



Improving Care for High-Need, High-Cost Medicare Patients

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BIPARTISAN POLICY CENTER

HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, BPC's Health Project seeks to develop bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The Health Project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

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GLOSSARY OF ACRONYMS

ACO: Accountable Care Organization

ADL: Activity of Daily Living

APM: Alternative Payment Model

CAHPS: Consumer Assessment of Healthcare Providers and Systems

CMS: Centers for Medicare and Medicaid Services

CMS-HCC: CMS-Hierarchical Condition Categories

CPC Plus: Comprehensive Primary Care Plus

D-SNPs: Dual-Eligible Special Needs Plans

FFS: Fee-for-Service

HOS: Health Outcomes Survey

LTSS: Long-Term Services and Supports

MA: Medicare Advantage

MLR: Medical Loss Ratio

MSSP: Medicare Shared Savings Program

PACE: Programs for All-Inclusive Care for the Elderly

PBPM: Per Beneficiary Per Month

TCM: Targeted Case Management

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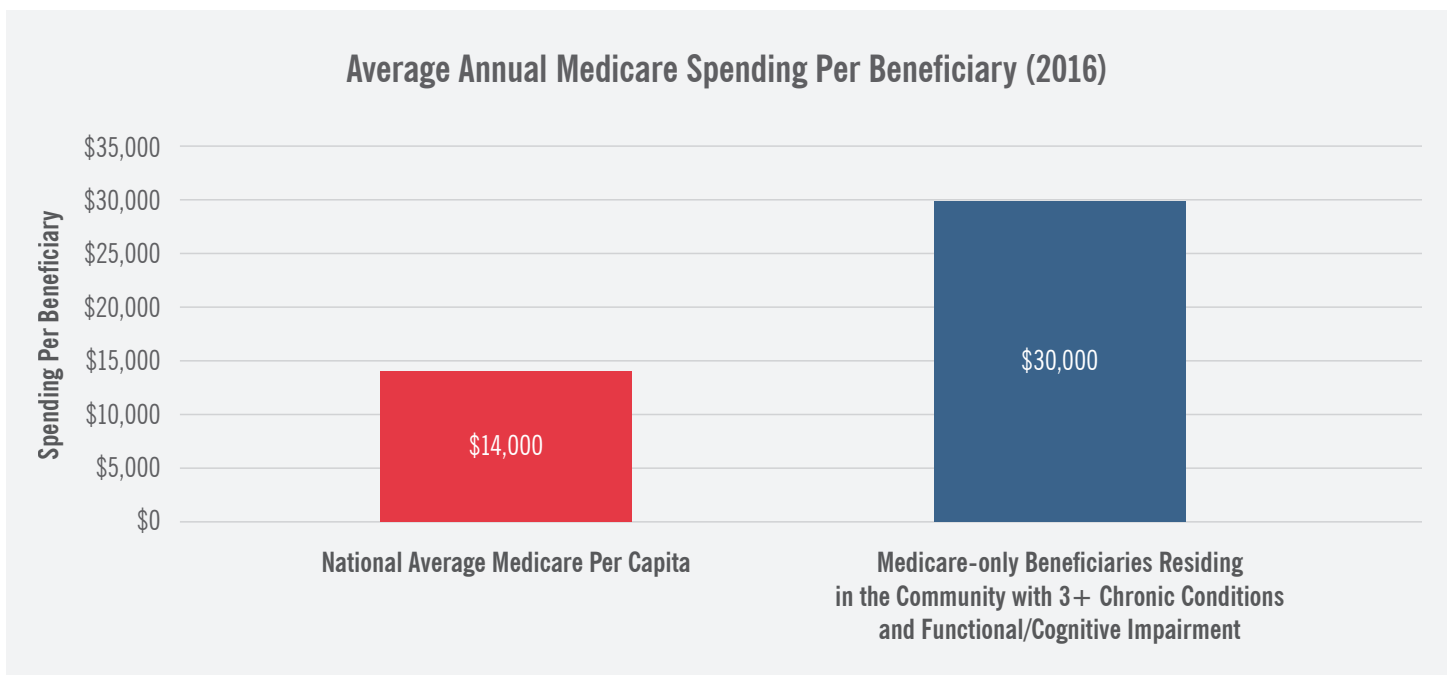
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Executive Summary

Clinical evidence suggests that frail and chronically ill Medicare beneficiaries who are not dually eligible for full Medicaid benefits could often greatly benefit from the integration of non-Medicare-covered social supports into the medical care model offered to them in the Medicare program. For instance, non-Medicare-covered support services such as in-home meal delivery, non-emergent transportation to medical appointments, and targeted case management services have demonstrated the propensity for reducing the need for avoidable hospitalizations.^{1,2,3}

These interventions can be particularly valuable for Medicare beneficiaries who are not dually eligible for full Medicaid benefits, reside in the community setting, have three or more chronic conditions, and have functional or cognitive impairment. A data analysis performed on behalf of the Bipartisan Policy Center projects that approximately 3.65 million Medicare beneficiaries meet the above criteria; the analysis also projects that these beneficiaries incur roughly \$30,000 in annual Medicare costs per beneficiary, or more than twice the national average annual Medicare Fee-for-Service spending amount per beneficiary.⁴

However, Medicare's payment rules and regulations have created significant care integration barriers for Medicare Advantage (MA) plans and health care provider groups, such as Accountable Care Organizations (ACOs) and patient-centered medical homes, which would otherwise furnish and finance these non-Medicare-covered supports and services. These barriers were outlined in great detail in a [preliminary report](#), issued in February 2017 by BPC.



Source: Acumen, LLC analysis on behalf of BPC, 2017.

After seeking and receiving feedback from many stakeholders and incorporating input from the BPC Health Project's leadership and senior fellows, BPC offers the final recommendations in this report to address, in a fiscally responsible manner, many of the barriers outlined in the preliminary report.

Final BPC Recommendations on Risk Adjustment and Quality Measurement Incentives

1. Improving Medicare's Risk Adjustment Model to Account for Functional Impairment: In conjunction with action on the recommendation to waive uniform benefit requirements, the Centers for Medicare and Medicaid Services (CMS) should examine potential modifications to the CMS-Hierarchical Condition Categories (CMS-HCC) risk adjustment model to ensure more accurate predictions of medical expenses for the highest- and lowest-cost Medicare beneficiaries. Under this scenario, CMS could enhance existing survey platforms used to measure frailty and/or develop a functional status assessment tool that would be implemented and used across MA and Medicare FFS to evaluate and document functional impairment of the Medicare beneficiary. If this approach proves feasible—and data gathered by CMS support the use of a frailty adjustment factor or other functional status measure in the risk model—the otherwise applicable risk scores could be adjusted upward for MA plans and ACOs with higher proportions of beneficiaries with functional impairments, and adjusted downward for MA plans and ACOs that treat fewer beneficiaries with functional impairments. To allow MA plans and ACOs to become more familiar with the impact that a frailty or functional impairment adjustment factor would have on risk scores, benchmarks, and bid pricing, CMS should phase in any finalized adjustment factor policy over multiple years.

2. Incentivizing the Provision of Non-Medicare-Covered Supports Through Quality Measurement: In conjunction with action on the recommendation to waive uniform benefit requirements, CMS should develop MA Star Ratings Program measures and ACO Quality Measurement metrics that evaluate the incorporation of non-Medicare-covered health-related social supports and services (that can be reasonably financed within existing MA rebates and ACO shared savings amounts) into the MA and ACO care model. MA plans and ACOs with greater levels of social support and service integration should be rewarded with higher scores on these quality measures, while MA plans and ACOs with less comprehensive integration of these services should receive lower scores. Additional quality measure-focused approaches could include applying one measure of all-cause hospital readmissions for beneficiaries with multiple chronic conditions and functional or cognitive impairments, and a separate measure of all-cause hospital readmissions for all other enrolled or attributed beneficiaries. For MA plans, consistent with [past Medicare Payment Advisory Commission recommendations](#), and to the extent feasible, CMS should improve the Star Ratings Program by examining options for assessing these and other quality measures at the plan benefit package level, rather than the contract level.

