S, and T) described challenges related to the delivery of WHP services by health care providers, including the challenge of offering ACP services only in VBID-eligible plans, the incorporation of ACP into provider performance management programs, the lack of information on whether providers already encouraged beneficiaries to engage in ACP, and the provision of training for PCPs on the delivery of ACP. A PO B representative described “lots of challenges” around the delivery of ACP services but noted that they have included “a section that talks about advance directives, palliative care . . . within the provider performance management programs,” which encourages providers to talk about end-of-life care planning early on.

Finally, representatives from four POs (W, R, J, and L) recognized the psychosocial, emotional, and cultural challenges of engaging beneficiaries in conversations around end-of-life care and ACP and documenting their preferences. For example, one representative discussed the complexity around ACP for beneficiaries with chronic conditions, including the emotional hesitancy and the perceived lack of priority for beneficiaries to complete advance directives, and how their organization is working to increase participation in ACP activities:

It’s complicated, emotionally complicated, especially when they’re already dealing with all of these other conditions. How many of us, if I sent you one of those [advance directives] today, would actually complete it today or the next week, especially if it’s online and you’re preferring another mechanism, right? . . . We are continuing to evaluate how to increase that because we do know that it can provide a sense of relief and security once it’s completed. (PO J)

Others discussed cultural challenges, especially in Puerto Rico, related to having beneficiaries sign advance directives because of a reluctance to engage in conversations around planning for end-of-life care with their providers and family members. A PO W representative noted that “in our culture, the end-of-life conversations [with providers or family] are not very common. . . . And our population usually continues with medical care during end of life even if they have a terminal condition.” Another representative explained that despite provider education about the importance of ACP, some beneficiaries might not want to discuss end-of-life issues

and document their preferences: “Receiving the document [advance directive], it’s going to be very difficult because not everyone wants to have that document” (PO R).

Impact of the COVID-19 Pandemic on WHP

The perceived impact of the COVID-19 pandemic on WHP activities was mixed. Representatives from four POs (G, M, O, and X) stated that they did not feel that COVID-19 affected WHP activities or the level of beneficiary engagement in these activities. PO J and L representatives expressed uncertainty around the impact of the COVID-19 pandemic on WHP activities. Some speculated that the pandemic might have increased participation in WHP activities conducted over the phone because of the availability of beneficiaries at home during public health emergency lockdowns. Representatives from POs L and N, whose WHP strategies rely on in-person engagement with providers, however, noted that engagement might have been lower because of fewer visits with health care providers or annual wellness visits to discuss ACP. A representative from PO L also described a potentially negative impact of using telehealth to deliver WHP by saying that

a lot of annual wellness visits in 2020 [were] billed as telehealth. I wouldn’t necessarily take our experience there to be indicative of what a provider might normally do. I think providers are most likely going to not talk about everything over telehealth that they might talk [about] if they had the person in their office.

Other representatives stated that as a result of the pandemic, their organization has been exploring ways to “enhance [the organization’s] ability to bring these conversations in novel ways so that they’re as impactful by phone in some ways that they are in person” (PO T).

Summary

VBID-participating POs were required to deliver WHP services to all beneficiaries in their intervention plans. Most POs viewed WHP activities as important offerings, and some mentioned that VBID encouraged them to expand their WHP offerings and to look for novel ways to deliver these services. Because the majority of POs offered similar services before the model test, the representatives we interviewed generally reported positive experiences with WHP requirements.

Participating POs used a variety of ways to furnish WHP services, including such familiar strategies as CM sessions and annual wellness visits, as well as more novel strategies, such as online platforms that guide beneficiaries through a series of scenarios. Most POs offered both remote and in-person options for WHP services, and about half offered completely self-guided options. Some representatives from POs that offered self-guided approaches stated feeling uncertain of the effectiveness of the services, whereas those relying on providers to deliver WHP services reported concerns about trustworthiness of the data about service completion. In general, from the perspectives of participating POs, guided approaches to delivery of WHP services that engage beneficiaries in conversations about their end-of-life care preferences and help them

document their wishes seem to be successful for initiating and continuing discussions around preferences and goals for the future. Although some POs offered rewards, others felt that providing them in exchange for beneficiary participation was not worth the financial investment.

Challenges to implementation included accurate tracking or reporting of WHP benefit use, working with providers to incorporate ACP into their care delivery, and emotional and cultural barriers to participation in end-of-life conversations (specifically in Puerto Rico). EMR systems appear to be equipped to handle WHP activity tracking, but getting providers to consistently code for activities in the preferred manner was a challenge for some POs. PO representatives did not view the COVID-19 pandemic as affecting WHP service delivery, for the most part. However, some thought that WHP participation might have been greater because of beneficiaries being more available at home, whereas others saw the decrease in in-person visits as a detriment to ACP conversations.

