Delivery System Reform:
Improving Care for Individuals Dually Eligible for Medicare and Medicaid

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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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Executive Summary

Since 2013, the Bipartisan Policy Center's Health Project has released recommendations to improve value in the U.S. health care system and to finance long-term services and supports (LTSS).[a] Collectively, those recommendations required a comprehensive analysis of alternative payment models (APMs), as well as the financing and integration of health and LTSS. The range of issues involved highlighted the importance of the Medicare and Medicaid programs in addressing the needs of individuals with complex conditions, especially low-income Medicare beneficiaries who are eligible for both Medicare and Medicaid, known as "dual-eligible" beneficiaries.

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a Bipartisan Policy Center, 2016, "Initial Recommendations to Improve the Financing of Long-Term Care." Available online at: http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/01/BPC-Health-Long-Term-Care.pdf.

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The Medicare Access and CHIP Reauthorization Act included an aggressive timeline for the implementation of Medicare physician payment reforms that increase incentives for physician participation in APMs, most of which envision greater coordination of care. While care coordination can be beneficial for all patients, the targeting of services to high-need Medicare patients with chronic conditions, including beneficiaries who are dually-eligible for both Medicare and Medicaid, can be particularly effective in improving outcomes and lowering hospital utilization. As existing reimbursement structures are expanded and new reimbursement models are implemented in Medicare and Medicaid for dual-eligible beneficiaries, policymakers face both challenges and opportunities in the delivery of services to vulnerable populations with complex care needs.

As a part of this report, BPC commissioned an analysis of 2011 Medicare and Medicaid claims and administrative data, to compare cost and utilization patterns for full-benefit dual-eligible beneficiaries relative to other Medicare beneficiaries.[b] Among other trends, this analysis demonstrated that:

- On average, full-benefit dual-eligible beneficiaries have risk scores that are 50 percent higher than the average risk score for all other Medicare beneficiaries. The average full-benefit dual-eligible beneficiary has six chronic conditions, while all other Medicare beneficiaries average only four chronic conditions.[1]
- One-tenth of the full-benefit dual-eligible population accounted for 38.5 percent of total combined Medicare and Medicaid spending on all full-benefit dual-eligible beneficiaries in 2011.[2]
- Average annual Medicare spending for full-benefit dual-eligible beneficiaries is more than twice as high as average annual Medicare spending for all other Medicare beneficiaries.[3]
- Full-benefit dual-eligible beneficiaries have higher rates of hospitalizations and re-hospitalizations for medical conditions such as hypertension, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD), for which comprehensive care can often prevent the need for a hospital inpatient admission for treatment.[4]
- Full-benefit dual-eligible beneficiaries with hypertension are 33 percent more likely to be hospitalized at least once during the year as compared with all other Medicare beneficiaries with hypertension; of Medicare beneficiaries with hypertension who are hospitalized during the year, full-benefit dual-eligible beneficiaries are more than twice as likely to be re-hospitalized during the same year.[5]
- While full-benefit dual-eligible beneficiaries with CHF or COPD exhibit roughly similar initial hospitalization rates as all other Medicare beneficiaries with CHF or COPD, full-benefit dual-eligible beneficiaries are nearly twice as likely to be subsequently re-hospitalized for those conditions during the year.[6]
- For full-benefit dual-eligible beneficiaries with multiple chronic conditions, those with depression have on average 80 percent higher Medicare spending than those without depression.[7]

Evidence suggests that for the conditions outlined above, as well as other ambulatory care sensitive conditions, primary care can potentially reduce hospital admissions and that targeting these

b Full-benefit dual-eligible beneficiaries are those dual-eligible individuals 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 LTSS and certain non-clinical services, such as targeted case-management services and transportation to medical appointments. By contrast partial-benefit dual-eligible beneficiaries are dual-eligible individuals who qualify for Medicare-covered services along with financial assistance from Medicaid to pay for their Medicare premiums and Medicare cost-sharing expenses.

interventions to patients most likely to benefit is critical to success.[8,9] Whether or not full integration of Medicare and Medicaid services will improve quality and lower the total cost of care for dual-eligible beneficiaries will vary based on numerous factors including the care delivery model and state implementation, but there is potential for improved quality and greater value.

A recent evaluation of the Minnesota Senior Health Options program, which coordinates care for dual-eligible beneficiaries, showed a 48 percent reduction in inpatient hospitalizations and a 26 percent reduction in the total number of hospital stays for patients who were hospitalized during the year.[10] In addition, the program was successful in reducing emergency department visits and increasing the use of home and community-based LTSS.[11] Targeting treatment to patients likely to benefit from interventions is a necessary element of a successful care model.[12] These new data will assist in that targeting.

While federal and state policymakers, health plans, and providers have much to learn about the delivery and integration of clinical health services, behavioral health services, and LTSS, evidence suggests that potential for improving quality, value, and patient satisfaction warrants continuing efforts to better integrate these services. BPC recommendations include changes to existing reimbursement structures, consolidating regulatory authority for duals programs within the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services (CMS), and building on lessons learned through implementation of existing programs and demonstrations to develop a consolidated framework for programs serving dual-eligible beneficiaries. Critical to that framework is the ability to combine Medicare and Medicaid financing streams into an integrated benefit structure that allows flexibility in benefit design to address patient needs. Ultimately, delivery system reform presents the opportunity to better integrate Medicare and Medicaid services in a way that improves quality and access to services, while also presenting opportunities to begin to address social determinants of health.

BPC Recommendations

Recommendations to Align Programs for Dual-Eligible Beneficiaries

Medicare Advantage Special-Needs Plans (SNPs)

1. Permanently authorize Medicare Advantage Dual-Eligible SNPs. However, all plans should meet the requirements of Fully Integrated Duals Special-Needs Plans, which fully integrate clinical health services, behavioral health, and LTSS by January 1, 2020.
2. Authorize the Department of Health and Human Services (HHS) secretary to align the Medicare and Medicaid grievance and appeals processes. Where adopting one standard would adversely affect a beneficiary, the HHS secretary should resolve the issue to the benefit of the enrollee. For example, under the aligned process, Medicare claims, like Medicaid claims under current law, should be paid during appeal.
3. The HHS secretary should ensure that the combined Medicare and Medicaid benefits offered through all SNPs are seamless to the beneficiary and to providers. Materials provided to a beneficiary must show the combined benefit, the plan must have a single cost-sharing structure, a single care manager, a single enrollment process and enrollment card, a single claims submission process, and a single contact number for beneficiaries and providers.

Financial Alignment Demonstrations

1. For ongoing demonstrations, CMS should:
    a. Revise contracts to ensure that, where appropriate, rates reflect unanticipated costs of infrastructure investment or significant differences in cost associated with serving certain special-needs populations, such as those with previously untreated mental illnesses or homeless individuals. Note: CMS has made these adjustments in some states;
    b. Ensure that adjustments do not result in increased cost to the federal government over the five-year demonstration period;
    c. Work with states to develop unique state-specific quality and access measures, and to the extent there are savings, permit states to share in a greater percentage of those savings or, where appropriate for high-performing states, permit added flexibility in the scope of covered benefits, while assuring that beneficiaries continue to receive optimal access to care; and
    d. Align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services.
2. CMS should establish additional demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries based on findings from the evaluations of the first-round demonstrations. New demonstrations will allow additional states to gain experience providing managed LTSS to dual-eligible populations and coordinating these services with Medicare acute care.

Program of All-Inclusive Care for the Elderly (PACE)

1. Through newly authorized demonstration authority, CMS should test:
    a. An expansion to individuals, regardless of age, who meet all other PACE criteria and who do not require a nursing home level of care;

b. An option that permits individuals to enroll in PACE, but opt out of adult day services; and

c. An option that includes both Medicare-covered services and a beneficiary "buy-in" of a limited LTSS benefit that is less than the full-range of Medicaid-covered LTSS for individuals who are not eligible for Medicaid and whose income exceeds 300 percent of Social Security income.

2. CMS should permit PACE organizations to enroll beneficiaries during the month, rather than requiring them to wait until the first of the month to enroll. CMS should pro-rate the monthly per-capita payment.

Recommendations to Integrate Care for Dual-Eligible Beneficiaries

Align Oversight of Programs Serving Dual-Eligible Beneficiaries within the Centers for Medicare and Medicaid Services

Consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office. Congress directed HHS to establish an office responsible for integrating care for dual-eligible beneficiaries; however, existing agencies within CMS retain regulatory authority over programs serving dual-eligible beneficiaries. Consolidating this authority will help ensure that decisions affecting these programs are made through the lens of an integrated program that takes into account the impact on beneficiaries, as well as state implementation.

Reimbursement structures would include SNPs, PACE, current and future demonstrations, and a new contract authority described below. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a leadership team whose single focus is addressing the unique needs of low-income populations with complex needs through an entity that has the authority to address those needs.

Develop a Revised Regulatory Structure

1. Policymakers should build on lessons learned from existing programs and demonstrations to develop a contractual model similar to the innovative "three-way" contract between CMS, states, and plans under the financial alignment demonstration. A new model three-way contract should be uniform with respect to basic structure, beneficiary protections, quality requirements, care coordination, and continuity of care requirements. At the same time, it should be flexible enough to permit variation in delivery, provider, and reimbursement models, as well as state-level decisions, such as eligibility for optional populations.

2. In developing a framework for a model contract:

   a. The HHS secretary should make decisions based on recommendations of an informal working group consisting of stakeholder organizations, including consumer and family representatives, non-provider experts in the delivery of clinical health services, LTSS, including home and community-based care, community and public health services for special-needs populations, employers (for those participating in a Medicaid buy-in program), disability experts, health plans, health care providers, state Medicaid officials and other relevant stakeholder organizations. The HHS secretary should promulgate regulations based on the framework developed; or

   b. Alternatively, require negotiated rulemaking under the Administrative Procedure Act to develop the framework of a three-way contract. This approach, while more complicated than the regular "notice-and-comment" rulemaking process, would provide for greater transparency and give an equal voice to all members of the appointed rulemaking committee.

Introduction

Since 2013, the Bipartisan Policy Center's Health Project has released recommendations to improve value in the U.S. health care system and to finance long-term services and supports (LTSS).[c] Collectively, those recommendations required a comprehensive analysis of alternative payment models (APMs), as well as the financing and integration of health and LTSS. The range of issues involved highlighted the importance of the Medicare and Medicaid programs in addressing the needs of individuals with complex conditions, especially low-income Medicare beneficiaries who are eligible for Medicare and Medicaid, known as "dual-eligible" individuals.