Final BPC Recommendations for Medicare Advantage

1. Modifying the Uniform Benefit Requirement: Congress should direct CMS to modify the MA uniform benefit requirement to allow MA plans to target non-Medicare-covered health-related social supports and services to plan enrollees who: (1) are not dually eligible for full Medicaid benefits; (2) have three or more chronic conditions; and (3) either have functional or cognitive impairment. Supports and services covered under this policy must be reasonably related to optimizing health or functional status, and must be part of a “person-centered care plan,” as defined by CMS. CMS should take steps to establish appropriate conditions of participation for MA plans availing themselves of this flexibility and should ensure that the offer of these targeted services cannot be inappropriately used for marketing purposes by MA plans. These non-Medicare-covered health-related supports and services can be included as mandatory supplemental benefits, financed through existing MA rebates. This recommendation is consistent with the general policy approach of the Senate Finance Committee’s [“Creating High-Quality Results and Outcomes Necessary to Improve Chronic \(CHRONIC\) Care Act of 2016.”](#)

2. Waiving the Primarily Health-Related Requirement and Other Supplemental Benefit Rules: CMS should provide an exception to the current requirement that supplemental benefits be primarily health-related and should also waive existing regulatory limitations on the provision of in-home meal delivery services, case management services, and home modifications as supplemental benefits. This exception should only apply to benefits that are targeted to enrollees who are not dually eligible for full Medicaid benefits and who have three or more chronic conditions and functional or cognitive impairment. Such benefits must be a part of a person-centered care plan, as defined by CMS. This recommendation is consistent with the general policy approach of the CHRONIC Care Act of 2016.

3. Counting Health-Related Non-Medical Supports and Services Costs Toward the Medical Loss Ratio: CMS should modify the definition of “incurred claims costs” in medical loss ratio (MLR) regulations to include the costs of health-related supports and services provided on an in-kind basis to enrollees who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. Such supports and services must be a part of a person-centered care plan. For audit and verification purposes, MA plans should be required to keep records of payment of claims or other invoices for such services whose costs are included in the “incurred claims costs” calculation.

Final BPC Recommendations for ACOs and Medical Homes

1. Clarifying ACO Patient Incentive Waivers and Extending Waivers to the CPC Plus Model: CMS should clarify that the Patient Incentive Waiver under the Medicare Shared Savings Program (MSSP) Program and the Next Generation ACO Program will allow for the free or no-charge provision of non-Medicare-covered health-related supports and services that optimize health or functional status for ACO-attributed beneficiaries who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. The waiver should be limited to supports that are identified in a person-centered care plan, as defined by CMS. CMS should also provide a Patient Incentive Waiver, similar to the waiver applicable for MSSP ACOs and Next Generation ACOs, for participants in “Track Two” of the Comprehensive Primary Care (CPC) Plus Initiative, provided that the in-kind furnishing of supports and services by CPC Plus practices are part of a person-centered care plan, as defined by CMS.

2. Establishing Voluntary Enrollment Pathways within MSSP ACOs: Consistent with past BPC recommendations, CMS should establish voluntary enrollment processes within the MSSP and make related changes to the underlying attribution and payment reconciliation structures to ensure that ACOs have a more predictable pool of attributed beneficiaries and care expenses, as ACO participants transition to greater risk-sharing.

In this report, BPC also provides details of a data analysis relating to the costs of providing four illustrative non-Medicare-covered supports. While BPC’s recommendations provide the flexibility for MA plans, ACOs, and health care providers to prescribe, furnish, and finance the specific non-medical support intervention that works best for a particular chronically ill Medicare patient, for the purposes of illustration, the analysis projected the costs of the following four services: in-home meal delivery, minor home modifications, non-emergent medical transportation, and targeted case management. The analysis suggests that, if changes to the uniform benefit requirement were adopted, MA plans would be able to finance many if not all of the four illustrative benefits (when targeted to high-need, chronically ill populations) by making only minor reductions in the value of existing supplemental benefits that the MA plans currently offer to all MA enrollees. The analysis also indicates that while some of the four illustrative supports could be financed by ACOs through shared savings payments, the ACOs may need to target these services to smaller groups of very high-need patients in order to make free provision of these supports financially viable.

Through the policy changes included in the recommendations of this report, the Medicare program could create pathways for MA plans, ACOs, and other providers to better tailor care plans for frail and chronically ill Medicare patients, in a manner that integrates traditional medical care with non-Medicare-covered social supports. Although work needs to be done to develop analogous solutions to address the non-Medicare-covered social support needs and chronic care management issues for beneficiaries who are enrolled in Medicare Fee-for-Service, these recommendations present the opportunity for tangible, bipartisan fixes to policy problems that have impeded the evolution of person-centered care in the Medicare program.

Introduction

Chronically ill Medicare beneficiaries who are not dually eligible for full Medicaid benefits^a could often greatly benefit from the integration of critical non-Medicare-covered social supports into the medical care model offered to them in the Medicare program. The integration of these supports and services is particularly important for chronically ill Medicare-only^b beneficiaries who also have functional or cognitive impairments.^c Such supports include, but are not limited to, in-home meal delivery, minor home modifications, targeted case management services, and transportation to medical appointments.

Evidence from many studies suggests that the provision of these non-Medicare-covered supports and services can have a positive impact in reducing hospitalizations and emergency department visits,^{5,6} as well as reducing the need for other medical services and nursing home care.⁷ However, Medicare's payment rules and regulations have created significant barriers for Medicare Advantage (MA) plans and health care providers to furnish and finance these non-Medicare-covered supports and services.

In a [preliminary report](#) issued in February 2017, the Bipartisan Policy Center outlined these barriers and presented potential policy options to allow better integration of these non-Medicare-covered supports and services for Medicare-only beneficiaries with multiple chronic conditions and functional or cognitive impairment. The preliminary report identified and addressed these barriers through the lens of the following Medicare payment models:

- MA Plans
- Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)
- Comprehensive Primary Care Plus (CPC Plus) Model Participants
- MA Dual-Eligible Special Needs Plans (D-SNPs)
- Programs for All-Inclusive Care for the Elderly (PACE) Organizations
- Next Generation (NextGen) ACOs

After seeking and receiving feedback from many stakeholders and incorporating input from the BPC Health Project's leadership and senior fellows, BPC offers the final recommendations in this report to address, in a fiscally responsible manner, many of the barriers outlined in the preliminary report. Details on these recommendations are provided below.

This report also provides an illustrative analysis that projects the cost that MA plans and Medicare providers would incur in financing and furnishing several non-Medicare-covered supports and services in a targeted manner.

^a In this report, Medicare beneficiaries who are eligible for "full Medicaid benefits" refers to Medicare beneficiaries who qualify for the full range of Medicaid-covered benefits, in addition to Medicare-covered services. This full range of Medicaid-covered benefits includes clinical health services that are not covered by Medicare, as well as long-term services and supports, and certain non-clinical services, such as targeted case management services and transportation to medical appointments. By contrast, so-called "partial benefit" dual-eligible beneficiaries are individuals who only qualify Medicare-covered services along with financial assistance from Medicaid to pay for their Medicare premiums and Medicare cost-sharing expenses.

^b This report refers to Medicare beneficiaries who are not dually eligible for full Medicaid benefits, including "partial benefit" dual-eligible individuals, as "Medicare-only" individuals.

^c This report refers to a person requiring assistance with two or more activities of daily living (ADLs) as a person "with functional impairment." Functional assessments measure the following ADLs: ambulating, bathing, dressing, feeding, transferring, and toileting. This report refers to a person requiring substantial supervision to protect such person from threats to health and safety due to severe cognitive impairment as a person "with cognitive impairment."