PART V: CONCLUSIONS

Chapter 10. Conclusion

Beginning in 2020, Phase II of the MA VBID model test substantially expanded the VBID Flexibilities POs were permitted to offer during the first phase of the model; allowed POs to offer several new BDIs, such as Cash Rebates, and to target beneficiaries on the basis of their SES; and introduced the Hospice component and the WHP component. RAND evaluated the first two years of Phase II using a mixed-methods approach that integrated descriptive analyses and quantitative data modeling with qualitative analysis of interviews with participating and nonparticipating POs, vendors, and in-network and OON hospices. This report focused on model test participation, implementation experiences, and early outcomes of the BDI and Hospice components. From these findings, several themes and comparisons with Phase I outcomes have emerged.

Key Findings

Interest in VBID is gaining momentum, but the ability to offer VBID-like benefits outside of the model test and concerns about lack of ROI persist among nonparticipants and those who leave the model

The expansion of the model test during its second phase led to growth in the number of participating POs, which nearly doubled between the end of Phase I (ten POs participated in 2019) and the second year of Phase II (19 POs participated in 2021). The ability to offer reduced Part D co-payments and to help address SDOH among the most vulnerable beneficiaries increased POs' interest in VBID. Although the model expanded substantially, only four Phase I POs continued their VBID participation in Phase II.

PO representatives described the decision to join the model as a multistep process that involved collaboration among numerous internal stakeholders and required leadership support and interdepartmental collaboration. POs joined the model because they thought it aligned well with their business priorities, offered an opportunity to improve care quality while reducing costs, and encouraged the tailored benefit designs that better address the needs of their enrollees. POs that decided not to participate cited multiple competing priorities, including the implementation of UF and SSBCI outside of the model test, limited financial and staffing resources, expected burdens of complying with VBID reporting requirements, lack of a clear ROI, and concerns about confusing beneficiaries with varied benefit designs within the same plan.

Phase I participants had largely reported the same reasons for joining the model test, and nonparticipants had also worried about the expected burden of compliance with model

requirements and uncertain ROI (Eibner et al., 2018). It is worth noting that concerns about the lack of ROI were not only a reason for not joining the model but also a reason for leaving it. Two Phase II model test participants left VBID in 2022 primarily because of concerns about insufficient ROI, which they attributed to a small number of eligible and participating beneficiaries and the substantial reporting and administrative requirements of the model test. Although the reasons for joining or leaving the model test did not seem to vary by component (e.g., BDI versus Hospice), the ability to offer VBID-like benefits outside of the model test was cited as a reason for leaving the model test by POs that implemented VBID Flexibilities in both phases.

Participating parent organizations used the BDI component to help beneficiaries address SDOH

Between 2020 and 2021, an increasing number of D-SNPs joined the VBID model. Because these types of plans serve only low-income beneficiaries, entering D-SNPs into the model test might help POs offer BDI benefits, including non-PHRSBs and Cash Rebates, to their enrollees who most need them. Moreover, compared with eligible nonparticipating plans, BDI-participating plans had a higher percentage of LIS-eligible enrollees. From an implementation standpoint, allowing targeting based on LIS- or dual-eligible status facilitated the identification and tracking of eligible beneficiaries, which had been a commonly cited implementation challenge among Phase I participants (Eibner et al., 2018; Eibner et al., 2020). Although ease of implementation was on the minds of many POs as they designed their BDI interventions, offering additional benefits only to beneficiaries eligible for LIS in their plans might have also helped POs more precisely identify the beneficiaries who might most appreciate having extra benefits.

VBID Flexibilities was the most commonly implemented BDI subcomponent in 2020 and 2021, as measured by the number of plans implementing it. Reduced cost sharing for high-value medical services and outpatient prescription drugs was the most commonly implemented category of VBID Flexibilities. POs that offered supplemental benefits were more likely to offer non-PHRSBs than PHRSBs. Financial assistance with buying healthy food items was the most frequently offered non-PHRSB.

Phase II of the model test gave POs more ways to incentivize their beneficiaries to utilize high-value services and consequently take better care of their health. In Phase I of the VBID model, the majority of participating POs made the receipt of VBID benefits (e.g., reduced cost sharing) conditional on beneficiary participation in CM/DM activities (Eibner et al., 2020). POs continued to do so in Phase II, with more than 60 percent of plans that offered VBID Flexibilities in 2020, and about half of plans that offered VBID Flexibilities in 2021, conditioning VBID benefits on requirements such as engaging with a care manager. CM is an important part of these plans' interventions, reflecting a goal of improving overall care coordination. However, only

about 10–12 percent of targeted beneficiaries in plans with such participation requirements took action and became eligible to receive VBID benefits.