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As part of the Patient Protection and Affordable Care Act (ACA), Congress gave the Health and Human Services (HHS) secretary unprecedented authority to test new health care payment models in Medicare and to expand the scope of models that lower costs and/or improve or maintain quality of care.[13] In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA),[14] Congress imposed an aggressive timeline to implement physician payment reform based on participation in APMs and models that improve coordination across the care continuum. As new reimbursement structures are implemented in Medicare, policymakers must recognize the challenges associated with making certain that vulnerable populations with complex needs are ensured continuity of care and do not lose access to services. At the same time, policymakers should also seek opportunities in delivery system reform to improve quality and access to services.

In recent years, public health researchers have joined with health plans and provider organizations to better understand and document treatment of patients with complex health care needs. There is emerging consensus around common elements of successful care models, strategies for stratifying risk to target services for improved outcomes, and the importance of addressing social determinants of health,[d] particularly for low-income patients. Public health experts define social determinants to include a broad array of issues that include but are not limited to: income, employment, and environmental health. However, for the purposes of this discussion, we refer to a limited array of evidence-based interventions that include a subset of many of the health-related services that have potential to improve patient outcomes. These services are not reimbursed under Medicare's fee-for-service (FFS) payment structures, and other reimbursement structures may lack the necessary flexibility to address these types of interventions.[15] As a result, the current reimbursement structures fail to adequately reimburse health care providers for services necessary to align existing care models with the growing population of Medicare beneficiaries with multiple chronic conditions and complex needs, making care models fiscally unsustainable over the long-term.

This report examines reimbursement structures that serve dual-eligible beneficiaries, including Special-Needs Plans (SNPs) in Medicare Advantage (MA), the Program of All-Inclusive Care for the Elderly (PACE), and Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative demonstration. BPC will issue a second report in 2017 to address similar issues in other Medicare reimbursement structures, including MA, the Medicare Shared Savings Program (MSSP), and Medicare demonstrations.

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d Social determinants of health can be defined as social, economic, and physical conditions of an individual's life and surrounding environment, such as income, housing, and nutritional factors, that impact the health outcomes of the individual. For more details on efforts to identify social determinants of health, see: HHS Office of Disease Prevention and Health Promotion. *Healthy People 2020: Social Determinants of Health.* Available online at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

Caring for High-Need Populations

A variety of considerations are driving policymakers' increased focus on developing solutions within federal health programs to address high-need patients[e] and individuals with multiple chronic conditions.[16] This specific population incurs higher per-capita health care and LTSS costs relative to the overall Medicare beneficiary population.[17] High-need beneficiaries also account for a disproportionate share of federal health care spending, as Medicare beneficiaries with four or more chronic conditions accounted for only 37 percent of the beneficiary population, but incurred 74 percent of total Medicare costs in 2010.[18] These high-need beneficiaries with four or more chronic conditions accounted for 90 percent of Medicare hospital readmissions in 2010.[19]

People with multiple chronic conditions typically have higher utilization of services, such as emergency room visits, hospitalizations, and eventual need for LTSS.[20] Individuals with multiple chronic conditions may also experience functional or cognitive impairments.[21] In the Medicare program, the most prevalent chronic conditions include hypertension, hyperlipidemia, diabetes, and coronary artery disease.[22]

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e In this report, we use the term "high-need" patients to describe patients with clinically complex conditions, cognitive or physical limitations, or behavioral health problems that contribute to outsized use of health care services, as previously defined in Commonwealth Foundation research available here: http://www.commonwealthfund.org/publications/blog/2015/oct/fostering-a-high-performance-health-system-sickest-and-frailest.

Efforts to Address High-Need Populations

Evidence suggests that models of care that integrate health care and social services can, in some cases, confer substantial health benefits for patients and allow for improved efficiency in health care delivery.[23] For example, one study suggests that the integration between health care and housing services, when targeted at high-need individuals who are homeless, can result in net health care savings both for the patient and the health care system as a whole.[24] Another study links increased access to nutritional assistance to positive health outcomes for high-risk women, children, and individuals with disabilities.[25]

However, other research on the integration of health care and social support services indicates that improved health outcomes and reduced spending for the dual-eligible population cannot be achieved solely through financial integration of social supports and acute care payment arrangements.[26] Instead, cultural changes to health plan approaches to care management (in addition to financial integration), such as increased focus on person-centered care planning, are found to be a necessary component for successful models of care.[27] Financial-integration advances under the Dual-Eligible SNP (D-SNP) model in MA and the PACE model show promise in better integrating care, but changes to programmatic requirements for PACE plans and D-SNPs could allow for greater progress, as discussed in more detail below.

Increasingly, researchers suggest the value of focusing on a subset of health-related interventions to address social determinants of health as a means of improving health outcomes and increasing value. This focus has led to a call for more outcomes-based payment models, in which providers are incentivized to target these social determinants of health to improve care, especially for high-need patients.[28]

Elements of Successful Care Models

Research suggests that common elements of successful care models include: targeting patients likely to benefit from interventions, comprehensive patient assessments, evidence-based care planning and patient monitoring, and promoting patient and caregiver engagement, among other practices.[29] These research findings also indicate that the provision of preventive home visits can result in improvements in functional autonomy, survival rates, and lengths of hospital stays.[30]

One additional feature of successful models of care is the provision of comprehensive transitional care after hospitalization.[31] High-need patients with chronic conditions have an increased risk of hospital readmission due to poor follow-up and coordination between the hospital and primary care providers.[32] By engaging patients and their caregivers in the hospital-discharge planning process, conducting regular follow-up visits (at least once a month), and ensuring coordination between the hospital and primary care providers, transitional care interventions may reduce both short-term and long-term hospital readmissions for high-need patients.[33]

Finally, analyses of care-management programs suggest that successful models must balance the need to focus on complex, high-need patients with the imperative of ensuring that the illness is still manageable and that palliative or hospice care would not be a more appropriate approach.[34] This research also indicates that using specially trained care managers in a team-based approach that includes physicians is often beneficial for care-management programs that focus on complex patients.

Barriers to the Spread and Scale of Successful Care Models

Barriers to the spread and scale of sustainable care models include financial incentives, capacity to change, culture and workforce, infrastructure, and evidence.[35] Researchers note that a lack of reimbursement within the FFS payment system for providing care coordination and supportive services creates an impediment to implementing patient-focused care models for high-need patients.[36] Caseload stresses on primary care providers and professional uncertainty relating to adoption of patient-centered care were identified as "capacity-for-change barriers" and cultural barriers to successful care model implementation.[37]

The recommendations in this report suggest ways to mitigate barriers by identifying legal and policy obstacles to the spread and scale of these models. One significant barrier has been reimbursement in federal and state programs, such as Medicare and Medicaid. Provider organizations seeking to improve care integration for patients with multiple chronic conditions frequently discover federal or state reimbursement rules that preclude payment for, and in some cases preclude coverage of, services that health providers believe could avert costlier emergency or hospital inpatient visits.

In recent years, there has also been an increasing focus in academic research on the influence of non-medical factors—such as income, education level, employment status, and access to housing and nutritious food—on health status, especially for those with complex needs.[38] These social determinants of health are estimated to influence approximately 40 percent of health outcomes.[39] Some social determinants of health are directly linked to several chronic conditions affecting the high-need population. For example, a lower-income is linked to a higher risk of hospital readmission, living conditions are linked to a risk of asthma, and access to healthy foods can affect the risk of diabetes.[40]

Increasingly, policymakers are exploring ways to bridge the gap between clinical health services and health-related services that have an impact on health status. As a part of a recent report on the taxonomy of a fully integrated insurance plan, the Long-Term Quality Alliance highlighted several critical elements of fully integrated plan models, including: establishing single comprehensive care plans that utilize interdisciplinary teams, developing risk stratification of membership, and having a plan for accepting responsibility for integrating medical care, post-acute care, behavioral health, pharmacy, transitional care, and LTSS, including transportation and some alignment with housing.[41]

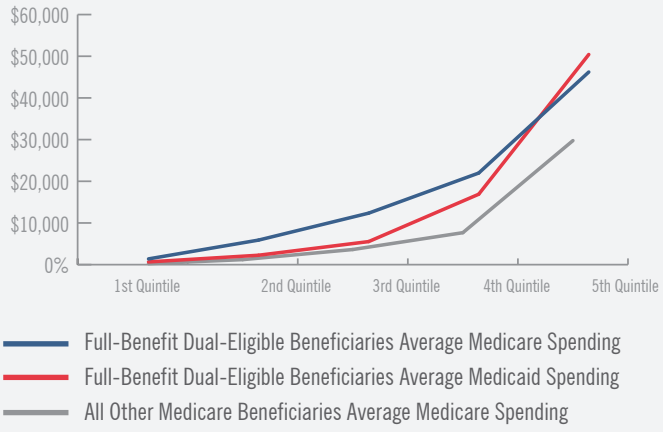
Preliminary evidence shows that the most promising approaches to non-clinical health-related interventions that have potential to address social determinants of health include assistance with housing and nutrition. However, policymakers have expressed concern about the need to ensure that such efforts strike the appropriate balance of providing assistance without resulting in a significant shift of costs to federal entitlement programs.[42] In Medicare, accountable care organizations (ACOs) have allocated independent, non-Medicare-reimbursed resources toward providing short-term housing upon hospital discharge for vulnerable patients in an effort to reduce hospital readmissions and help keep Medicare per-beneficiary spending below predetermined spending benchmarks.[43] Increasingly, CMS has granted waivers under Medicaid for states seeking to provide even greater flexibility in coverage of community-based services to lower health care costs, as well as providing guidance on regulatory allowances for the coverage of housing-related activities and services under Medicaid.[44] Examples of other social determinants of health-focused community-based services that could lower costs include coverage of air conditioners for children with asthma and small refrigerators for diabetic patients who have no other means to safely store insulin.

Special Characteristics of Dual-Eligible Beneficiaries

Common challenges for high-need patients are exacerbated for low-income elderly patients and individuals with disabilities who are eligible for both Medicare and Medicaid coverage. In some cases, a dual-eligible individual may be very similar to a traditional Medicare beneficiary, such as an older American with diabetes and heart disease. Conversely, a dual-eligible individual may be relatively healthy from a physical standpoint, but management of the beneficiary's Alzheimer's disease may require constant supervision. A dual-eligible beneficiary may be a young adult with an intellectual disability in supported employment. A dual-eligible individual could also be a middle-aged patient with a serious mental illness or a working individual who is physically disabled but otherwise healthy.