Scope of the Beneficiary Population

For the purposes of the illustrative data analysis discussed in more detail below, BPC examined the current population of Medicare-only beneficiaries who: (1) have three or more chronic conditions; (2) have functional or cognitive impairment; and (3) are “community-dwelling” individuals who do not reside in an institutional or nursing facility setting. This recent data analysis performed on behalf of BPC suggests that roughly 3.6 million Medicare-only beneficiaries meet these three criteria.⁸ The analysis projects that of the 3.6 million applicable beneficiaries, roughly 3 million are enrolled in Medicare Fee-for-Service (FFS)—accounting for approximately 7.8 percent of the overall population in Medicare FFS.⁹

Of these 3 million Medicare FFS beneficiaries who meet the three-part criteria, the analysis projects that between 30,000 and 60,000 beneficiaries are attributed to NextGen ACOs or ACOs participating in Track Two or Track Three of the MSSP. An additional 650,000 Medicare-only beneficiaries meet the three-part criteria and are enrolled in MA plans, comprising roughly 3.5 percent of the total population enrolled in MA.

This analysis also estimates that in 2016, Medicare-only beneficiaries who meet the three-part criteria incurred roughly \$30,000 per year in total spending on Medicare-covered services,¹⁰ on average—including both cost-sharing obligations and Medicare payments—which is more than double the national average of roughly \$14,000 in total spending on those services per Medicare FFS beneficiary in 2016.¹¹

Complementary Prior BPC Work on Integrating Supports and Services for Dual-Eligible Individuals

While this report focuses on payment policies and regulatory modifications to allow for better integration of non-Medicare-covered supports into care models for Medicare-only beneficiaries, BPC has also produced extensive analyses of programs serving Medicare/Medicaid “dual-eligible” individuals.

Among many other recommendations, as a part of a [September 2016 report](#) on dual-eligible programs, BPC recommended:

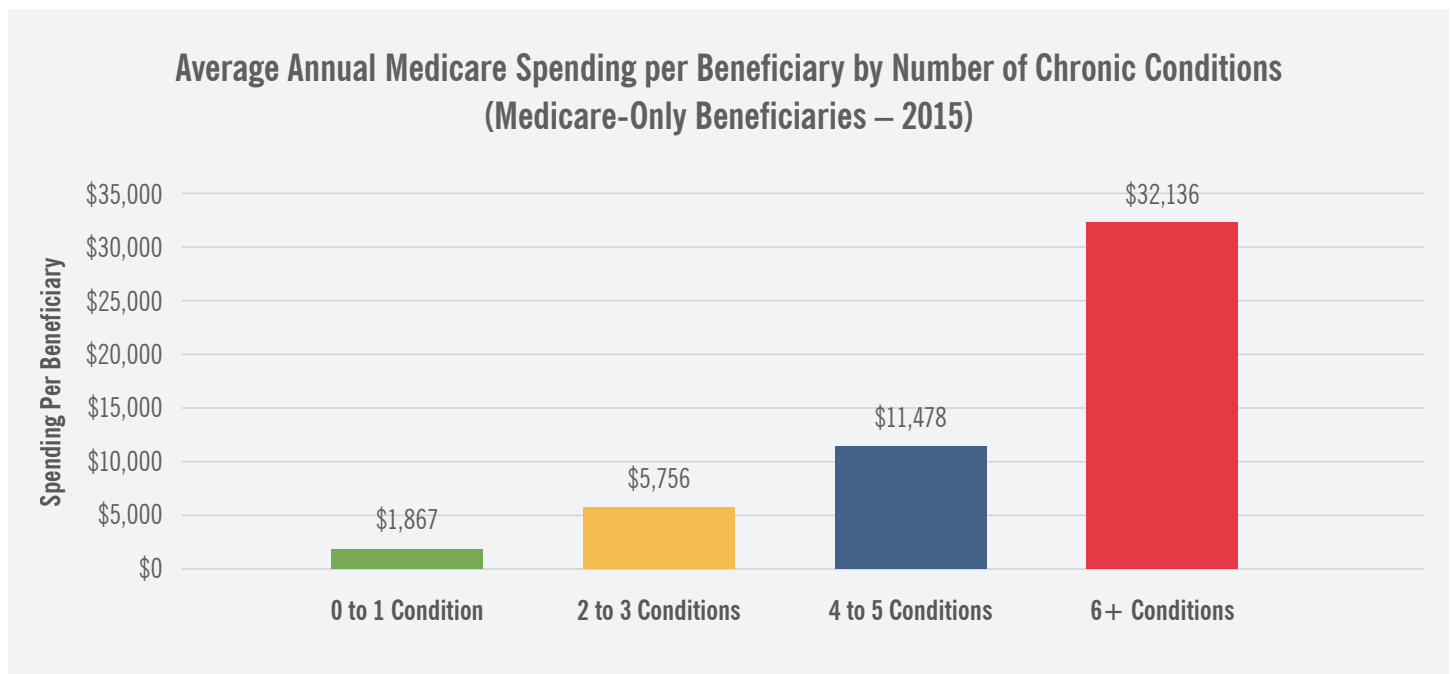
- The development of a new three-way contract model between the Centers for Medicare and Medicaid Services (CMS), states, and health plans (or risk-bearing providers), under which the health plan/provider would provide streamlined and integrated coverage of Medicare and Medicaid benefits.
- Health plans and risk-bearing providers under the three-way contract should be permitted to offer any item or service that is reasonably related to optimizing health or functional status, provided that the item or service is part of a care plan developed by the patient’s interdisciplinary care team, regardless of whether the support or service is covered under Medicare or Medicaid.

Importance of Integrating Social Supports with Traditional Medical Care

Medicare beneficiaries with multiple chronic conditions and functional or cognitive impairment are at much greater risk for adverse clinical outcomes, and generally incur much higher Medicare expenses, compared with all other Medicare beneficiaries. In 2015, among Medicare-only individuals, Medicare per beneficiary expenditures for individuals with multiple chronic conditions were roughly seven times higher than per beneficiary spending for beneficiaries with one or no chronic conditions.¹² Even among Medicare beneficiaries with chronic conditions, in 2012, Medicare per beneficiary spending for patients with functional impairment *and* chronic conditions was 2.5 times higher than Medicare spending per beneficiary for individuals who had chronic conditions but did *not* have functional impairment.¹³

Cognitive impairment is an equally important predictor of medical costs among chronically ill Medicare patients. In 2009, Medicare beneficiaries who had both (1) Alzheimer’s disease or other dementia and (2) three or more chronic conditions incurred Medicare costs that were twice as high as Medicare beneficiaries who had three or more chronic conditions but who did not have Alzheimer’s/other dementia.¹⁴

Medicare beneficiaries with multiple chronic conditions also have a much higher prevalence of hospital readmissions compared with all other Medicare beneficiaries. In 2015, Medicare beneficiaries with four or more chronic conditions comprised only 36 percent of the population, but accounted for 92 percent of all Medicare hospital readmissions.¹⁵ These Medicare beneficiaries with four or more chronic conditions also accounted for 76 percent of total Medicare spending in 2015.¹⁶