Starting in 2020, POs were also allowed to offer beneficiaries incentives, such as gift cards, for participating in RI programs that often rewarded them for completing CM/DM-like activities. Although the number of POs offering RI programs decreased between 2020 and 2021, the number of plans offering them more than tripled during this period. This change was driven by one PO that increased the number of plans with RI programs 11-fold. As a result of introducing the RI programs, beneficiaries enjoy more flexibility in how they can spend their financial incentives. Instead of needing to go to see a doctor to actually experience a financial benefit from CM/DM participation, beneficiaries in plans that offer RI can choose how to use the financial incentive in a way that best addresses their needs. Despite this flexibility, relatively few targeted beneficiaries took the actions necessary to earn RI.

The characteristics of the participants and their interventions—the growing number of D-SNPs that POs entered into the model test, their choice of BDI interventions, the addition of hospice supplemental benefits, and the interest in targeting beneficiaries based on their LIS status—illustrate POs’ intentions to help beneficiaries address their SDOH. This is consistent with a general trend in MA to offer supplemental benefits, such as transportation and in-home support services, to address SDOH in an attempt to improve long-term health outcomes (Kornfield et al., 2021). At the same time, however, our interviews showed that beneficiary interest in supplemental benefits has spurred POs to offer them in an attempt to remain competitive in the market. We also found that POs that offered Cash Rebates did so not only to help beneficiaries but also to increase the number of enrollees in their plans.

Parent organizations implementing the Hospice component focused on expanding care options for beneficiaries with complex needs and higher health care expenditures

Compared with nonparticipants, plans that offered the Hospice benefit as part of the VBID model test were more likely to be D-SNPs, with no monthly premiums and lower OOP maximums, which suggests that POs might have been particularly focused on beneficiaries who are in poorer health, have higher health care expenditures (Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, 2022), and might be less likely than those with higher SES to receive palliative or hospice care (Karikari-Martin et al., 2016). Implementing the Hospice component in D-SNPs might point to the POs’ focus on increasing utilization of palliative and hospice care services among low-income beneficiaries with complex health care needs, with the aim of improving care coordination, reducing use of acute care services, and lowering costs at the end of life (Tangeman et al., 2014; Whitney and Chuang, 2016; Zimbroff et al., 2021).

Hospice-participating POs identified beneficiaries who might be eligible for palliative care, TCC, and hospice using provider referrals, proprietary claims- or EMR-based algorithms, or both; beneficiaries did not need to self-identify or participate in specific activities to qualify.

TCC offerings were typically customized to beneficiaries' needs and focused on services that patients have historically wanted to continue for treatment of their medical condition but were not permitted to maintain if they elected hospice. Supplemental hospice benefits included elimination of cost sharing for prescription drugs and respite care and access to additional in-home services. These benefits were designed to promote quality of life at the end of life for beneficiaries and families who might not otherwise be able to afford home and safety modifications or additional respite care.

Participating parent organizations' implementation experiences varied by the type of model component and length of participation in the model test

PO representatives generally did not consider BDI component implementation to be very challenging. Although they identified several “moderate” or “slight” challenges, including data reporting requirements, working with vendors, and communicating with beneficiaries and providers, PO representatives felt that these challenges resolved with time. Although administering multiple sets of benefits within a plan, identifying eligible beneficiaries, and tracking beneficiary eligibility were cited as key implementation challenges during Phase I of the VBID model test, they were considered only somewhat challenging by POs in Phase II—primarily by those that joined VBID in 2020 or later (i.e., were new to the model test in Phase II).

In contrast, implementation of the Hospice component proved to be substantially more challenging and resembled some of the challenges reported by POs that participated in Phase I. In particular, POs that implemented the Hospice component considered data reporting to CMS and the identification and tracking of beneficiaries eligible for palliative care, TCC, and hospice to be especially challenging. Communicating with hospices and beneficiaries about the new Hospice component benefits was also considered challenging. These difficulties could be partially attributed to the fact that Hospice is a new VBID component and that POs had not previously been responsible for developing or maintaining a hospice network or processing or adjudicating hospice claims, so they had a steep learning curve in getting up to speed about hospice care in general.

POs contracted with a wide variety of organizations, including medical transportation brokers, claims processing vendors, organizations providing online ACP services, and OTC card and healthy food vendors, among others, to help implement the model, deliver benefits, or both. Although POs considered working with vendors to be moderately challenging, vendors did not report any major implementation challenges. The few challenges vendors named included not having a good understanding of the model test early on and needing to update their data systems to keep up with the changes required to deliver or track the delivery of their services as part of the model test. Vendors noted that they relied on preexisting relationships with POs to quickly get up to speed on VBID requirements and hoped that the expansion of services they offer to

participating POs could help them quickly recoup additional investments that they had to make early on during the implementation.