Many dual-eligible beneficiaries have higher medical acuity, significant cognitive and functional impairments, and a greater need for care coordination and assistance with activities of daily living (ADLs).[45] While only 20 percent of Medicare beneficiaries (and only 14 percent of Medicaid beneficiaries) were dually eligible in 2011, dual-eligible individuals accounted for 35 percent of the Medicare program spending, and 33 percent of combined federal and state spending on Medicaid.[46]

Figure 1. Average Spending Per Beneficiary by Quintile of Total (Combined Medicare and Medicaid) Spending (CY 2011)



Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

In fiscal year (FY) 2015, approximately 10.3 million individuals qualified as being dually eligible for Medicare and Medicaid coverage.[47] Roughly 60 percent of dual-eligible beneficiaries were over age 65, while the remaining 40 percent of dual-eligible beneficiaries were individuals with disabilities under age 65.[48] While not all dual-eligible beneficiaries are expensive, these patients are among the most medically complex individuals in the health system, and they often have wide-ranging care needs that require additional services and supports.[49] An estimated 87 percent of full-benefit dual-eligible beneficiaries have multiple chronic conditions, while 54 percent of full-benefit dual-eligible beneficiaries have at least one behavioral-health condition or cognitive impairment.[50] Roughly 29 percent of these patients have two or more ADL limitations.[51]

Depression and Alzheimer's disease[f] ranked among the most prevalent chronic conditions for dual-eligible beneficiaries, along with conditions such as heart disease, congestive heart failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD), which are widespread in both the dual-eligible and non-dual subpopulations.[52] Behavioral-health issues, particularly for the dual-eligible population, often amplify the complexity of the health status of beneficiaries with chronic conditions.

This report focuses specifically on dual-eligible beneficiaries as a means of targeting a high-need population where current reimbursement structures within Medicare and Medicaid have created barriers to integrated financing and delivery of care.

Medicare's Role for Dual-Eligible Beneficiaries

1. Eligibility

Individuals become eligible for Medicare through one of several pathways. The predominant eligibility pathway for Medicare enrollment is age-based eligibility. In 2012, roughly 83 percent of Medicare beneficiaries qualified on the basis of being age 65 or older.[53] An additional 16 percent of beneficiaries are eligible for Medicare coverage on the basis of disability.[54] For these Medicare beneficiaries with disabilities, Medicare eligibility is triggered by the individual having received Social Security Disability Income (SSDI) payments for a permanent disability for at least 24 months.[55] Finally, beneficiaries may qualify for Medicare coverage on the basis of being afflicted with End-Stage Renal Disease (ESRD). These patients are eligible for Medicare irrespective of their age and any disabling conditions, and make up 0.8 percent of the overall Medicare population.[56]

f Including Alzheimer's-related dementia.

g The Medicare program also provides automatic enrollment in premium-free Medicare Part A and Medicare Part B for individuals that are receiving "full retirement" cash benefit payments under Social Security or are eligible to receive payments under the Railroad Retirement Board benefits program. See Centers for Medicare and Medicaid Services. *Original Medicare (Part A and B) Eligibility and Enrollment*. Available online at: https://www.cms.gov/medicare/eligibility-and-enrollment/origmedicarepartabeligenrol/index.html.

The original Medicare FFS benefit is divided into Medicare Part A and Medicare Part B. Most individuals are eligible for "premium-free" Part A benefits, unless the beneficiary (and the beneficiary's spouse, as applicable) was not employed in a Medicare payroll-tax-covered position for at least 40 calendar quarters (ten years).[g] In order to receive Medicare Part A coverage, individuals who fail to meet the 40-quarters threshold must pay Part A premiums that are tied to the number of quarters worked in a payroll-tax-applicable employment position.[57] However, all Medicare beneficiaries who qualify for enrollment on the basis of disability (and most beneficiaries with ESRD) receive premium-free Part A coverage, regardless of whether the 40-quarters threshold is met.

By contrast, all Medicare beneficiaries who elect to enroll in Medicare Part B coverage must pay income-indexed monthly premiums for Part B-covered services,[58] although certain dual-eligible beneficiaries receive assistance with Part B premiums and cost-sharing through the Medicare Savings Programs,[59] and many dual-eligible beneficiaries have their Medicare Part B premiums paid by a state Medicaid program.

2. Benefits

For dual-eligible beneficiaries, Medicare is the primary payer of acute care and clinical health services. As such, Medicare covers clinical health services such as hospitalization, physician office visits, surgical procedures, and in certain circumstances, skilled home health care, skilled nursing facility care, and rehabilitation services.[h, 60] In general, the Medicare Part A benefit covers hospital inpatient services and post-acute care services delivered in either inpatient facilities or through home health care provided in a beneficiary's residence. Medicare Part B covers professional services furnished by physicians and other non-physician practitioners, hospital outpatient facility and ambulatory surgical center services, certain home health services, dialysis services, and clinical-laboratory services.

3. Delivery and Reimbursement Models

Medicare Part A- and Part B-covered services are largely provided through Medicare FFS, which operates several distinct and separate payment systems and fee schedules for different facility types and service categories. While about 70 percent of Medicare beneficiaries remain in Medicare FFS, roughly 30 percent of beneficiaries elect to receive Part A- and Part B-covered services through managed care plans, known as MA plans.[61] These plans, established under Part C of Medicare, receive risk-adjusted capitated payments in exchange for accepting full risk for the costs of a beneficiary's care. Finally, for prescription drug coverage, Medicare beneficiaries have the option of enrolling in Medicare Part D prescription drug plans offered by commercial insurance carriers and pharmacy benefit-management entities. These plans contract with pharmacies for coverage of drug therapies at the point of service and with pharmaceutical manufacturers for drug rebates.[62] Roughly 71 percent of Medicare beneficiaries are enrolled in Part D coverage, provided through standalone Part D plans, or via MA-Prescription Drug coverage that is integrated into a beneficiary's MA plan.[63] Part D coverage is financed through a combination of beneficiary premiums and government payments made to the plans by the Centers for Medicare and Medicaid Services (CMS).

h Other services covered by Medicare include: laboratory and X-ray services, physical therapy, prescription drugs, durable medical equipment, and hospice.

Medicaid's Role for Dual-Eligible Beneficiaries

1. Eligibility

Much like Medicare eligibility, dual-eligible beneficiaries can qualify for Medicaid coverage through one of many eligibility pathways. These beneficiaries may have low-incomes and or disabling conditions, and be eligible to receive cash assistance under the Supplemental Security Income program.[64] They may be low-income adults who qualify for Medicaid and age into Medicare, at which point Medicare becomes the primary insurer, and Medicaid provides secondary, or wrap-around, coverage.[65] A dual-eligible individual may also be an older American who exhausts his or her savings, or has monthly medical and LTSS expenses that cause the beneficiary to "spend-down" into Medicaid coverage.

2. Benefits

For full-benefit dual-eligible individuals, who qualify for the full range of Medicaid-covered benefits, Medicaid covers clinical health services that are not covered by Medicare, as well as non-clinical services, such as targeted case-management services and transportation to medical appointments. States must cover certain mandatory benefits under Medicaid, while other services are optional. In this role, Medicaid covers LTSS, including many services dealing with beneficiaries' impairments with ADLs, in either an institutional setting for nursing facility residents or via personal-care services and other home and community-based services provided in a beneficiary's home or in a community setting.[66] For "partial-benefit" dual-eligible individuals, who are eligible for financial assistance from Medicaid based on their income but are not eligible to receive Medicaid-covered services, Medicaid may cover their Medicare premiums and cost-sharing for services covered by Medicare.[67]

3. Delivery and Reimbursement Models

Though the Medicare and Medicaid programs are both authorized under the Social Security Act, Medicare is administered by the federal government, whereas Medicaid is jointly financed by the federal government and the applicable state government. While federal rules apply to Medicare, Medicaid is administered by the state in accordance with federal rules.

An individual's experience with care management of Medicare and Medicaid service needs could be fundamentally different based on the timing of the commencement of eligibility for each program. Beneficiaries with permanent disabilities can qualify for Medicaid on the basis of their eligibility for Supplemental Security Income (SSI), with Medicaid coverage becoming effective immediately, while waiting for the two-year SSDI-related waiting period to pass before becoming eligible for Medicare on the basis of disability. These beneficiaries who become eligible for Medicaid well before becoming eligible for Medicare are likely to have significant fragmentation of coverage for different Medicaid-covered services across separate Medicaid managed care plans (e.g., a beneficiary could have different combinations of Medicaid FFS and multiple Medicaid limited-benefit managed care plans providing coverage for dental services, behavioral health services, and LTSS services). For many dual-eligible beneficiaries, the separation of Medicare and Medicaid benefits, and the "carving out" of certain Medicaid benefits from managed care contracts, can lead to a fragmented care model, in which the beneficiary must navigate multiple plans or payers depending on the type of service being furnished.

For instance, in 2011, roughly 4.4 million dual-eligible beneficiaries were enrolled in at least one limited-benefit Medicaid managed care plan.[68] Of these beneficiaries, approximately 400,000 dual-eligible individuals were enrolled in more than one limited-benefit Medicaid managed care plan, most commonly for limited-benefit dental coverage or limited-benefit behavioral health services coverage.[69] Adding to the benefit fragmentation complexity,

a dual-eligible beneficiary's enrollment in these multiple limited-benefit Medicaid managed care plans comes in addition to separate enrollment in Medicare FFS or an MA plan for their Medicare-covered services.