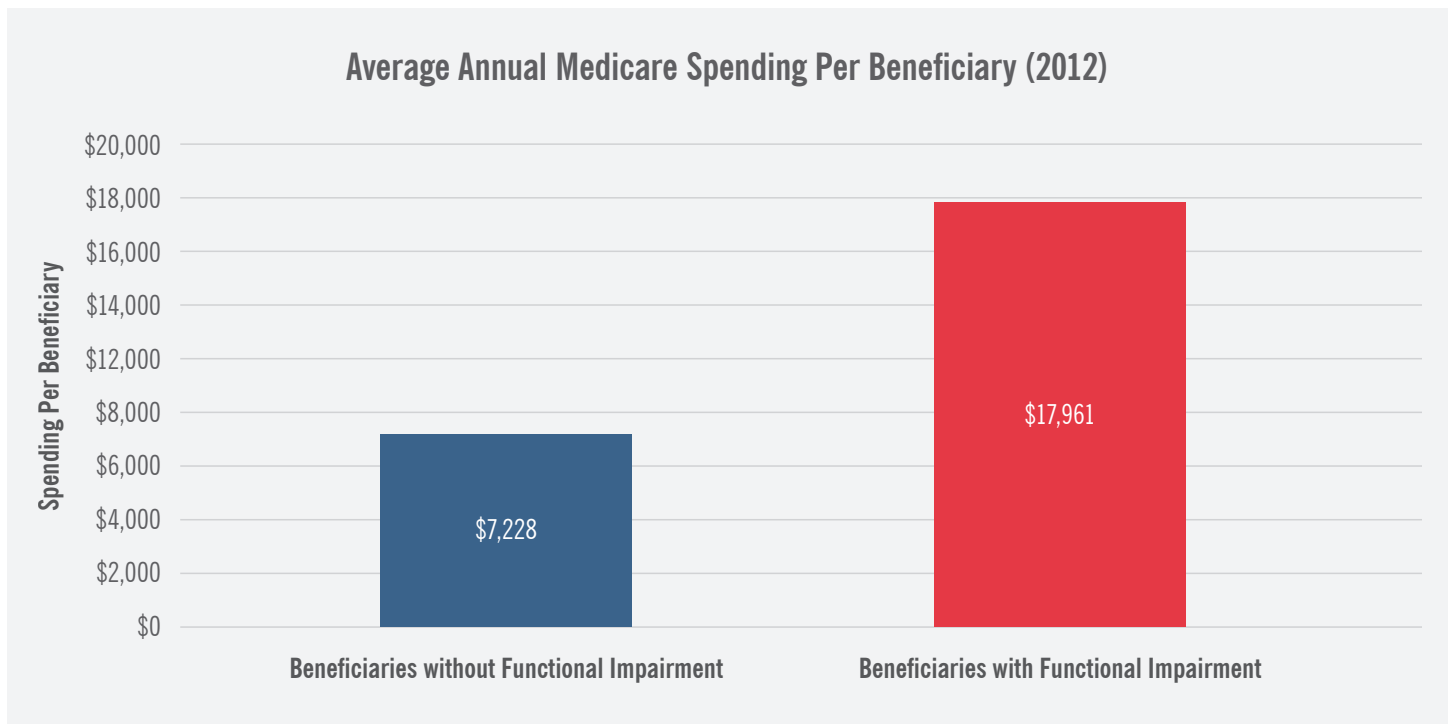
Source: Centers for Medicare and Medicaid Services, 2015.

Given the prevalence of high-need, high-cost beneficiaries to cycle in and out of the hospital and have adverse, costly, and potentially avoidable outcomes, it is appropriate to focus on approaches to improving their care by integrating supports aimed at their health-related non-medical needs. Studies suggest that addressing non-medical needs with appropriate social supports can reduce hospitalizations and overall costs.

The Geriatric Resources for Assessment and Care for Elders, or “GRACE,” Model demonstrated that an annual \$2,201 per beneficiary investment in focused care management and care coordination services generated annual medical care savings of \$4,291 per beneficiary for high-risk patients with complex care needs.¹⁷

Similarly, investment in non-emergency medical transportation was estimated to have an 11-to-1 return on investment, achieved through savings from reductions in short-stay hospitalizations that can be prevented through timely medical transportation trips.¹⁸ Additionally, the application of an in-home meal delivery program operated in Pennsylvania for individuals with severe chronic conditions resulted in a 27 percent decline in medical costs for patients receiving the meal assistance.¹⁹

Finally, under the Community Aging in Place, Advancing Better Living for Elders, or “CAPABLE,” Model conducted in Maryland, high-risk elderly patients with chronic conditions are provided with an in-home coordinated care program that includes the support of a handyman to install necessary minor home modifications, such as railings or pull-up bars, to protect against falls and aid in ambulation. Analysis suggests that the application of the CAPABLE Model resulted in a slight reduction in hospitalizations and hospital readmissions relative to a control group.²⁰



Source: Anne Tumlinson Innovations, “Functional Impairments a Key Factor in Medical Spending,” 2014.

Policy recommendations in this report focus on achieving better integration of these and other non-Medicare-covered supports and services by adjusting Medicare payment rules and regulations related to: the MA program, MSSP Track Two and Track Three for ACOs, the NextGen ACO Model, and the CPC Plus Model. BPC focuses on these models because each care model incorporates the assumption of financial risk for the cost of a beneficiary's care across an extended, usually yearlong, duration—which provides adequate incentive for the applicable plans and providers to utilize new flexibilities in a way that controls costs. Additional details on each model of care can be found in the [February 2017 preliminary report](#).

In 2016, the MA and ACO models of care provided care for more than 25 million Medicare beneficiaries, or roughly 45 percent of the Medicare-enrolled population.²¹ However it will be important to develop complementary efforts to improving the availability of these critical non-Medicare-covered supports and services among the Medicare-only population enrolled in traditional Medicare FFS.

These policy recommendations will allow for MA plans and Medicare providers to foster better integration of social supports into the care models for frail and chronically ill Medicare-only beneficiaries in a manner that does not add new federal costs to the Medicare program.

Recommendations for Flexibility in Medicare Advantage

As outlined in greater detail in the February 2017 preliminary report, MA plans face three regulatory obstacles in providing non-Medicare-covered supports and services to high-need, high-cost frail and chronically ill Medicare-only beneficiaries.

First, in most cases, MA's "uniform benefit" requirements prohibit plans from targeting non-Medicare-covered supports toward in-need subpopulations of enrollees, resulting in the plans needing to offer the supports to all enrollees in order to cover the supports as supplemental benefits financed through MA rebates.²² This requirement to provide coverage of the benefit in a uniform manner can often be prohibitively expensive.

Second, MA rules require that supplemental benefits must be "primarily health-related," while also applying specific limits on the supplemental benefit coverage of certain valuable social supports, such as home-delivered meals and minor home modifications.²³ The primarily health-related requirement can create uncertainty as to whether an MA plan can offer a non-medical social support as a supplemental benefit, even where resulting positive impacts—in the form of reduced hospitalizations—may be clear. The additional specific benefit limits noted above can also constrict an MA plan's ability to tailor person-centered supplemental benefit designs.

Finally, MA rules relating to the medical loss ratio (MLR) requirement in many cases do not allow an MA plan to count the costs of non-Medicare-covered supports that are *not* included as supplemental benefits toward the plan's MLR.²⁴ This MLR restriction can provide a strong disincentive for plans to furnish non-Medicare-covered supports to beneficiaries at no charge, outside of the supplemental benefit structure.

To address these issues, BPC offers the following recommendations.

1. Modifying the Uniform Benefit Requirement: Congress should direct the Centers for Medicare and Medicaid Services (CMS) to modify the MA uniform benefit requirement to allow MA plans to target non-Medicare-covered health-related social supports and services to plan enrollees who: (1) are not dually eligible for full Medicaid benefits; (2) have three or more chronic conditions; and (3) either have functional or cognitive impairment. Supports and services covered under this policy must be reasonably related to optimizing health or functional status, and must be part of a “person-centered care plan,” as defined by CMS. CMS should take steps to establish appropriate conditions of participation for MA plans availing themselves of this flexibility and should ensure that the offer of these targeted services cannot be inappropriately used for marketing purposes by MA plans. These non-Medicare-covered health-related supports and services can be included as mandatory supplemental benefits, financed through existing MA rebates. This recommendation is consistent with the general policy approach of the Senate Finance Committee’s [“Creating High-Quality Results and Outcomes Necessary to Improve Chronic \(CHRONIC\) Care Act of 2016.”](#)

2. Waiving the Primarily Health-Related Requirement and Other Supplemental Benefit Rules: CMS should provide an exception to the current requirement that supplemental benefits be primarily health-related and should also waive existing regulatory limitations on the provision of in-home meal delivery services, case management services, and home modifications as supplemental benefits. This exception should only apply to benefits that are targeted to enrollees who are not dually eligible for full Medicaid benefits and who have three or more chronic conditions and functional or cognitive impairment. Such benefits must be a part of a person-centered care plan, as defined by CMS. This recommendation is consistent with the general policy approach of the *CHRONIC Care Act of 2016*.