POs, vendors, and hospices had different perspectives on the impact of COVID-19 on VBID implementation. Although in-person service delivery was most affected by the pandemic, POs that implemented the BDI component and vendors were often able to pivot to virtual or contactless service delivery and succeeded in replacing contractors that were not able to maintain their operation during the pandemic. They also noted some positive impacts, including greater interaction between care managers and beneficiaries who had more free time, increased use of telehealth services, and increased demand for farmers markets and mail-order pharmacy benefits. In contrast, POs that implemented the Hospice component interventions, as well as in-network and OON hospices, considered the COVID-19 pandemic to be a major competing priority, which constrained hospices' ability to provide in-home care and slowed down the implementation of the Hospice component.

Regardless of which components they implemented, POs found leadership support and cross-functional teams to be two key implementation facilitators, consistent with the evaluation of Phase I of the model, in which both were among the top three facilitators identified (Eibner et al., 2018). Although the majority of POs that implemented the BDI component also thought that financial investments were key implementation facilitators, only a minority of POs that implemented the Hospice component thought the same. PO representatives did agree that implementation of the BDI and Hospice components required additional changes in the IT infrastructure (claims processing was of particular concern to POs that implemented the Hospice component); additional time to ensure compliance with VBID reporting and auditing requirements; and efforts to expand marketing and educational campaigns to both beneficiaries and providers.

BDI implementation increased enrollment and reduced MAPD bids

In 2021, BDI implementation was associated with a marginally significant 6.2-percent increase in enrollment ($p = 0.06$, 95% CI [-0.2 percent, 12.9 percent]). The changes in enrollment might reflect that beneficiaries saw such BDI offerings as reduced cost sharing and additional supplemental benefits interventions as a selling point, increasing their likelihood of joining participating plans. However, we have not yet interviewed beneficiaries to confirm this possibility.

To enter the model test, POs needed to project savings over a five-year time horizon, indicating that they likely viewed VBID as having the potential to lower their costs. This expectation was borne out in our findings that plan bids fell by \$5.37 ($p = 0.01$, 95% CI [-\$9.30, -\$1.44]) in 2021, driven by a reduction in MA bids. However, the mechanism driving the reduction in bids is not yet known. Lower bids might reflect POs' assumption that BDI will encourage beneficiaries to take a more active role in managing their health, potentially averting such costly complications as avoidable hospitalizations and ED use. It is also possible that POs

expected that their BDI offerings would attract health-conscious beneficiaries into their plans or beneficiaries with low costs relative to the payments that plans receive after risk adjustment. Prior research has documented the possibility that MA insurers might selectively target beneficiaries that tend to be profitable under CMS's risk adjustment methodology (Carey, 2017).

Despite lower MAPD bids, we estimated that BDI implementation was associated with a \$1.93 increase in MAPD monthly premiums ($p < 0.01$, 95% CI [\$0.89, \$2.97]). This finding could reflect increases in the Part D bid, which might have been driven by participating plans covering a larger portion of drug spending for VBID-eligible beneficiaries. We also estimated that VBID was associated with a sizable increase in the projected cost of mandatory supplemental benefits, which plans must generally fund through premium increases or buy down with rebates. Of note, in CMS's request for VBID applications, participating POs were instructed to price the cost of VBID Flexibilities interventions as mandatory supplemental benefits. As a result, at least a portion of increased mandatory supplemental benefit costs associated with BDI interventions reflect costs associated with additional benefits for VBID-eligible beneficiaries only, rather than expanded availability of supplemental benefits to all enrollees. Whether driven by increased drug spending or supplemental benefits costs, the premium increase implies that some nontargeted beneficiaries could face higher costs because of their plans' offer of BDI benefits to others.

Parent organizations varied in the way they operationalized Hospice component requirements

Although POs varied in regard to how they identified beneficiaries for Hospice component services, how they established eligibility criteria for TCC, and whether they offered hospice supplemental benefits, one of the most notable differences among them was the approach they used to establish and manage their hospice networks. While some POs contracted with just one or two hospices they owned, others contracted with all hospices operating in a given plan's service area. In general, POs tended to contract with larger hospices and those that were part of hospice chains, perhaps hoping to create efficiencies in contract negotiations and implementation processes.

Half of the POs we interviewed reported negotiating rates for in-network hospices that were lower than FFS rates, sometimes asking for a 10- to 12-percent discount from these rates, and sometimes indicating that in-network status would help hospices increase their daily census. Payment rates were the biggest sticking point in negotiations between POs and hospices. Some in-network hospices were unhappy with their 2021 implementation experiences, noting that they had not seen the expected increases in patient volume to offset lower rates and higher administrative costs. Many OON hospices expressed concerns about becoming in-network providers in the future but noted that they might feel compelled to join PO networks so that they can continue to provide care to MA beneficiaries as the model expands.