Dual-Eligible Beneficiaries in Managed Care

The Medicare FFS delivery approach remains the predominant form of Medicare coverage for dual-eligible beneficiaries. As of June 2015, only about 20 percent of the nation's 10.3 million dual-eligible beneficiaries were enrolled in the types of organized systems of care examined in this report, such as D-SNPs, MMPs, and PACE models.[i] Of this group, nearly 1.7 million beneficiaries, or about 16.5 percent of the dual-eligible population, were enrolled in D-SNPs under the MA program.[70] Roughly 355,000 additional dual-eligible beneficiaries were enrolled in an MMP under the Financial Alignment Initiative,[71] while approximately 33,000 beneficiaries were enrolled in PACE.[72]

The prevalence of managed care enrollment for Medicaid-covered services is limited among dual-eligible beneficiaries; only 17 percent of elderly Medicaid beneficiaries and only 37 percent of Medicaid beneficiaries with disabilities were enrolled in a comprehensive managed care plan in 2012.[73] By contrast, 58 percent of full-benefit dual-eligible beneficiaries received their Medicaid benefits through Medicaid FFS arrangements in 2011.[74]

Figure 2. Dual-Eligible Beneficiaries Enrolled in Organized Systems of Care

Total Dual-Eligible Beneficiaries (June 2015)	10.3 Million
Total D-SNP Enrollment (June 2015)	1,693,593
Total MMP Enrollment (June 2015)	354,904
Total PACE Enrollment (September 2015)	33,003
Combined D-SNP/MMP/PACE Enrollment	20.2% of Dual–Eligible Population

Source: Centers for Medicare and Medicaid Services.

i Based on CMS enrollment data for 2015, out of 10.33 million dual-eligible beneficiaries, 1,693,593 beneficiaries were enrolled in D-SNPs, while 354,904 were enrolled in Medicare-Medicaid Plans under the Financial Alignment Initiative, and an additional 33,003 beneficiaries were enrolled in PACE—together account for 2,081,500 dual-eligible beneficiaries, or 20.2 percent of the total dual-eligible population.

BPC Data Analysis

As a part of this report, BPC commissioned an analysis of Medicare and Medicaid service-utilization data, which was aimed at identifying key features of care patterns for full-benefit dual-eligible beneficiaries,[k] as compared with all other Medicare patients.[j] In comparing full-benefit dual-eligible beneficiaries with all other Medicare beneficiaries, this analysis focused on a number of characteristics, including per-capita spending, average number of chronic conditions per beneficiary, hospitalization rates, and a variety of other elements (see Appendix for more details).

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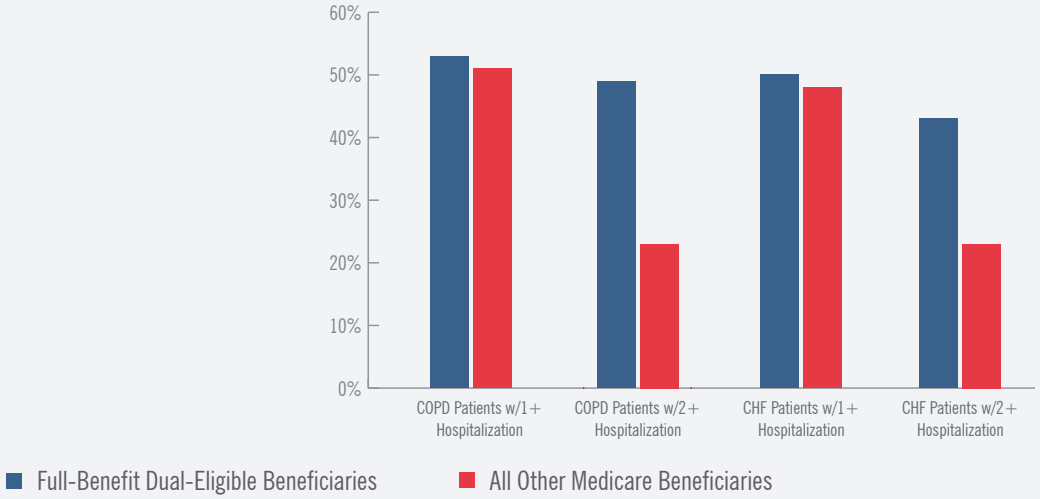
j The BPC analysis excludes Medicare beneficiaries with ESRD from both the full-benefit dual-eligible beneficiary category and the "all other Medicare beneficiaries" category. ESRD patients were excluded from the analysis for a number of reasons. As a result of their need for regular dialysis treatments and serious co-morbidities, ESRD beneficiaries have extremely high costs. The Medicare program also pays for their care differently than for other beneficiaries, using a special "composite rate." Although they comprise only 0.8 percent of Medicare beneficiaries, ESRD beneficiaries account for an outsized portion of total Medicare spending. Given their unique health needs and care model, this special population differs significantly from other dual-eligible beneficiaries and other Medicare patients with multiple chronic conditions.

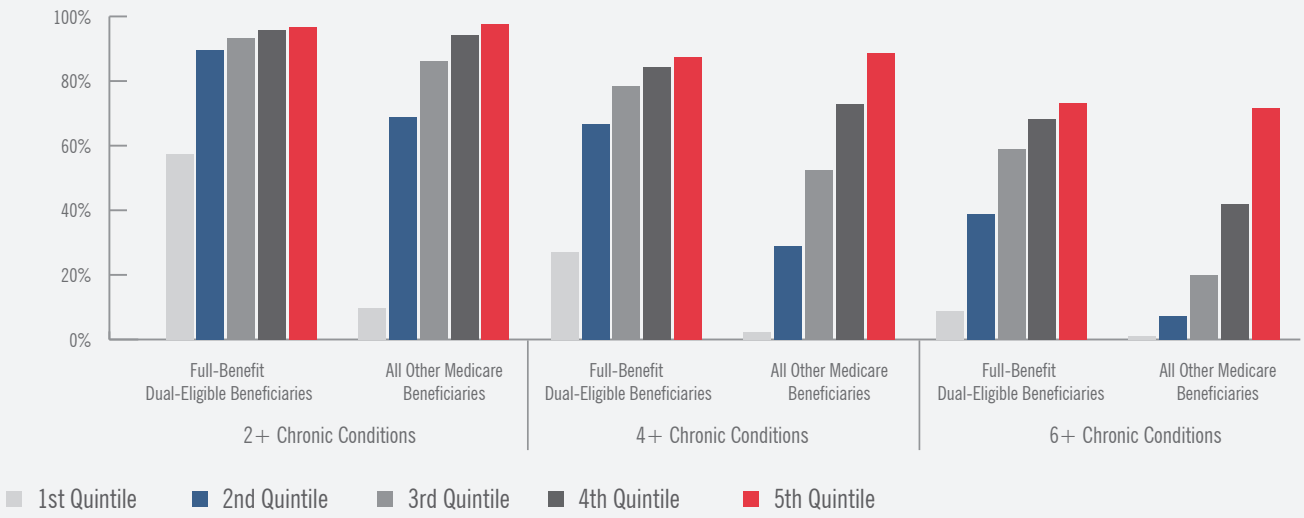
k Because of the marked differences between full-benefit dual-eligible beneficiaries and partial-benefit dual-eligible beneficiaries, as well as the relative similarity of partial-benefit dual-eligible beneficiaries to non-dual-eligible Medicare beneficiaries, our analysis includes partial-benefit dual-eligible beneficiaries in the "all other Medicare beneficiaries" category, along with Medicare beneficiaries who are not eligible for any assistance from Medicaid.

Figure 3. Re-Hospitalization Differences for Beneficiaries with Ambulatory Care Sensitive Conditions (CY 2011)



Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center

Figure 4. Average Number of Chronic Conditions by Quintile (CY 2011)



Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

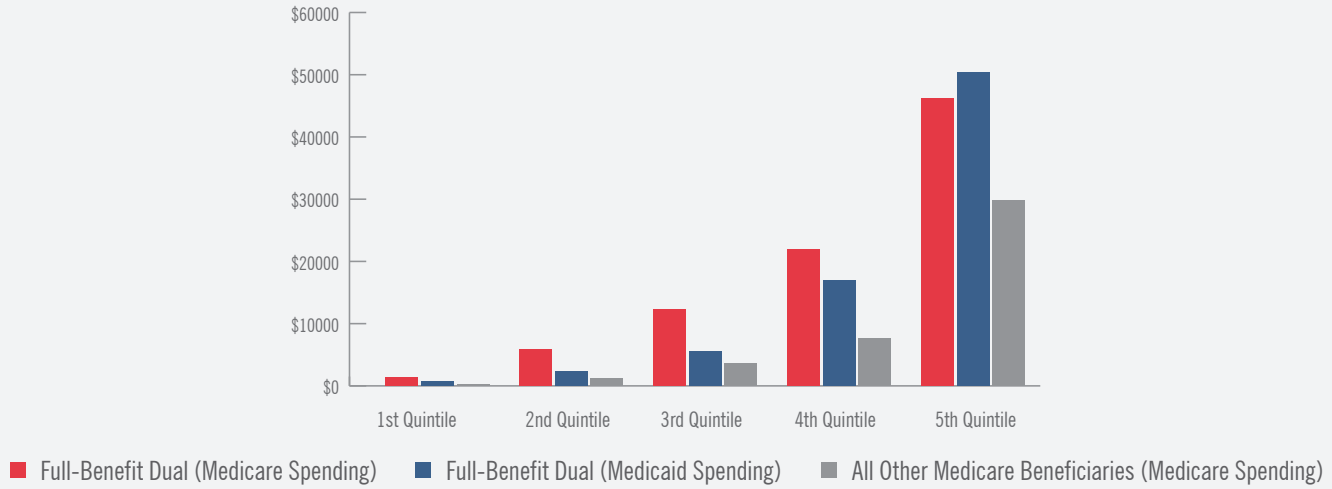
BPC's analysis indicates that full-benefit dual-eligible beneficiaries display a number of unique characteristics that result in higher spending and worse clinical outcomes compared with all other Medicare beneficiaries. In particular, BPC's analysis demonstrates that, on average, full-benefit dual-eligible beneficiaries have risk scores that are 50 percent higher than the average risk score for all other Medicare beneficiaries.[75] These risk scores measure a patient's health acuity and condition severity relative to the average Medicare beneficiary and are derived from a combination of factors, including age and medical conditions for which the beneficiary has been diagnosed. Risk scores are designed and used in various rate-setting methodologies to help predict how costly an individual patient may be for a given year, as compared with the average Medicare patient.

The BPC analysis also indicates that the average annual Medicare spending for full-benefit dual-eligible beneficiaries is more than twice as high as the average annual Medicare spending on all

other Medicare beneficiaries.[76] Combined Medicare and Medicaid spending within the full-benefit dual-eligible population is heavily concentrated among the most expensive subpopulation. In 2011, one-tenth of the full-benefit dual-eligible population accounted for 38.5 percent of total combined Medicare and Medicaid spending for all full-benefit dual-eligible beneficiaries.[77]

For full-benefit dual-eligible beneficiaries with multiple chronic conditions, those with depression have, on average, 80 percent higher Medicare spending than those without depression. In 2011, 48 percent of full-benefit dual-eligible beneficiaries with six or more chronic conditions had diagnoses of depression, with an average Medicare per-beneficiary spending totaling $31,572 per year.