3. Counting Health-Related Non-Medical Supports and Services Costs Towards the MLR: CMS should modify the definition of “incurred claims costs” in MLR regulations to include the costs of health-related supports and services provided on an in-kind basis to enrollees who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. Such supports and services must be a part of a person-centered care plan. For audit and verification purposes, MA plans should be required to keep records of payment of claims or other invoices for such services whose costs are included in the “incurred claims costs” calculation. With the implementation of the uniform benefit and primarily health-related rule flexibilities discussed above, it is anticipated that most non-Medicare-covered supports provided by MA plans could be included as supplemental benefits, which already count toward the MLR. However, there could be some instances where plans may furnish supports and services outside of the supplemental benefit structure, at no charge. In those instances, these changes to MLR accounting rules would be impactful.

Recommendations for Flexibility in Provider-Based Models

ACOs and patient-centered medical homes participating in the CPC Plus Model are faced with two regulatory barriers that can impede the providers’ abilities to furnish non-Medicare-covered supports and services at no charge to the beneficiary. First, program integrity rules and related waivers to those rules can create uncertainty regarding the legality of providing certain non-Medicare-covered services at no charge. Second, the current beneficiary attribution model for ACOs can result in uncertainty as to which beneficiaries an ACO is actually responsible for financially, which in turn creates disincentives toward investment in non-Medicare-covered social supports.

Medicare program integrity rules, such as the Anti-Kickback Statute and the prohibition against beneficiary inducements, are designed to prevent health care providers from being able to give rewards or other remuneration to Medicare beneficiaries or other entities as a way of steering Medicare beneficiaries toward seeking more Medicare-covered services from the very health care providers that furnish the remuneration. While there is an obvious need for these program integrity protections in a traditional Medicare FFS environment, where service volume is often paramount for providers' finances, flexibility is needed for providers who are participating in alternative payment models (APMs) that require the provider to assume financial risk for the cost of a beneficiary's care. For these providers, the concern over service volume-driving beneficiary inducements should be lower, because the providers have a set spending benchmark that weighs against incentives for volume growth. While CMS and the U.S. Department of Health and Human Services-Office of the Inspector General provide ACOs with Patient Incentive Waivers from the beneficiary inducement prohibition and the Anti-Kickback Statute, the waivers require that the items and services that are offered at no charge must meet certain criteria, such as advancing one of several enumerated "clinical goals."²⁵ ACO program participants and providers report that some uncertainty persists as to whether offering non-Medicare-covered supports and services fits into the waivers' allowances.²⁶ CPC Plus Model participants are not currently provided with a waiver from the beneficiary inducement and Anti-Kickback Statute rules, despite assuming financial risk for the cost of aligned beneficiaries' care.²⁷ Notably, in January 2016, CMS established an exception to the beneficiary inducement and Anti-Kickback Statute rules for providers offering non-emergent medical transportation to Medicare beneficiaries, irrespective of whether the provider was participating in an APM, provided that the transportation met certain criteria.²⁸ However, many of the other important non-Medicare-covered supports discussed above are not currently granted such an exception.

Finally, the MSSP for ACOs lacks voluntary enrollment or attestation options for Medicare FFS beneficiaries to actively enroll or otherwise choose to align with a particular ACO. This lack of voluntary enrollment opportunities not only creates uncertainty within the ACO regarding its attributed beneficiary population (due to substantial year-to-year shifts in attributed beneficiaries), but it also acts as a barrier to patient engagement. ACOs have reported that the combination of that uncertainty with the lack of patient engagement can, together, serve as a disincentive for ACOs to make the long-term investment in providing non-Medicare-covered supports to Medicare patients at no charge.

In order to remove these barriers to care integration, BPC offers the following recommendations.

1. Clarifying ACO Patient Incentive Waivers and Extending Waivers to the CPC Plus Model: CMS should clarify that the Patient Incentive Waiver under the MSSP ACO and NextGen ACO programs will allow for the free or no-charge provision of non-Medicare-covered health-related supports and services that optimize health or functional status for ACO-attributed beneficiaries who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. The waiver should be limited to supports that are identified in a person-centered care plan, as defined by CMS. CMS should also provide a Patient Incentive Waiver, similar to the waiver applicable for MSSP ACOs and NextGen ACOs, for participants of "Track Two" of the CPC Plus Model. The in-kind furnishing of supports and services under this waiver must be limited to services that are a part of a person-centered care plan, as defined by CMS.

2. Establishing Voluntary Enrollment Pathways within MSSP ACOs: Consistent with past BPC recommendations, CMS should establish voluntary enrollment processes within the MSSP and make related changes to the underlying attribution and

payment reconciliation structures to ensure that ACOs have a more predictable pool of attributed beneficiaries and care expenses, as ACO participants transition to greater risk-sharing.

Recommendations for New Incentives Through Risk Adjustment & Quality Measurement

Notwithstanding the additional flexibilities provided in the recommendations above, and even with the ability for MA plans and providers to target non-Medicare-covered supports and services to the highest risk beneficiaries, in some instances the needed intervention may still be too costly to finance solely through shared savings (for ACOs) or rebate dollars (for MA plans). Although the preliminary report included a potential policy option to increase spending benchmarks for ACOs and MA plans that provide non-Medicare-covered supports and services targeted at high-need, high-cost beneficiaries, BPC has determined that this policy option would not be viable in the current environment, given the budgetary and political pressure to control (rather than increase) Medicare outlays. Such a policy could also have an unintended effect of increasing Medicare Part B premiums as a result of the increases to spending benchmarks.

Some stakeholders have suggested that if MA plans subcontract with providers or other entities to provide Medicare Part A and Part B benefits, the subcontracted entity, operating under a capitation arrangement, could then use dollars allocable to MA plan bids (for Part A/B services coverage) to also finance other non-Medicare-covered services. Such an approach, if workable, could broaden the pool of available financing for non-Medicare-covered supports beyond just rebate dollars for supplemental benefits. This approach is worthy of further study and legal analysis.

However, other policy changes to quality measurement programs and risk adjustment mechanisms could also have the effect of incentivizing, and providing indirect financial support for, the provision of non-Medicare-covered social supports by MA plans and ACOs.

Risk Adjustment

CMS uses the CMS-Hierarchical Condition Categories (CMS-HCC) risk adjustment model to modify spending benchmarks and payments for MA plans and ACOs in order to account for differences in the medical complexity of beneficiaries who are enrolled in or attributed to an individual MA plan or ACO, relative to costs of care for an average beneficiary. The current CMS-HCC model has substantially under-predicted the actual medical expenses of the highest-cost beneficiaries, while significantly over-predicting the actual medical costs of the lowest-cost beneficiaries.²⁹ In 2010 and 2011, the model under-predicted the medical costs of the highest-cost beneficiaries by 29 percent and over-predicted the actual expenses of the lowest-cost beneficiaries by 62 percent.³⁰ A practical effect of this under-prediction of actual medical costs for high-cost beneficiaries is significantly fewer financial resources for care, and a disincentive to attract the types of frail beneficiaries who are likely to be high-cost individuals.