POs exercised varying levels of administrative oversight and involvement in hospice care. While some were minimally involved, others spent a substantial amount of time and effort to ensure that hospices did not bill for care that was directly related to the beneficiary's terminal condition. Although hospices generally reported that PO oversight was similar to that provided by FFS Medicare, a concerned minority indicated that PO oversight was burdensome and interfered with patient care.

Hospices were skeptical about the model test as implemented but viewed the carve-in as the future of hospice care delivery

In-network and OON hospices raised various concerns about the Hospice component design and implementation during its first year of implementation, and many reported experiencing implementation challenges similar to those of POs, including the need to adapt IT systems or to manage claims and payment processing. Identifying and tracking beneficiary eligibility was also a shared challenge that led to some instances of delays in benefits approvals. Data reporting was another shared concern, but hospices viewed POs' requirements rather than CMS's requirements as the culprit. Hospice representatives discussed duplicative claims processes and excessive reporting and auditing requirements from POs that required additional staff time to work through, as well as frustrating delays in payment processing. Both in-network and OON hospices noted that these challenges felt particularly burdensome because they required a disproportionate amount of effort for a very small subset of their patients. Although the quality and types of care provided to VBID beneficiaries and other patients were the same, representatives cited considerably more effort involved on the administrative end for VBID beneficiaries.

Looking ahead, many hospice representatives stated that they felt they had to become (or remain) in-network providers to be able to stay in business because they considered the hospice carve-in to MA to be the future of hospice. Some hospices expressed concerns that lower reimbursement rates, higher administrative costs, and expanded hospice networks might result in exclusion of smaller hospices from PO networks, hospice closures, and changes in patient care.

Hospice representatives felt that three factors could make the model more attractive to hospices. First, developing a model-wide minimum definition of palliative care, TCC, and hospice care is important for ensuring consistency across POs and hospices, in terms of services delivered and care quality. Although all POs offered palliative care as part of VBID, only a small fraction of in-network hospices were contracted to provide it. Some hospices wanted to be involved further upstream in beneficiary care by providing palliative care or by helping POs identify beneficiaries who could benefit from hospice. Maintaining adequate reimbursement rates by either requiring POs to offer FFS rates or limiting rate discounts was the second suggestion. Finally, raising awareness of the VBID model among POs, hospices, and beneficiaries would be important to help set expectations of all stakeholders.

Plans' participation in the Hospice component did not appear to drive major changes in enrollment or service utilization in 2021

We found no evidence that participation in the Hospice component was associated with plans' total enrollment, MAPD bids, beneficiary premiums, or supplemental benefits costs. However, we found that MA bids fell by a statistically significant \$22.40 PMPM ($p = 0.01$, 95% CI [-\$38.12, -\$6.68]). This decline might have resulted from participating plans' expectations that more beneficiaries would use palliative and hospice care, thereby averting costly acute care utilization. Although these expectations might have informed bids, the anticipated changes did not come to fruition; interviewed POs and hospices generally did not report changes in the number of beneficiaries using palliative care or the timing of election or length of stay in hospice in 2021.

POs are still educating hospices and other providers about Hospice component services and refining their tools for identifying eligible beneficiaries and referring them to palliative care, TCC, and hospice services. Therefore, it might be too early to observe changes in target outcomes related to utilization or care patterns and quality. Only limited quantitative Hospice component data were available for this report; however, POs and hospices reported that fewer VBID beneficiaries received palliative care than they had expected in 2021, and there was very limited utilization of TCC and hospice supplemental benefits.

Hospices reported that the number, type, and timing of beneficiary referrals to hospice were largely unchanged since the initiation of VBID. More VBID beneficiaries received care in OON hospices than in-network hospices in 2021. This pattern might change over time as the model begins to allow POs to use tools to steer beneficiaries to in-network hospices.

POs reported generally positive experiences with the WHP component

The WHP component is new for Phase II of VBID and is the only required component of the model test. This component was designed as an opportunity for beneficiaries to engage in ACP, including conversations around preferences for end-of-life care. Participating POs reported that their organizations were committed to offering WHP, and some had provided ACP services prior to the implementation of VBID, which prompted some organizations to expand their offerings as part of the model test. POs used a variety of approaches and modes for delivering WHP to beneficiaries, including representative-guided and self-guided ACP activities. WHP implementation was considered only "slightly challenging." POs mentioned tracking and reporting the delivery of WHP services, delivering WHP services by health care providers, and confronting emotional and cultural challenges of engaging beneficiaries in conversations around end-of-life care as the most challenging aspects of the WHP component implementation. Despite these challenges, POs reported that by promoting ACP conversations earlier in the disease progression, they moved conversations around ACP upstream and normalized the process of engaging in end-of-life discussions and goals of care conversations.