Figure 5. Average Spending per Beneficiary by Quintile of Total (Combined Medicare & Medicaid) Spending (CY 2011)



Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Full-benefit dual-eligible beneficiaries also have higher rates of hospitalizations and re-hospitalizations for several ambulatory care sensitive conditions, such as hypertension, CHF, and COPD. Ambulatory care sensitive conditions are medical conditions for which comprehensive care in the community and outpatient settings can often prevent the need for a hospital inpatient admission to treat the condition.[78] In this context, hospitalizations for ambulatory care sensitive conditions can be viewed as a poor health outcome from a quality-of-care perspective. BPC's analysis shows that full-benefit dual-eligible beneficiaries with hypertension are 33 percent more likely to be hospitalized at least once during the year, and are twice as likely to be re-hospitalized during the year, as compared with all other Medicare beneficiaries with hypertension.[79] While full-benefit dual-eligible beneficiaries with CHF and COPD exhibit roughly similar initial hospitalization rates as all other Medicare beneficiaries with CHF and COPD, approximately 86 percent of these full-benefit dual-eligible beneficiaries were subsequently re-hospitalized for those conditions during the year, compared with a re-hospitalization rate of only about 48 percent for all other Medicare beneficiaries who were hospitalized for CHF or COPD during the year.[80] These much higher rates of potentially preventable re-hospitalizations among full-benefit dual-eligible beneficiaries suggest that employing systems of care with the ability to better align financing and delivery of Medicare- and Medicaid-covered services could both improve quality and reduce costs.

Policy Implications

Whether or not full integration of Medicare and Medicaid services will improve quality and lower the total cost of care for dual-eligible beneficiaries will likely vary based on the care delivery model and state implementation, but there is potential for improved quality and greater value. A recent evaluation of the Minnesota Senior Health Options program by RTI International, for example, demonstrated from 2010 to 2012 that the program achieved a 48 percent reduction in inpatient hospitalizations and a 26 percent reduction in the total number of hospital stays for patients who were hospitalized during the year.[81] In addition, the program was successful in reducing emergency department visits and increasing the use of home- and community-based LTSS.[82]

While the Minnesota study compares individuals in Medicare FFS with those enrolled in fully integrated plans, other evidence indicates that fully integrated SNPs demonstrate higher quality than non-integrated SNPs, particularly for individuals with disabilities. In a 2014 report, the Government Accountability Office noted that Fully Integrated Duals Special-Needs Plans (FIDE-SNPs) were far more likely than other D-SNPs to meet criteria for high quality.[83] Further surveys of patients enrolled in the Financial Alignment Initiative indicate high rates of satisfaction with the care they receive.[84] Focus groups conducted by the University of California show overall satisfaction with the California financial alignment demonstration to be high. On a scale from one to ten, the average satisfaction score for those enrolled in Cal MediConnect was eight, with beneficiaries citing expanded care-coordination services helpful in navigating their managed care plan and determining satisfaction.[85]

There is no question that there is much to learn about integrating care for dual-eligible beneficiaries. While a relatively small number of states have more than a few years of experience fully integrating Medicare and Medicaid services for dual-eligible beneficiaries over age 65, even fewer have experience with the under 65 population, which MMP sponsors characterize as having higher than average rates of untreated behavioral health issues and/or prevalence of homelessness. BPC recommendations acknowledge the variation in states' experiences by amending existing reimbursement models, including MA SNPs, MMPs and additional demonstrations, and PACE. At the same time, BPC recommendations envision a pathway for CMS, states, and providers to transition to a structure that allows greater integration of services. This approach promotes patient-centered care that recognizes the unique characteristics of people dually eligible for Medicare and Medicaid, and the challenges of providing high-quality care to a vulnerable population.

Recommendations: Aligning Reimbursement Structures for Dual-Eligible Beneficiaries

Medicare Advantage Special-Needs Plans

1. Permanently authorize Medicare Advantage D-SNPs. However, all plans should meet the requirements of Fully Integrated Duals Special-Needs Plans, which fully integrate clinical health services, behavioral health and LTSS by January 1, 2020.

2. Authorize the HHS secretary to align the Medicare and Medicaid grievance and appeals processes. Where adopting one standard would adversely affect a beneficiary, the HHS secretary should resolve the issue to the benefit of the enrollee. For example, under the aligned process, Medicare claims, like Medicaid claims under current law, should be paid during appeal.

3. For fully integrated D-SNPs, the HHS secretary should ensure that the combined Medicare and Medicaid benefits offered through the fully integrated plan are seamless to the beneficiary and to providers. Materials provided to a beneficiary must show the combined benefit, the plan must have a single cost-sharing structure, a single care manager, a

single enrollment process and enrollment card, a single claims submission process, and a single contact number for beneficiaries and providers.

Permanent Authorization and Integration

As of 2016, 17.6 million Medicare beneficiaries, or 31 percent of the Medicare population, are enrolled in MA, Medicare's private managed care option.[86] SNPs, a subset of MA plans, were established under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. SNPs were introduced as a means of better coordinating Medicare and Medicaid benefits for dual-eligible beneficiaries. Three categories of SNPs were established: those serving institutional residents (Institutional Special-Needs Plans, or I-SNPs); those serving Medicare beneficiaries with severe or disabling chronic conditions (Chronic Condition Special-Needs Plans, or C-SNPs); and those enrolling individuals who are dually eligible for Medicare and Medicaid (D-SNPs). D-SNPs were intended to permit better coordination of care between the Medicare and Medicaid programs for dual-eligible beneficiaries by allowing plans to offer "the full array of Medicare and Medicaid benefits, and supplemental benefits, through a single plan so that beneficiaries have a single benefit package and one set of providers to obtain the care they need."[87] More recently, Congress authorized FIDE-SNPs.[88] Unlike D-SNPs, these plans must provide access to all Medicare and Medicaid-covered benefits through a single managed care organization.

SNPs came under considerable scrutiny during the initial years of operation because of rapid growth, concerns about high payment rates, and lack of quality care coordination for patients with complex needs.[89] After the first few years, rapid growth rates began to level, and enrollment has been steady. In recent years, SNPs have continued through a series of reauthorizations by Congress. These extensions added additional program requirements to address previous concerns, including requirements that plans have contracts with states to offer Medicaid benefits, submit a Model of Care subject to review by the National Committee for Quality Assurance, and become subject to quality-based payment procedures for all MA plans.[90] Most recently, MACRA extended the authority of the program through December 31, 2018.[91]

D-SNPs

In 2013, the Medicare Payment Advisory Commission (MedPAC), an independent congressional agency established to advise the Congress on issues affecting the Medicare program, issued a report making recommendations on the future of SNPs.[92] MedPAC found that while D-SNPs, in the aggregate, performed on average or below average relative to other SNPs and MA plans, D-SNPs that had contracts with states to provide managed Medicaid services—such as integrating LTSS, behavioral health, or both—performed well on quality measures. MedPAC recommended that Congress permanently authorize D-SNPs that clinically and financially integrate care, by a vote of 16 to zero, with one member absent.[93]

However, most Medicaid managed care plans enrolling dual-eligible beneficiaries do not cover the full range of Medicaid benefits to which dual-eligible beneficiaries are entitled, making it difficult, if not impossible, to fully align and integrate services.[94] The most common benefits excluded are behavioral health services and some or all of Medicaid LTSS covered by the state. While D-SNPs are at risk for Medicare benefits, not all offer Medicaid benefits on a risk basis. In many states, these plans coordinate Medicaid benefits and those that do cover Medicaid benefits are limited to acute care benefits not covered under Medicare (e.g., transportation, vision).

In cases in which benefits are not within the scope of services offered by a plan, the ability of providers to coordinate care is limited. This lack of care coordination is particularly serious for dual-eligible beneficiaries, 69 percent of whom have four or more chronic conditions.[95] For example, if a patient with diabetes and depression receives diabetes treatment from a physician in a plan that covers treatment of medical conditions, and the beneficiary receives behavioral health services from a separate provider, there is little incentive for the mental health provider to ensure that the

patient's depression does not interfere with the patient's ability to manage blood-sugar levels. This could result in poor quality of care, poor patient outcomes, and higher acute care spending through emergency department visits and unnecessary hospitalizations.

D-SNPs that meet a high standard of integration and specified performance on quality-based standards are permitted to offer supplemental benefits beyond those currently permitted for MA plans.[96] In 2016, CMS clarified that, "flexible supplemental benefits must not be duplicative of Medicaid, including the state Medicaid or local Medicaid benefits for enrollees who are eligible to receive identical Medicaid services."[97] This permits an eligible D-SNP to offer a flexible supplemental benefit that would be covered under Medicaid to those enrollees who are otherwise ineligible to receive the identical Medicaid service.[98] This policy change, for example, would permit a D-SNPs to offer supplemental benefits that may be available to a small subset of dual-eligible individuals who would be eligible for services under a Medicaid waiver, but who were not enrolled because the number of waiver "slots" is limited. Under a stricter interpretation of the statue, plans would be precluded from offering those waiver benefits to all dual-eligible enrollees, if the state covered the benefit for any single dual-eligible individual in the state.

Supplemental benefits must be made available to eligible beneficiaries at no extra cost, and may include non-skilled in-home support services, in-home food delivery, support for caregivers, home assessments, modifications, assistive devices for home safety, and adult day-care services.[99]

The implications of allowing D-SNPs to expire vary based on the state in which an individual resides. Where states do not require dual-eligible beneficiaries to receive all or part of their services through managed care, a dual-eligible beneficiary will either remain in the same plan, which will revert to a regular MA plan, or will move to Medicare FFS. Medicaid benefits would be received either through FFS arrangements or through one or more Medicaid managed care plans. Without fully integrated D-SNPs, dual-eligible beneficiaries face a complex array of plans. As discussed, they may receive their Medicare benefits through either FFS or an MA plan.