One possible method for ensuring a more accurate risk adjustment model would be to incorporate a measure of functional impairment into the CMS-HCC model. Research indicates that functional impairment status can be a very strong predictor of medical costs, especially for patients with chronic conditions.³¹ At various points in the evolution of the CMS-HCC model, CMS

and other policy experts have examined the potential for applying a frailty adjustment factor to the risk adjustment model for MA.³² The frailty adjustment factor is currently used in the PACE model, and for certain D-SNPs, to increase risk scores—and corresponding risk adjustment payment—for PACE organizations and D-SNPs that enroll beneficiaries with high levels of frailty or functional impairment, as measured by difficulty performing activities of daily living (ADLs).³³ The frailty adjustment factor increases risk scores for beneficiaries who have difficulty with ADLs, on a sliding scale where risk scores are increased the most for beneficiaries who have difficulty performing five-to-six ADLs, and where risk scores are increased the least for beneficiaries who have difficulty with one-to-two ADLs.³⁴

To offset the increase in risk scores for these functionally impaired beneficiaries, the frailty adjustment factor reduces risk scores for beneficiaries who do not have difficulty performing ADLs. Because obtaining and updating data on ADL limitations for an entire enrollee population is not practicable, CMS uses survey response data from the Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to identify a sample of enrollees of a specific plan or PACE organization who responded to the survey and answered the portion of the questionnaire related to ADL limitations.³⁵ CMS then aggregates and averages the ADL limitations per respondent for each plan or PACE organization and uses that average ADL score to set a frailty adjustment factor that is then applied uniformly to the risk scores of all enrollees.

Prior CMS Analysis on Expanded Use of Frailty Adjustment Factors

CMS and its contractors have noted several administrative concerns with applying a frailty adjustment factor across all MA plans.

- First, survey data from the HOS are currently only sampled at the contract level, rather than the plan benefit package level. As a result, aggregated ADL/frailty scores would be applied uniformly across many MA plans that are offered by a *single issuer* under the issuer's contract with CMS, even though frailty may vary significantly within different MA plans offered by the same issuer.
- Second, CMS noted timing issues with the frailty adjuster, as an MA plan would need to submit bids that incorporated expected frailty (and frailty scores) of their enrollees months before MA Open Enrollment, when the plan's actual pool of enrollees is determined.
- Finally, the analysis from CMS and its contractors suggests that CMS would need to determine ADLs at a county level in order to standardize MA's County ratebooks and payment amounts with risk scores and expected frailty adjustments.

While these changes to HOS data sampling and modifications to determine ADLs at the county level could be costly to administer, the potential improvement to the risk model and realignment of incentives for MA plans and ACOs to care for frail and chronically ill patients is important, and worthy of continued examination by CMS. Changes would also need to be made to survey platforms used for ACO beneficiaries, in order to incorporate survey questions on ADL limitations, which could then be used to apply a frailty adjustment factor to CMS-HCC risk scores in risk adjustment for ACO benchmarks.

BPC offers the following recommendation to address concerns with current incentives under the CMS-HCC risk adjustment model.

1. Improving Medicare’s Risk Adjustment Model to Account for Functional Impairment: In conjunction with action on the recommendation to waive uniform benefit requirements, CMS should examine potential modifications to the CMS-HCC risk adjustment model to ensure more accurate predictions of medical expenses for the highest- and lowest-cost Medicare beneficiaries. Such a modification could incorporate a frailty adjustment factor or other measure of functional impairment. Under this scenario, CMS could enhance existing survey platforms used to measure frailty and/or develop a functional status assessment tool that would be implemented and used across MA and Medicare FFS to evaluate and document functional impairment of the Medicare beneficiary. If this approach proves feasible—and data gathered by CMS support the use of a frailty adjustment factor or other functional status measure in the risk model—the otherwise applicable risk scores could be adjusted upward for MA plans and ACOs with higher proportions of beneficiaries with functional impairments, and adjusted downward for MA plans and ACOs that treat fewer beneficiaries with functional impairments. To allow MA plans and ACOs to become more familiar with the impact that a frailty or functional impairment adjustment factor would have on risk scores, benchmarks, and bid pricing, CMS should phase in any finalized adjustment factor policy over multiple years.

Quality Measurement

In addition to critical changes to the risk adjustment model, modifications to Medicare’s quality measurement programs for MA plans and ACOs could improve incentives for MA plans and ACOs to furnish and finance non-Medicare-covered supports and services for high-need, high-cost Medicare beneficiaries.

The quality measurement program for MA, known as the “Star Ratings” program, assesses quality performance for MA plans across 32 measures (or 44 measures for MA plans that also provide prescription drug coverage under Medicare Part D).³⁶ Metrics contained in the measure set include measures such as rates of breast cancer screenings among enrollees, as well as reported beneficiary satisfaction, as derived from CAHPS surveys.³⁷ Performance on these measures is assessed at the contract level (rather than the individual plan benefit package level), as the scores for these measures are aggregated across all MA plans within a contract between an insurance issuer and CMS. This aggregate contract level performance score is compared against contract level performance scores of other issuers to determine the star rating for each MA contract.³⁸ Star ratings are allocated on a 1 to 5 scale. For MA contracts that garnered at least a 4-star rating for 2017, CMS will provide “quality bonuses” to all MA plans within the MA contract, in the form of a 5 percent increase in spending benchmarks for those MA plans.³⁹ In 2017, 41 percent of MA contracts attained a star rating of 4 or higher.⁴⁰ Given the potential for significant increases in applicable benchmarks (through quality bonuses), MA plans have a strong financial incentive to perform well on the specific quality metrics that are measured in the Star Ratings program. Although the current Star Ratings measure set includes metrics that assess falls risk mitigation and care coordination, applying new measures to focus on the provision of non-Medicare-covered supports and services for chronically ill and frail enrollees could drive high-impact changes in plans’ care designs.

Similarly, the quality measurement programs for ACOs present a financial incentive for ACO-participating providers to modify their care models in response to metrics that are assessed in the quality measurement program. For 2017, ACOs in the MSSP are assessed based on their performance on 31 quality measures.⁴¹ The NextGen ACO program uses the same basic measure set as the MSSP, with some minor exceptions.⁴² ACOs that achieve higher performance on these quality measures are entitled to share in a greater percentage of

the Medicare savings that are generated when actual Medicare per beneficiary spending on the ACO's beneficiaries is held below the ACO's spending benchmark.⁴³ In this respect, the link between an ACO's performance of quality measures and the ACO's sharing rate creates a financial incentive for ACOs to modify their care models in response to the quality measures being assessed.

To promote better incorporation of non-Medicare-covered supports into the care model designs of MA plans and ACOs, BPC offers the following recommendation for changes to MA and ACO quality measures.

2. Incentivizing the Provision of Non-Medicare-Covered Supports Through Quality Measurement: In conjunction with action on the recommendation to waive uniform benefit requirements, CMS should develop MA Star Ratings Program measures and ACO Quality Measurement metrics that evaluate the incorporation of non-Medicare-covered health-related social supports and services (that can be reasonably financed within existing MA rebates and ACO shared savings amounts) into the MA and ACO care model. MA plans and ACOs with greater levels of social support and service integration should be rewarded with higher scores on these quality measures, while MA plans and ACOs with less comprehensive integration of these services should receive lower scores. Additional quality measure-focused approaches could include applying one measure of all-cause hospital readmissions for beneficiaries with multiple chronic conditions and functional or cognitive impairments, and a separate measure of all-cause hospital readmissions for all other enrolled or attributed beneficiaries. For MA plans, consistent with [past Medicare Payment Advisory Commission recommendations](#),⁴⁴ and to the extent feasible, CMS should improve the Star Ratings program by examining options for assessing these and other quality measures at the plan benefit package level, rather than the contract level.

Illustrative Analysis of Pricing and Costs of Social Support Integration

The data analysis conducted on behalf of BPC examined the Per Beneficiary Per Month (PBPM) cost of providing an illustrative set of non-Medicare-covered supports to Medicare-only beneficiaries who: (1) have three or more chronic conditions; (2) have functional or cognitive impairment; and (3) are "community-dwelling" individuals who do not reside in an institutional or nursing facility setting. While BPC's recommendations provide the flexibility for MA plans, ACOs, and health care providers to prescribe, furnish, and finance the specific non-medical support intervention that works best for a particular chronically ill Medicare patient, for the purposes of illustration, the analysis projected the costs of the following four services:

- In-Home Meal Delivery
- Minor Home Modifications
- Non-Emergent Medical Transportation
- Targeted Case Management (TCM)

The analysis projects the unadjusted monthly cost *per beneficiary in the eligible subpopulation of enrollees*, and in most cases also estimates a cost per recipient for those services. However, the aggregate PBPM cost per MA or FFS enrollee is a better figure for comparison with the \$89 average PBPM rebate amounts that MA plans receive for 2017⁴⁵ and the \$10.36 average PBPM shared savings payments received⁴⁶ in 2014 by ACOs^d in the Pioneer ACO program or Track Two of the MSSP.