Looking Ahead

Phase II of the VBID model test brought significant changes to the benefit design options available to MA plans, including the expansion of the range of benefits previously available under Phase I of the model test and the introduction of RI programs, Cash Rebates, and Hospice benefits within MA. The data collected from the first two years of this phase indicate that these changes appear to have made VBID more attractive to POs, particularly with regard to the BDI component options. Our evaluation to date answered questions about why POs decided to join or not join the model; how model test participants differed from nonparticipants; how participating POs designed their VBID interventions; what implementation challenges POs and hospices experienced and how they overcame them; and whether implementation of BDI and Hospice component interventions was associated with key outcomes, including beneficiary participation in the model, plan enrollment, bids, premiums, and supplemental benefits.

Initial results suggest an association between BDI and Hospice component implementation and reductions in plan bids, which is generally consistent with the model's intention to reduce Medicare spending. However, plan bids are based on actuarial projections and past experience rather than realized outcomes, suggesting that these results should be interpreted with caution. Conceptually, the goal of the VBID model test is to improve beneficiary health and to reduce costly complications that stem from poorly managed chronic conditions, socioeconomic barriers that might lead to suboptimal utilization, and poor care coordination. Nonetheless, it is too early to assess the actual effects of the model test on beneficiaries' utilization, spending, and health care quality. It might take several years for a meaningful relationship to develop between VBID and outcomes, because part of the goal is to stave off costly, downstream complications of chronic disease that might unfold slowly over a beneficiary's lifetime. In addition, some POs might still be fine-tuning their interventions. The Hospice component, in particular, is wholly novel in the context of MA plans, and this evaluation contains only one year of data on experiences and outcomes with that component.

This evaluation is ongoing, and future reports will be able to incorporate more data on the topics of this report, including the utilization of palliative care, TCC, and hospice, while also including new analyses on the relationship between BDI and Hospice components and health care utilization, health outcomes, patient experiences of care, and health care spending. We will also probe deeper to assess the impacts of the model using a broader variety of outcomes and a wider array of perspectives, including from beneficiaries.

Abbreviations

ACP	advance care planning
ADL	activities of daily living
BDI	Benefit Design Innovations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CHF	congestive heart failure
CI	confidence interval
CM	care management
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COVID-19	coronavirus disease 2019
C-SNP	Chronic Condition Special Needs Plan
DD	difference-in-differences
DM	disease management
D-SNP	Dual Eligible Special Needs Plan
ED	emergency department
EMR	electronic medical record
ESRD	end-stage renal disease
FDA	U.S. Food and Drug Administration
FFS	Fee-for-Service
HPMS	Health Plan Management System
ID	identification
IT	information technology
LIS	low-income subsidy
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MAPD	Medicare Advantage plan with Part D coverage
MOLST	Medical Order for Life-Sustaining Treatment
MTM	medication therapy management
NOE	Notice of Election
NPPO	nonparticipating parent organization
OACT	Office of the Actuary (Centers for Medicare & Medicaid Services)
OON	out-of-network
OOP	out-of-pocket
OTC	over-the-counter
PBP	plan benefit package

PCP	primary care provider
PDSS	Part D Senior Savings
PHRSB	Primarily Health-Related Supplemental Benefit
PMPM	per member, per month
PO	parent organization
POLST	Physician Order for Life-Sustaining Treatment
RF	Reusable Framework
RFA	request for applications
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
UF	Uniformity Flexibility
VBID	Value-Based Insurance Design
WHP	Wellness and Health Care Planning

References

- Agarwal, Rajender, Ashutosh Gupta, and A. Mark Fendrick, “Value-Based Insurance Design Improves Medication Adherence Without an Increase in Total Health Care Spending,” *Health Affairs*, Vol. 37, No. 7, July 2018, pp. 1057–1064.
- Callaway, Brantly, and Pedro H. C. Sant’Anna, “Difference-in-Differences with Multiple Time Periods,” *Journal of Econometrics*, Vol. 225, No. 2, December 2021, pp. 200–230.
- Carey, Colleen, “Technological Change and Risk Adjustment: Benefit Design Incentives in Medicare Part D,” *American Economic Journal: Economic Policy*, Vol. 9, No. 1, February 2017, pp. 38–73.
- Carr, Deborah, and Dmitry Khodyakov, “End-of-Life Health Care Planning Among Young-Old Adults: An Assessment of Psychosocial Influences,” *Journal of Gerontology: Social Sciences*, Vol. 62B, No. 2, March 2007a, pp. S135–S141.
- Carr, Deborah, and Dmitry Khodyakov, “Health Care Proxies: Whom Do Young Old Adults Choose and Why?” *Journal of Health and Social Behavior*, Vol. 48, No. 2, June 2007b, pp. 180–194.
- Centers for Medicare & Medicaid Services, “Medicare Advantage Value-Based Insurance Design Model,” webpage, undated. As of February 22, 2022:
<https://innovation.cms.gov/innovation-models/vbid>
- Centers for Medicare & Medicaid Services, “Chapter 4—Benefits and Beneficiary Protections,” in *Medicare Managed Care Manual*, Baltimore, Md., 2016a. As of February 22, 2022:
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>
- Centers for Medicare & Medicaid Services, *Medicare Managed Care Manual*, Baltimore, Md., 2016b. As of April 4, 2022:
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326>
- Centers for Medicare & Medicaid Services, *Medicare Advantage Network Adequacy Criteria Guidance*, Baltimore, Md., January 10, 2017. As of February 22, 2022:
https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf

Centers for Medicare & Medicaid Services, *Value-Based Insurance Design Model Incorporation of the Medicare Hospice Benefit into Medicare Advantage: CY 2021 Request for Applications*, Baltimore, Md., 2020a. As of March 22, 2022:
<https://innovation.cms.gov/files/x/vbid-hospice-rfa2021.pdf>

Centers for Medicare & Medicaid Services, *Value-Based Insurance Design Model Request for Applications for CY 2021*, Baltimore, Md., March 13, 2020b. As of March 4, 2022:
<https://innovation.cms.gov/files/x/vbid-rfa2021.pdf>

Centers for Medicare & Medicaid Services, *Calendar Year (CY) 2023 Phase 2 Network Adequacy Requirements Policy and Technical Guidance*, Baltimore, Md., 2022a. As of August 4, 2022: <https://innovation.cms.gov/media/document/vbid-hospice-ph2-nw-adq-guide>

Centers for Medicare & Medicaid Services, “Medicare Advantage Value-Based Insurance Design Model,” webpage, 2022b. As of March 22, 2022:
<https://innovation.cms.gov/innovation-models/vbid>

Choudhry, Niteesh K., Michael A. Fischer, Benjamin F. Smith, Gregory Brill, Charmaine Girdish, Olga S. Matlin, Troyen A. Brennan, Jerry Avorn, and William H. Shrank, “Five Features of Value-Based Insurance Design Plans Were Associated with Higher Rates of Medication Adherence,” *Health Affairs*, Vol. 33, No. 3, March 2014, pp. 493–501.

CMS—*See* Centers for Medicare & Medicaid Services.

Code of Federal Regulations, Title 42, Public Health; Part 100; Chapter IV, Centers for Medicare & Medicaid Services, Department of Health and Human Services; Subchapter B, Medicare Program; Part 422, Medicare Advantage Program; Subpart C, Benefits and Beneficiary Protections; Section 422.100, General requirements.

Coleman, Kathryn A., Medicare Drug & Health Plan Contract Administration Group, Centers for Medicare & Medicaid Services, “Reinterpretation of ‘Primarily Health Related’ for Supplemental Benefits,” memorandum to Medicare Advantage organizations and Section 1876 cost contract plans, Baltimore, Md., April 27, 2018a. As of February 22, 2022:
<https://www.nahc.org/wp-content/uploads/2018/05/HPMS-Memo-Primarily-Health-Related-4-27-18.pdf>

Coleman, Kathryn A., Medicare Drug & Health Plan Contract Administration Group, Centers for Medicare & Medicaid Services, “Reinterpretation of the Uniformity Requirement,” memorandum to Medicare Advantage organizations and Section 1876 cost plans, Baltimore, Md., April 27, 2018b. As of February 22, 2022:
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/hpms%2520memo%2520uniformity%2520requirements%25204-27-18_2.pdf