Similarly, for Medicaid benefits, medical services might be delivered through a benefit arrangement that could be FFS or managed care, depending on the state in which the beneficiary resides. However, other benefits—such as oral health, behavioral health (including mental health and substance abuse) services, LTSS, or transportation services—might be delivered through another limited-benefit plan. Each limited-benefit plan manages specific services and has a specific network of providers, benefits, processes, and performance standards. Due to the segmentation of different limited-benefit plans covering distinct services, a beneficiary could have five different plans that they must navigate to meet their health needs. Today, most full-benefit dual-eligible beneficiaries are enrolled in three or more plans. According to the Medicaid and CHIP Payment Advisory Commission (MACPAC), 60 percent of those currently enrolled in D-SNPs also have a limited-benefit plan.[100]

Grievance and Appeals

The grievance and appeals processes for Medicare have different rules and timelines than those processes for Medicaid. These differences can cause confusion, and it can be time consuming for beneficiaries to navigate the two processes. The HHS secretary does not currently have the authority to align these processes, although the administration has sought this authority in FY 2015, 2016, and 2017 budget proposals.[101, 102, 103] The MA standards for grievances and appeals should be the minimum standard, but as under Medicaid, claims should be "paid while pending appeal."

Administrative Alignment

Multiple enrollments, cost-sharing, and other administrative requirements are barriers to the coordination of benefits and

are confusing to beneficiaries. D-SNP-enrolled dual-eligible beneficiaries receive separate cards, member handbooks, and provider directories—one for Medicare benefits and one for Medicaid benefits—and are technically enrolled in two separate plans even though the same managed care organization administers both plans. A single enrollment and administrative process would be less confusing to beneficiaries, would reduce administrative complexities at the plan and provider levels, and would require the alignment of enrollment dates, out-of-pocket costs, contact numbers, and claims submission processes in the Medicare and Medicaid programs.

Financial Alignment Initiative

1. For ongoing demonstrations, CMS should:
    a. Revise contracts to ensure that, where appropriate, rates reflect unanticipated costs of infrastructure investment or significant differences in cost associated with serving certain special-needs populations, such as those with previously untreated mental illness or homeless individuals. Note: CMS has made these adjustments in some states.
    b. Adjustments should not result in increased cost to the federal government over the five-year demonstration period.
    c. Work with states to develop unique state-specific quality and access measures, and to the extent there are savings, permit states to share in a greater percentage of those savings or, where appropriate for high-performing states, permit added flexibility in the scope of covered benefits.
    d. Align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services.
2. CMS should establish additional demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries, based on findings from the evaluations of the first-round demonstrations. New demonstrations will allow additional states to gain experience providing fully integrated managed services to dual-eligible populations.

Background

In 2011, CMS announced a three year demonstration to test new payment and service delivery models under Medicare and Medicaid to reduce costs and improve quality of care for dual-eligible beneficiaries. The demonstration, known as the Financial Alignment Initiative, proposed two models: a fully capitated model and a managed FFS model. For the fully capitated model, the agency adopted an approach that used a "three-way" contract among CMS, a state, and a health plan. In effect, private insurance plans entered into an agreement to provide Medicare benefits (under contract with CMS) and Medicaid benefits (under contract with the state) to dual-eligible beneficiaries within a single contract for services, in theory ensuring full integration of Medicare and Medicaid rules and benefits.

First, CMS entered into a memorandum of understanding with a state outlining the terms and conditions of the demonstration. For example, this could include the number of enrollees, type of participants—such as persons aged 65 or under with disabilities—and projected savings targets, among other requirements. The states and CMS jointly selected the participating plans. One of the more controversial aspects of the proposal was CMS's announcement that states would be permitted to implement a system of "passive enrollment" through which dual-eligible beneficiaries were auto-enrolled in a managed care plan, but were permitted to opt out at any time.

Reimbursement to plans is based on a blended capitated rate for the full range of benefits. Rates are developed by CMS with each state, and are derived from baseline spending in both programs, minus anticipated savings resulting from integration, and improved care management. The rate assumed upfront savings to both CMS and the state. For example, the per-member per-month payment is

based on a rate that is equal to the sum of the county-level MA risk-adjusted benchmark and an amount based on the state's prior year Medicaid spending for a dual-eligible beneficiary, minus 1 percent in the first year of the demonstration, minus 2 percent in the second year, and minus 3 percent in the third year. The anticipated savings vary by state.[104]

The three-way contracts among states, health plans, and the federal government were largely based on the standard MA contracts, with adjustments made to include Medicaid services covered by the state. While contract provisions vary by state, they include provisions designed to ensure that enrollees have continued access to their out-of-plan health care providers during a transition period and to ensure timely assessment and development of an individualized care plan by a team of health professionals, while also addressing network adequacy and cost-sharing protections.

As noted above, fully capitated MMPs participating in the Financial Alignment Initiative demonstration are generally required to demonstrate savings during the first three years of the demonstration. Recent publications from MedPAC and MACPAC indicate that agency officials, plans, and states have raised concerns that those savings targets can be unrealistic because they do not take into account the initial infrastructure investments required to serve a heterogeneous population whose costs are significantly higher than non-duals enrolled in Medicare.[105, 106] While there is variation from state to state, some experts suggest that it could take a number of years to recoup the investments given the relatively low level of reimbursement, as compared with Medicaid costs in some states.

In order to improve predictive accuracy for the duals population, CMS has conducted an analysis of the Hierarchical Condition Category risk-adjustment model to address potential flaws in the accuracy of risk adjustment for full-benefit duals.[m] In addition, many individuals enrolled in the demonstration were not receiving treatment for services in the years prior to the demonstration start date, which resulted in inaccurate estimates of the cost of providing services. This "unmet need" is particularly problematic for homeless and mentally ill populations.

Benefit Alignment

In the Medicare-Medicaid Coordination Office's (MMCO) annual report to Congress regarding the status of the Financial Alignment Initiative, the MMCO highlighted a problem associated with differing coverage standards in cases in which Medicare and Medicaid both cover a benefit.[107] The differences in coverage standards have led to confusion as to whether the Medicaid or the Medicare standard should apply in making a coverage decision.

Overlapping benefits include home health services and durable medical equipment (DME). The MMCO has cited the importance of resolving the issue and has noted that "prompt access to DME—including repairs—is critical to maintaining and preventing complications that harm the beneficiary and result in needless costs (for example, ER visits or hospital admissions)."

Differences in benefits between Medicare and Medicaid are also prevalent in rehabilitation and therapy services, offered in both outpatient and home health settings. While Medicaid benefits in these areas tend to be more comprehensive, Medicare benefits can be limited. For instance, the duration of rehabilitation and physical therapy services coverage under Medicare FFS is often limited by a variety of factors related to FFS payment system rules, including manual claims review of necessity of outpatient physical therapy services above the annual dollar value "cap," recertification for home health episodes at the end of a 60-day therapy-based home health episode of care, and the "homebound requirement" for

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l Beginning in 2017, CMS will incorporate changes to the Hierarchical Condition Category model to better capture the costs that MA plans incur in managing care and providing services for dual-eligible beneficiaries.

coverage under the Medicare home health benefit.

Program of All-Inclusive Care for the Elderly (PACE)

1. CMS should test:
    a. An expansion to individuals, regardless of age, who meet all other PACE criteria and who do not require a nursing home level of care;
    b. An option that permits individuals to enroll in PACE, but opt out of adult day services; and
    c. An option that includes both Medicare-covered services and a beneficiary "buy-in" of a limited LTSS benefit that is less than the full-range of Medicaid-covered LTSS for individuals who are not eligible for Medicaid and whose income exceeds 300 percent of Social Security income.
2. CMS should permit PACE organizations to enroll beneficiaries during the month, rather than requiring them to wait until the first of the month to enroll. CMS should have the ability to pro-rate the monthly per-capita payment.

Background

PACE is a provider-based, staff-model program that integrates Medicare and Medicaid services to frail individuals age 55 and older. The PACE model provides all Medicare- and Medicaid-covered services, meals, and adult day health-center services, but it may also cover all other services determined necessary by the care team to improve or maintain an individual's health, including in-home services. In order to be eligible, individuals must be certified by the state as requiring a nursing home level of care.[n]

As of February 2016, there were 118 PACE organizations operating in 32 states that enrolled a total of 34,538 individuals.[109] According to discussions between BPC and the National PACE Association, the largest PACE program is serving 3,000 enrollees, while the average serves 300 beneficiaries. The typical PACE enrollee is 80 years old, has 7.9 medical conditions and is limited in about three ADLs. Roughly 49 percent of these beneficiaries have been diagnosed with dementia, yet 90 percent of participants live in the community (National PACE Association, 2013).

There is literature on PACE programs that suggests that the model of care reduces hospitalizations, nursing home utilization, and mortality.[110] However, quality data on individual PACE providers is not publicly available. Additionally, MedPAC found in its 2012 report that Medicare spending on PACE enrollees exceeds what it would have been had these beneficiaries remained in traditional FFS (and the payment rate is also higher than that of D-SNPs, due to the reimbursement adjustments discussed below).[111]

Benefits offered by PACE

The PACE care model is centered around adult day health centers, and enrollees receive care from a coordinated care team (in PACE terminology, the "interdisciplinary team," or IDT). This team consists of a primary care physician, registered nurse, social worker, occupational therapist, physical therapist, dietitian, home care coordinator, personal-care attendant, driver, activity coordinator, and the PACE center manager. The services provided by the IDT in adult day care are supplemented by in-home and referral services. The IDT develops a plan of care for each enrollee, taking into account three tracks of care goals: habilitative, palliative, and active treatment (acute care).[112]

Compared with other integrated care models for dual-eligible beneficiaries, PACE providers are afforded greater flexibility to deliver services that are not traditionally Medicare-covered services, such as home modifications, as long as these services are within the enrollee's plan of care needs. Providers accept full financial risk and have flexibility in services provided—as long as they are deemed necessary by the team to improve and maintain

n The nursing home level of care qualification varies significantly from state to state

an individual's health.