^d For the purposes of this comparison, BPC uses 2014 Pioneer ACO financial performance data and 2014 MSSP Track Two ACO financial performance data as a proxy for NextGen ACOs and Track Three ACOs, respectively. Financial performance data for NextGen ACOs and MSSP Track Three ACOs is not yet publicly available.

Projected Average Cost in 2016 per Eligible Enrollee for Specified Non-Medicare-Covered Supports

Benefit	Average Cost Per Eligible Enrollee Per Month	
	Option One	Option Two
Non-Emergency Medical Transportation	\$50	\$50
In-Home Meal Delivery <i>Weekly Frozen Meals</i> <i>Daily Fresh Meals</i>	\$36	\$72
Minor Home Modifications	\$6	\$6
Targeted Case Management	\$30	\$30
TOTAL	\$122	\$158

Source: Acumen, LLC analysis on behalf of BPC, 2017.

In order to simulate the impact of changes in supplemental benefit offerings that could occur under a waiver of the uniform benefit requirement, the analysis also projects the change in aggregate PBPM costs across all enrollees in an MA plan, if the costs of the four new benefits—for the subset of MA enrollees who meet the three-part criteria—were spread across all beneficiaries enrolled in the MA plan. This allows for an assessment of the resulting net reduction in the value of other MA rebate-financed supplemental benefits that are available to *all MA enrollees*. This reduction would be necessary to offset the cost of the heightened, targeted non-medical supports coverage (through supplemental benefits) for the *eligible subpopulation of MA enrollees*.

Although this analysis did not attempt to estimate any savings to the Medicare program that could result from the four targeted interventions, there is strong evidence to suggest that the implementation of these non-Medicare-covered supports can result in reduced hospitalizations.⁴⁷

In-Home Meal Delivery

BPC research confirms that in-home meal delivery is primarily offered in the form of either weekly delivery of mostly frozen “bulk” meals, or daily delivery of mostly fresh meals.

The analysis performed on behalf of BPC suggests that daily home delivery of 33 meals per month, on average, would generate monthly costs of \$360 *per recipient*, while weekly bulk delivery of frozen meals, also averaging 33 meals per month, would result in monthly costs of \$180 *per recipient*.⁴⁸ It is important to note that not every Medicare-only beneficiary who meets the three-part criteria would necessarily be prescribed and elect to receive in-home meal delivery, as MA plans, ACOs, and CPC Plus providers would furnish and finance meal delivery for beneficiaries for whom in-home meal delivery is determined to be

an important part of a person-centered care plan. Other beneficiaries might also opt against an in-home meal delivery service plan for reasons of personal preference. In light of these considerations, the analysis assumes that roughly 20 percent of beneficiaries who meet the three-part eligibility criteria would ultimately be prescribed and elect to receive home-delivered meals. That assumed participation rate would result in average monthly costs of \$36 *per eligible enrollee* for bulk delivery of frozen meals, or \$72 per month for daily delivery of fresh meals.

Although the monthly *per recipient* costs of in-home meal delivery would greatly exceed the average monthly MA rebate of \$89 PBPM, if BPC's uniform benefit requirement waiver recommendation is adopted for MA supplemental benefits, the additional costs of the targeted in-home meal delivery benefit for eligible beneficiaries who ultimately participated could be spread across the entire MA enrollee population. In that environment, the additional PBPM costs across the *entire enrolled population* would be only \$1.25 PBPM for weekly delivery of frozen meals, or \$2.50 PBPM for daily delivery of fresh meals.⁴⁹ In this scenario, an MA plan could finance the benefit—for the subpopulation of beneficiaries who meet the three-part criteria and ultimately participated in the meal delivery program—for a \$2.50 (or less) reduction in the monthly value of other supplemental benefits available to *all MA enrollees*. This would translate to a 2.8 percent reduction in those other supplemental benefits relative to the \$89 average PBPM rebate. If the provision of in-home meal delivery to a targeted set of beneficiaries resulted in reductions in acute care service volume that reduced Medicare Part A/B spending, then the necessary reduction in the value of other supplemental benefits (that are available to all enrollees) would be even smaller, if any supplemental benefit reduction would be needed at all.

Minor Home Modifications

Minor home modifications can encompass a variety of alterations to the domicile of an individual patient in order to allow for the patient to remain in the home setting and reduce the risk of falls. Such modifications can include installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate medical equipment and supplies.

The analysis estimates that the average cost per modification project would be roughly \$720 in 2016. Unlike other social support benefits, a given home modification, such as a railing installation or widening of a doorway, often needs to be made only once for a given Medicare beneficiary and can last for years.⁵⁰ As a result, the analysis projects that only approximately 10 percent of Medicare-only beneficiaries who meet the three-part criteria would require a home modification in any given year. Therefore, the analysis estimates that a home modification benefit would have an expected cost of \$72 *per eligible enrollee* per year, or roughly \$6 per eligible enrollee per month.

Again, if BPC's uniform benefit requirement waiver recommendation is adopted for MA supplemental benefits, the additional costs of the minor home modification benefit for eligible beneficiaries who ultimately require a home modification could be spread across the entire MA enrollee population. In this scenario, the added cost of the benefit, when spread across all of the enrollees in an MA plan, would be only \$0.25 PBPM. Offsetting the cost of the minor home modification benefit—for MA enrollees who meet the criteria and ultimately do require a home modification during the year—would require only a

0.3 percent reduction in the value of other supplemental benefits that are offered to all MA enrollees, relative to the current \$89 PBPM average MA supplemental benefit rebate. If the provision of minor home modifications to a targeted set of beneficiaries resulted in reductions in acute care service volume that reduced Medicare Part A/B spending, then the necessary reduction in the value of other supplemental benefits (that are available to all enrollees) would be even smaller, if any supplemental benefit reduction would be needed at all.

Non-Emergent Medical Transportation

Non-emergent medical transportation services are designed to provide safe and timely transportation to medical appointments and other routine care for patients who lack the resources or physical and cognitive abilities to complete the transportation independently or with a family member.

The analysis performed on behalf of BPC estimates that, on average, Medicare-only beneficiaries who meet the three-part eligibility criteria would incur roughly \$600 in annual non-emergent medical transportation costs per year.⁵¹ As a result, the average cost *per eligible enrollee* would be \$50 per month. The average of \$50 per eligible enrollee per month in transportation services spending would amount to roughly 1.25 non-emergent medical transportation round trips per eligible beneficiary per month. However, the analysis estimates that some segment of the subpopulation of Medicare-only beneficiaries who meet the three-part eligibility criteria would decline to use the benefit at all or would not be prescribed transportation as a part of a person-centered care plan, while other eligible beneficiaries might use the service with significantly higher frequency, well beyond the 1.25 round trip per month average.

When spreading the cost of the targeted non-emergent medical transportation services benefit across all enrollees in an MA plan, the analysis projects that the added aggregate average cost across all MA enrollees would be \$1.75 PBPM. Therefore, offsetting the cost of the targeted non-emergent medical transportation benefit would require a 2 percent reduction in the value of other supplemental benefits that are offered to all MA enrollees. If the provision of non-emergent medical transportation for a targeted set of beneficiaries resulted in reductions in acute care service volume that reduced Medicare Part A/B spending, then the necessary reduction in the value of other supplemental benefits (that are available to all enrollees) would be even smaller, if any supplemental benefit reduction would be needed at all.

Targeted Case Management

TCM services include many coordination assistance efforts designed to help patients gain access to and coordinate their use of medical, social, educational, and other services deemed appropriate for their needs. Under Medicaid, these TCM services are designed to assist patients who do not reside in institutional settings.