- Coleman, Kathryn A., Medicare Drug & Health Plan Contract Administration Group, Centers for Medicare & Medicaid Services, “Implementing Supplemental Benefits for Chronically Ill Enrollees,” memorandum to Medicare Advantage organizations, Baltimore, Md., April 24, 2019. As of February 22, 2022:
https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
- Driessen, Julia, and Turner West, “The Opportunities and Challenges of Including Hospice in the Medicare Advantage Benefits Package,” *Public Policy & Aging Report*, Vol. 28, No. 3, 2018, pp. 100–104.
- Eibner, Christine, Dmitry Khodyakov, Erin Audrey Taylor, Christine Buttorff, Courtney Armstrong, Marika Booth, Kathryn E. Bouskill, Matthew Cefalu, Stephanie Dellva, Michael Dworsky, Federico Girosi, Ann C. Haas, Monique Martineau, Blen Eshete-Roesler, Alice Kim, Julie Lai, Afshin Rastegar, Daniel Schwam, Tisamarie Sherry, and Shiyuan Zhang, *Evaluation Report of the First Three Years (2017–2019) of the Medicare Advantage Value-Based Insurance Design Model Test*, Santa Monica, Calif.: RAND Corporation, EP-68316, 2020. As of March 2, 2022:
https://www.rand.org/pubs/external_publications/EP68316.html
- Eibner, Christine, Dmitry Khodyakov, Erin Audrey Taylor, Christine Buttorff, Courtney Armstrong, Marika Booth, Kathryn E. Bouskill, Matthew Cefalu, Stephanie Dellva, Blen Eshete-Roesler, Alice Kim, Julie Lai, Afshin Rastegar, and Christopher Whaley, *First Annual Evaluation Report of the Medicare Advantage Value-Based Insurance Design Model Test: 2017, Year 1 of the Intervention*, Santa Monica, Calif.: RAND Corporation, EP-68317, 2018. As of March 2, 2022:
https://www.rand.org/pubs/external_publications/EP68317.html
- Guest, Greg, Kathleen M. MacQueen, and Emily E. Namey, “Comparing Thematic Data,” in Greg Guest, Kathleen M. MacQueen, and Emily E. Namey, eds., *Applied Thematic Analysis*, Thousand Oaks, Calif.: SAGE Publications, Inc., 2012, pp. 161–186.
- Hainmueller, Jens, “Entropy Balancing for Causal Effects: A Multivariate Reweighting Method to Produce Balanced Samples in Observational Studies,” *Political Analysis*, Vol. 20, No. 1, Winter 2012, pp. 25–46.
- Hirth, Richard A., Elizabeth Q. Cliff, Teresa B. Gibson, M. Richard McKellar, and A. Mark Fendrick, “Connecticut’s Value-Based Insurance Plan Increased the Use of Targeted Services and Medication Adherence,” *Health Affairs*, Vol. 35, No. 4, April 2016, pp. 637–646.

- Institute of Medicine of the National Academies, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, Washington, D.C., 2015.
- Karikari-Martin, Pauline, Judith J. McCann, Carol J. Farran, Liesi E. Hebert, Samuel C. Haffer, and Marcia Phillips, “Race, Any Cancer, Income, or Cognitive Function: What Influences Hospice or Aggressive Services Use at the End of Life Among Community-Dwelling Medicare Beneficiaries?” *American Journal of Hospice and Palliative Medicine*, Vol. 33, No. 6, July 2016, pp. 537–545.
- Kornfield, Thomas, Matt Kazan, Miryam Frieder, Robin Duddy-Tenbrunsel, Shruthi Donthi, and Alessandra Fix, *Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment*, New York: Commonwealth Fund, February 10, 2021.
- Lee, Joy L., Matthew Maciejewski, Shveta Raju, William H. Shrank, and Niteesh K. Choudhry, “Value-Based Insurance Design: Quality Improvement but No Cost Savings,” *Health Affairs*, Vol. 32, No. 7, July 2013, pp. 1251–1257.
- Medicare.gov, “How Hospice Works,” webpage, undated. As of March 22, 2022:
<https://www.medicare.gov/what-medicare-covers/what-part-a-covers/how-hospice-works>
- Medicare Payment Advisory Commission, “Chapter 13: The Medicare Advantage Program: Status Report,” in *Report to the Congress: Medicare Payment Policy*, Washington, D.C., March 2020, pp. 365–401. As of July 24, 2022:
https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch13_sec.pdf
- Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, Washington, D.C., February 2022.
- Public Law 105-33, Balanced Budget Act of 1997, August 5, 1997.
- Public Law 115-123, Bipartisan Budget Act of 2018, February 9, 2018.
- Shapiro, Jennifer R., Medicare Plan Payment Group, Centers for Medicare & Medicaid Services, “2022 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS),” memorandum to all Part D plan sponsors, Baltimore, Md., October 25, 2021. As of February 22, 2022:
<https://www.cms.gov/files/document/lis-memo.pdf>
- Sudore, Rebecca L., and Terri R. Fried, “Redefining the ‘Planning’ in Advance Care Planning: Preparing for End-of-Life Decision Making,” *Annals of Internal Medicine*, Vol. 153, No. 4, August 17, 2010, pp. 256–261.

Tangeman, John C., Carole B. Rudra, Christopher W. Kerr, and Pei C. Grant, “A Hospice-Hospital Partnership: Reducing Hospitalization Costs and 30-Day Readmissions Among Seriously Ill Adults,” *Journal of Palliative Medicine*, Vol. 17, No. 9, September 2014, pp. 1005–1010.

Whitney, Patricia, and Elizabeth J. Chuang, “Relationship Between Insurance and 30-Day Readmission Rates in Patients 65 Years and Older Discharged from an Acute Care Hospital with Hospice Services,” *Journal of Hospital Medicine*, Vol. 11, No. 10, October 2016, pp. 688–693.

Zimbroff, Robert M., Christine S. Ritchie, Bruce Leff, and Orla C. Sheehan, “Home-Based Primary and Palliative Care in the Medicaid Program: Systematic Review of the Literature,” *Journal of the American Geriatrics Society*, Vol. 69, No. 1, January 2021, pp. 245–254.