Payments to PACE providers

PACE providers receive separate capitated payments each month from the states to provide Medicaid services and from the federal government to provide Medicare services. Medicare payments are based on the MA risk-adjusted benchmark,[n] with dementia as an added condition and a frailty adjustment.[113] Medicare enrollees who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount. Each state that elects PACE as a Medicaid State Plan option must develop a payment amount based on the cost of comparable services for the state's nursing-facility-eligible population.[114]

- **Enrollment:** PACE providers may enroll individuals who are aged 55 or older, live in a PACE service area, are eligible for a nursing home level of care, and can live safely in the community. Strict eligibility requirements and a limited volume of enrollees at times may not justify the infrastructure investment required to start the program.[115]
- **Start-up Costs**: Both the National PACE Association and the June 2012 MedPAC report cited upfront capital-investment requirements as a limitation to scaling PACE.[116]
- **Medicaid Capitation Amount:** The capitation rate for Medicaid does not take into account existing unmet need. PACE programs are expected to show savings; however, they are often times providing services that are not covered elsewhere. Many of the services offered through PACE address behavioral health and homelessness, and these needs are not accounted for in the capitation amount.[117]
- **Quality Measures:** Due to the diverse nature of PACE enrollees, quality measures can vary greatly and do not necessarily reflect the different goals of care (habilitative, palliative, and active treatment). For example, a measure of hemoglobin in an 80-year-old will be different from that of a 55-year-old enrollee.[118]

Because PACE organizations have the flexibility to cover items or services as part of the enrollee's care plan, a coverage determination is not viewed as a barrier to scaling the model. According to BPC discussions with the National PACE Association, the primary barriers to scalability for the PACE program are significant start-up and operating costs that, when paired with eligibility limits, make per-capita operating costs very high.[119]

As part of the FY 2016 budget proposal, President Obama sought authority to conduct PACE demonstrations for persons between 21 and 55 years of age.[120] Recent legislation has sought to test the PACE model of care on a larger scale by removing the age requirement for enrollment.

As enacted in November 2015, the PACE Innovation Act of 2015 amends title XI of the Social Security Act to authorize HHS to waive applicable general and Medicaid requirements of PACE so that the program can be included in demonstration projects tested through the Center for Medicare and Medicaid Innovation (CMMI).[121] Ultimately, this bipartisan legislation seeks to allow for greater operational flexibility for PACE and to expand PACE to new populations. CMMI is reportedly preparing to use that authority to test expansion of PACE eligibility to individuals under age 55 who meet all other PACE criteria and who require a nursing home level of care. Through demonstrations, the secretary and states may test new options with lower start-up and program costs.

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n The MA risk adjustment is based on the CMS HCC model, in which a county benchmark rate is multiplied by the individual participant risk score to determine the risk-adjusted payment for each enrollee.

Recommendations to Integrate Care for Dual-Eligible Beneficiaries

Align Oversight of Programs Serving Dual-Eligible Individuals

Policymakers should consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within the agency, such as the MMCO. In establishing the MMCO, Congress directed HHS to form an office responsible for integrating care for dual-eligible beneficiaries. However, existing agencies within CMS retain regulatory authority over programs serving dual-eligible beneficiaries. Consolidating this authority will help ensure that decisions affecting these programs are made through the lens of an integrated program that takes into account the impact on beneficiaries and state implementation.

Reimbursement structures would include SNPs, PACE, permanent waiver authority for the Financial Alignment Initiative, and a new contract authority as outlined below. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a leadership team whose single focus is addressing the unique needs of low-income populations with complex needs through an entity that has the authority to address those needs. The Integrated Care Resource Center (ICRC) is currently funded through CMS and works with the MMCO to provide technical assistance to states in the integration of Medicare and Medicaid services. The continuation of funding for ICRC is critical to the ability of new states to gain experience in delivering coordinated care to the dual-eligible population.

Development of a Revised Regulatory Structure

1. Policymakers should build on lessons learned from existing programs and demonstrations to develop a contractual model similar to the innovative "three-way" contract among CMS, states, and plans under the Financial Alignment Initiative demonstration. A new model three-way contract should be uniform with respect to basic structure, beneficiary protections, quality, care coordination, and continuity of care requirements, while at the same time flexible enough to permit variation in delivery, provider, and reimbursement models.
2. In developing a framework for a model contract:
    a. The HHS secretary could be directed to develop a framework based on recommendations of an informal working group consisting of stakeholder organizations, including consumer and family representatives, employers, disability experts, health plans, and health care providers, state Medicaid officials as well as experts in the provision of clinical-health services, home and community-based care, LTSS, community and public-health services for special-needs populations, and other stakeholder organizations. The HHS secretary should promulgate regulations based on the framework developed; or
    b. Alternatively, require negotiated rulemaking under the Administrative Procedure Act to develop the framework of a three-way contract. This approach, while more complicated than informal notice and comment rulemaking, would allow for greater transparency and give an equal voice to all members of an appointed rulemaking committee.

Background: Revised Regulatory Structure

Section 2602 of the Affordable Care Act directed the HHS secretary to create a new office within CMS to integrate Medicare and Medicaid benefits and to better coordinate care for dual-eligible beneficiaries.[p] The new office, the MMCO, works with agencies responsible for regulation of Medicare and Medicaid programs and is responsible for demonstrations that better care for dual-eligible beneficiaries. The office submits an annual report to Congress on legislative recommendations for these programs, among many other tasks. While the MMCO is consulted on policy changes that impact dual-eligible beneficiaries, the office does not have direct regulatory authority to make final decisions about changes in programs affecting dual-eligible beneficiaries.

This structure has created a situation in which a final decision maker may not always have the best interests of a dual-eligible beneficiary as a priority when making decisions. Given the unique needs of this population and the special rules associated with each of the federal programs, the key decision maker should have the authority to make final decisions relating to programs serving dual-eligible beneficiaries, under the authority of the CMS administrator, as is currently the case for directors of the Center for Medicare and the Center for Medicaid and CHIP Services.

While the current leadership understands the importance of thinking of the delivery of benefits to dual-eligible beneficiaries as a whole, there is no guarantee that this will continue, or that future administrations will share the commitment to integrating care for dual-eligible beneficiaries. Providing operational authority within a division of CMS, which has responsibility for both programs, could help ensure that the best interests of the dual-eligible population are represented over the long-term.

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o The MA risk-adjustment is based on the CMS hierarchical condition category model in which a county benchmark rate is multiplied by the individual participant risk score to determine the risk-adjusted payment for each enrollee.

BPC recommends that the HHS secretary consolidate regulatory authority for programs serving dual-eligible individuals under the MMCO, with a director reporting to the CMS administrator. MMCO does not have regulatory authority comparable to that granted to the directors of the Center for Medicare and the Center for Medicaid and CHIP Services. As a result, MMCO can identify and recommend changes to better integrate services, but it does not have the authority to make adjustments to address the needs of dual-eligible beneficiaries.

While agencies are dedicated to operating programs and making changes that are in the best interests of Medicare-only or Medicaid-only populations, these agencies' responsibilities are to implement and oversee programs to the benefit of Medicare or Medicaid patients, which may not be in the best interests of dual-eligible individuals. Finally, although technical experts in their areas, agency officials may not necessarily have the technical knowledge of programs outside their regulatory authority or recognize the impact of their decisions on this unique population.

Programs under the regulatory authority of the MMCO should include SNPs, PACE, demonstration authority for programs affecting dual-eligible beneficiaries, and a new contract authority as outlined above. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a single leadership team whose single focus is addressing the unique needs of low-income populations with complex conditions. As part of the MMCO office, the continued funding for ICRC is valuable to ensure an open dialogue of best practices for dual-eligible programs, as well as to provide technical assistance to states in the design and implementation of programs serving the dual-eligible population.

Background: Revised Framework for Model Contract

Policymakers have long debated the respective roles of state and federal governments in providing health and LTSS to dual-eligible beneficiaries through two separate programs with different eligibility levels, benefits, and administrative structures. All of these points have merit. However, one significant issue—how to address issues of financing a federal program with uniform benefits—makes this a task that is beyond the scope of this project, and more aligned with BPC's Long-term Care Initiative.

Although the Financial Alignment Initiative has reportedly improved collaboration within CMS for programs serving dual-eligible beneficiaries, the agency has a long history of compartmentalizing the two programs.

CMS's regulatory structure for the Financial Alignment Initiative employed a three-way contract between CMS, states, and health plans. While recognizing that CMS was working to implement the program in a timely manner, and that the most logical framework was the use of D-SNPs, CMS based the contracts on the standard MA contract. Experts in serving low-income Medicare beneficiaries, however, have raised concerns that the lack of agency flexibility in making adjustments in these contracts to incorporate provisions standard to Medicaid managed care contracts has limited the ability of states and plans to adequately address the unique concerns of low-income Medicare populations.

These recommendations recognize that making small changes to existing regulatory structures will not eliminate all barriers inherent to reconciling two programs with different purposes and structures. This contractual framework would provide an underlying uniformity in structure for elements that should be common across states, such as access to important benefits and protections in the Medicare and Medicaid programs, quality measures, continuity of care, and access requirements, which must apply regardless of whether the reimbursement structure is a FIDE-SNP, an ACO, a patient-centered medical home, or a new structure identified as successful through demonstrations. At the same time, the framework should provide sufficient flexibility to account for differences in delivery from state to state and region to region.

Building on the approach used in the Financial Alignment Initiative, a three-way contract could be used to establish contractual

agreements between CMS, states, and fully integrated D-SNPs. Similarly, other organizations that bring providers together to offer services could enter into contracts with CMS and states to provide Medicare- and Medicaid-covered items and services. Under this approach, the HHS secretary could convene experts representing states, consumers, providers, and other stakeholder organizations to develop the framework for a model contract that could be modified based on the type of provider organization that seeks to contract with a state and CMS to provide the full range of integrated services to dual-eligible beneficiaries. Given the importance of the issues at stake in the contract, a negotiated rulemaking process under the Administrative Procedure Act could be an appropriate means of assuring that each stakeholder has adequate representation in the development of the contract. Of primary importance, however, is the need to draw from lessons learned from the SNPs and MMPs involved in the Financial Alignment Initiative.

For risk-based models operating under two-sided risk arrangements, plans and providers should be required to offer Medicare and Medicaid services, but for high-need patients, they should also be permitted to offer any item or service that is reasonably related to optimizing health or functional status, provided the item or service is part of a care plan developed by the patient's interdisciplinary care team. The negotiated rulemaking process should also be used to establish uniform marketing, grievance and appeals standards, and continuity of care. This process would ensure the integration of clinical services, behavioral care, and LTSS; it would ensure that the combined Medicare and Medicaid program presents a seamless single program to patients and their families.