The analysis projects an annual *per recipient cost* for TCM services equal to \$1,725 per year for Medicare-only beneficiaries who meet the three-part criteria.⁵² That would amount to monthly costs of \$144 *per recipient* for TCM services. Again, it is important to note that not all Medicare-only beneficiaries who meet the three-part criteria would necessarily be prescribed, or seek, TCM services. The analysis projects that roughly 20 percent of beneficiaries who meet the three-part criteria would

ultimately be prescribed and elect to receive TCM services.⁵³ That assumed participation rate would result in average monthly costs of about \$30 *per eligible enrollee* for the provision of TCM services.

If BPC’s uniform benefit-related recommendation is adopted for MA supplemental benefits, the additional costs of TCM services for eligible beneficiaries who ultimately were prescribed (and received) TCM services could be spread across the entire MA enrollee population. In that scenario, the added cost of the benefit, when spread across all of the enrollees in an MA plan, would be \$1.00 PBPM. Therefore, offsetting the cost of the TCM services benefit for eligible Medicare-only beneficiaries would require a 1.1 percent reduction in the value of other supplemental benefits that are offered to all MA enrollees. If the provision of TCM services for a targeted set of beneficiaries resulted in reductions in acute care service volume that reduced Medicare Part A/B spending, then the necessary reduction in the value of other supplemental benefits (that are available to all enrollees) would be even smaller, if any supplemental benefit reduction would be needed at all.

Combined Costs of Providing All Four Benefits to Eligible Medicare-only Beneficiaries

Based upon the projections and assumptions discussed above, the analysis estimates that the combined cost of providing all four of the illustrative benefits to the targeted subpopulation of Medicare-only beneficiaries who meet the three-part eligibility criteria would range from \$122 *per eligible enrollee* per month to \$158 *per eligible enrollee* per month, depending on whether meal delivery was provided in the form of weekly “bulk” delivery of frozen meals (“Option One”) or via daily delivery for fresh meals (“Option Two”).

Projected Average Cost in 2016 for Financing Non-Medicare-Covered Supports for Medicare-only Beneficiaries Who Are Enrolled in Medicare Advantage Plans and Meet the Three-Part Eligibility Criteria		
Benefit	Average Cost Per Eligible Member Per Month	
	Option One	Option Two
Non-Emergency Medical Transportation	\$1.75	\$1.75
In-Home Meal Delivery <i>Weekly Frozen Meals</i> <i>Daily Fresh Meals</i>	\$1.25	\$2.50
Minor Home Modifications	\$0.25	\$0.25
Targeted Case Management	\$1.00	\$1.00
TOTAL	\$4.25	\$5.50

Source: Acumen, LLC analysis on behalf of BPC, 2017.

The analysis projects that the combined costs of providing eligible Medicare-only MA enrollees with the four targeted non-Medicare-covered supports, when spread across all enrollees in an MA plan, would result in added aggregate average costs across all MA enrollees of between \$4.25 PBPM and \$5.50 PBPM. Therefore, offsetting the cost of these four targeted supports for eligible Medicare-only MA enrollees would require between a 4.8 percent and 6.2 percent reduction in the value of other supplemental benefits that are offered to all MA enrollees. Again, the academic literature suggests that the provision of these four illustrative benefits, when targeted to a chronically ill population, can often result in reductions in hospitalizations and other expensive care episodes. If that experience is borne out by MA plans targeting the four illustrative benefits to Medicare-only MA enrollees who meet the three-part eligibility criteria, it is likely that the necessary reduction in the value of other supplemental benefits (that are available to all enrollees) would be even smaller, if any supplemental benefit reduction would be needed at all.

Applicability to Medicare Advantage versus Accountable Care Organizations

While the analysis above demonstrates that all of the four illustrative targeted non-Medicare-covered supports could be financed within existing MA payments, if uniform benefit requirement changes under the report were adopted, the cost analysis raises some questions regarding the ability of ACOs to finance interventions.

When the no-charge furnishing of the supports is limited to Medicare-only beneficiaries who meet the three-part eligibility criteria, minor home modifications and (to a lesser extent) TCM services could be sufficiently financed within an aggregated annual shared savings payment that an ACO receives. Providing minor home modifications—at no charge, to a subpopulation of eligible Medicare-only beneficiaries who require a home modification during the year—would generate average monthly costs per ACO enrollee that are equivalent to about 5 percent of the average shared savings payment to a risk-bearing ACO.⁵⁵ Under the same assumptions, furnishing TCM services—to eligible Medicare-only beneficiaries who are ultimately prescribed and seek out TCM services—would result in average monthly costs per ACO enrollee that are equivalent to roughly 22 percent of the average shared savings payment to a risk-bearing ACO. The \$720 per-project cost of minor home modifications would amount to 2.4 percent of the \$30,000 average annual per beneficiary spending projected under the analysis for Medicare-only beneficiaries who meet the three-part eligibility criteria.⁵⁶ Meanwhile, the \$1,725 annual per recipient cost of TCM services, as projected in the analysis, would equal approximately 5.8 percent of total spending per beneficiary for Medicare-only beneficiaries who meet the eligibility criteria.

The costs of providing in-home meal delivery and non-emergent medical transport to eligible beneficiaries under the analysis would consume a significantly larger portion of average Medicare shared savings payments for risk-bearing ACOs. Average monthly in-home meal delivery costs per ACO enrollee would constitute between 27 percent and 54 percent of average monthly shared savings payments (depending on whether Option One or Option Two was chosen), while transportation costs would equal 37 percent of average shared savings payments for risk-bearing ACOs.⁵⁷ Likewise, the per recipient costs of in-home meal delivery, as projected under this analysis, would equal between 7.2 percent and 14.4 percent of total Medicare per beneficiary spending for Medicare-only beneficiaries who meet the eligibility criteria.⁵⁸

Given the lack of financial resources, within average shared savings payments, for risk-bearing ACOs to pursue offering non-Medicare-covered supports in a more comprehensive manner for Medicare-only beneficiaries who meet the three-part eligibility criteria, it would be important for ACOs to pinpoint even more targeted groups of beneficiaries from within the eligible subpopulation. For instance, ACOs could target no-charge meal delivery services to a subgroup of attributed beneficiaries who meet the broader three-part eligibility criteria *and* have a specific chronic condition, such as congestive heart failure or diabetes, for which in-home meal delivery of low-sodium or low-sugar meals has proved effective.

Conclusion

As delivery system reform efforts progress, policies to break down barriers to social support integration represent just the beginning of a multi-faceted approach to addressing the needs of high-need, high-cost Medicare patients. Through the policy changes included in the recommendations of this report, the Medicare program could create pathways for MA plans, ACOs, and other providers to better tailor care plans for frail and chronically ill Medicare patients, in a manner that integrates traditional medical care with non-Medicare-covered social supports. The clinical evidence shows that many of these non-Medicare-covered supports, including the interventions addressed in this report's illustrative analysis, have the propensity to improve patient outcomes and reduce avoidable high-cost medical events, such as hospitalizations and emergency department visits.

Although these policies will break down significant barriers for social support integration for MA plans, and even though beneficiary enrollment in Medicare managed care continues to grow, Medicare FFS continues to be the predominant form of Medicare coverage for community-residing Medicare-only beneficiaries who have three or more chronic conditions and functional or cognitive impairment. While the policies in this report relating to ACOs and medical home model participants can help to address a portion of the Medicare FFS population, more efforts are needed to develop analogous solutions to address chronic care management issues and the non-Medicare-covered social support needs of beneficiaries who are enrolled in Medicare FFS. Moreover, though the recommendations from this report can help alleviate some long-term services and supports needs for elderly individuals with functional or cognitive impairment, a more wide-ranging long-term care financing approach remains a critical policy challenge.

Nonetheless, the recommendations of this report present the opportunity for tangible, bipartisan fixes to policy problems that have impeded the evolution of person-centered care in the Medicare program. This report is only the latest in [BPC's continued effort](#) to examine and develop common-sense solutions to improve the nation's health care delivery system.

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Notes



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