This approach should permit complete integration of funds for providers willing to assume risk, and could be provided either through a managed care plan or another APM that assumes two-sided risk, such as an ACO or patient-centered medical home. The approach must include strong consumer protections, establish appropriate quality measures, and maintain fiscal integrity for federal spending.

Conclusion and Next Steps

While some integrated care models have proved successful in improving quality and slowing cost growth, others have not. Treating persons with complex medical conditions is especially challenging when patients have low incomes. Although many plans and providers understand how best to treat patients with chronic conditions, the current reimbursement structures under Medicare and Medicaid create barriers to the integration of services. While new delivery models are being tested through CMMI, the removal of reimbursement barriers would help accelerate the spread and scale of successful delivery models.

The recommendations made in this report are designed to address these legal and policy barriers and improve the coordination of services and reimbursement in current payment models that integrate the Medicare and Medicaid programs. Addressing barriers to financial alignment and clinical integration of services alone will not guarantee the spread and scale of successful care models. However, failure to address these barriers will make it difficult, if not impossible, for plans and providers to implement successful care models for high-need populations.

Although this report focuses on delivery and reimbursement models that serve dual-eligible beneficiaries, BPC will issue a report in 2017 that will address similar issues for high-need Medicare patients who are not dually eligible for Medicaid but may benefit from health-related interventions to address social determinants of health. These recommendations continue BPC's work to improve value through the financing and integration of health care services and LTSS, and they are intended to address the needs of individuals with complex health conditions over the long-term.

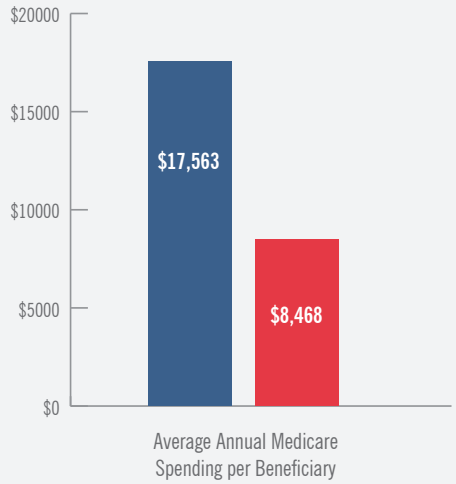
Appendix

Figure 1: Average Spend and Risk Score: Full-Benefit Dual-Eligible Beneficiaries Versus All Other Medicare Beneficiaries, 2011.

Rank and Group by Total Spending	Full-Benefit Dual-Eligible Beneficiaries			All Other Medicare Beneficiaries	
	Average Spending		Average Risk Score	Average Spending	Average Risk Score
	Average Medicare Spending	Average Medicaid Spending		Average Medicare Spending	
1st Quintile	$1,379	$655	0.70	$52	0.58
2nd Quintile	$5,891	$2,258	0.99	$1,203	0.67
3rd Quintile	$12,354	$5,531	1.41	$3,627	0.76
4th Quintile	$21,976	$16,894	1.99	$7,669	1.06
5th Quintile	$46,215	$50,425	2.86	$29,760	2.20

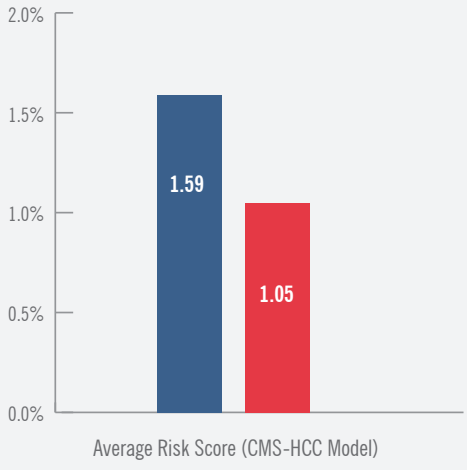
Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 2. Medicare per Beneficiary Spending (CY 2011)



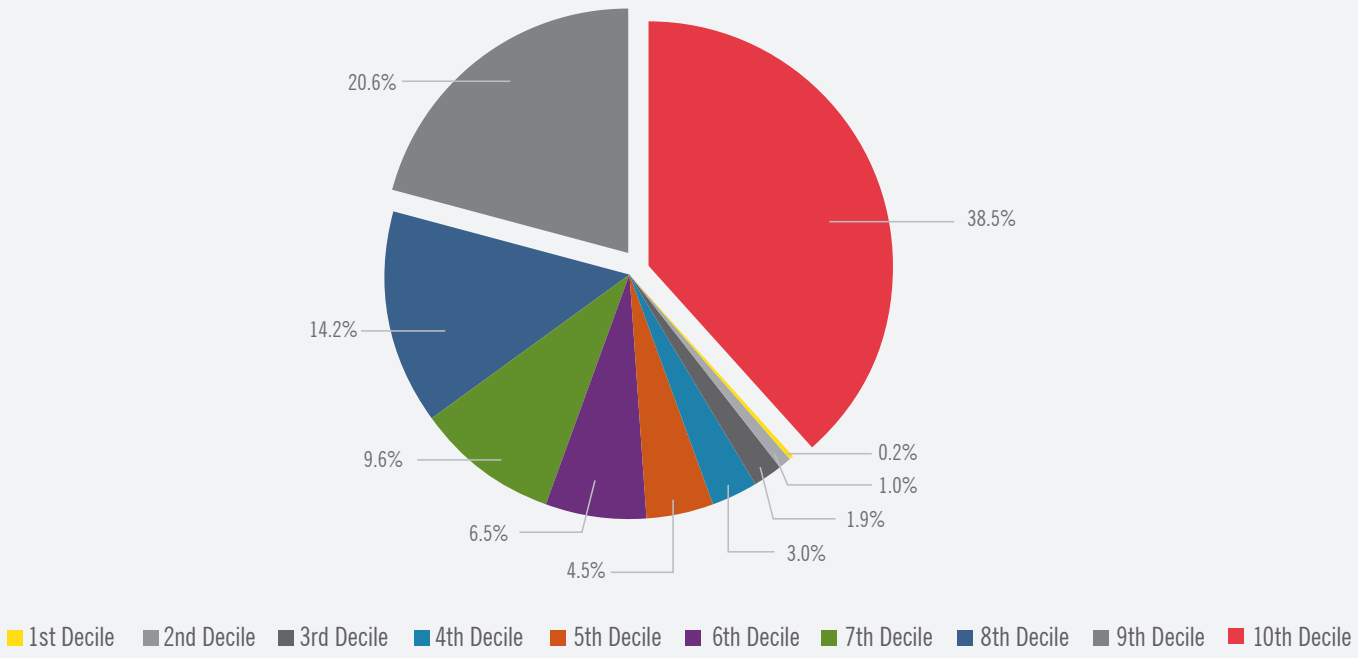
Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 3. Average Risk Score Full-Benefit Dual-Eligible Beneficiaries Versus All Other Medicare Beneficiaries (CY 2011)



Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 4. Distribution of Combined Medicare & Medicaid Spending for Full-Benefit Dual-Eligible Beneficiaries (CY 2011)



Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 5: Average Number of Chronic Conditions by Quintile, Full-Benefit Dual-Eligible Beneficiaries, 2011.

Rank and Group by Total Spending	Full-Benefit Dual-Eligible Beneficiaries					
	Average Number of Chronic Conditions	Zero Chronic Conditions	1 Chronic Condition	2 or 3 Chronic Conditions	4 or 5 Chronic Conditions	6 or more Chronic Conditions
1st Quintile	2.33	27%	16%	30%	18%	9%
2nd Quintile	4.89	4%	7%	23%	28%	39%
3rd Quintile	6.56	3%	4%	15%	19%	59%
4th Quintile	7.80	1%	3%	12%	16%	68%
5th Quintile	9.12	1%	2%	9%	14%	73%
Total	**6.14**	**7%**	**6%**	**18%**	**19%**	**50%**

Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 6: Average Number of Chronic Conditions by Quintile, All Other Medicare Beneficiaries

Rank and Group by Total Spending	All Other Medicare Beneficiaries					
	Average Number of Chronic Conditions	Zero Chronic Conditions	1 Chronic Condition	2 or 3 Chronic Conditions	4 or 5 Chronic Conditions	6 or more Chronic Conditions
1st Quintile	0.65	81%	10%	7%	2%	1%
2nd Quintile	2.62	12%	19%	40%	22%	7%
3rd Quintile	3.81	4%	10%	34%	32%	20%
4th Quintile	5.17	2%	4%	21%	31%	42%
5th Quintile	7.81	1%	2%	9%	17%	72%
Total	**4.01**	**20%**	**9%**	**22%**	**21%**	**28%**

Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 7: Full-Benefit Dual-Eligible Beneficiaries Spending and Risk Score by Chronic Condition, 2011.

	Percent of Full-Benefit Duals that Report the Condition	Average Spending		Average Risk Score
		Average Medicare Spending	Average Medicaid Spending	
Hypertension	62%	$22,749	$21,347	1.91
Ischemic Heart Disease	27%	$27,876	$22,730	2.30
CHF (Heart Failure)	19%	$32,442	$27,917	2.77
COPD	19%	$33,346	$21,665	2.65
Behavioral Health and Cognitive Impairments				
Any Behavioral Health and Cognitive Impairments	54%	$23,132	$30,744	1.83
Depression	32%	$27,356	$25,302	2.02
Anxiety Disorder	17%	$26,102	$23,545	1.87
Bipolar Disorder	9%	$26,412	$28,191	1.77
Schizophrenia	8%	$24,736	$29,824	1.72
Alzheimer's or Related Dementia	17%	$26,880	$38,644	2.30
Intellectual disabilities and related conditions	7%	$15,457	$78,036	1.24

Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center

Figure 8: All Other Medicare Beneficiaries Spending and Risk Score by Chronic Condition, 2011.			
	Percent of Beneficiaries that Report the Condition	Average Medicare Spending	Average Risk Score
Hypertension	53%	$12,443	1.35
Ischemic Heart Disease	26%	$15,927	1.68
CHF (Heart Failure)	12%	$23,639	2.40
COPD	10%	$22,636	2.28
Behavioral Health and Cognitive Impairments			
Any Behavioral Health and Cognitive Impairments	21%	$17,702	1.61
Depression	11%	$20,371	1.70
Anxiety Disorder	7%	$18,782	1.59
Bipolar Disorder	1%	$18,583	1.60
Schizophrenia	1%	$16,833	1.45
Alzheimer's or Related Dementia	8%	$20,880	1.90
Intellectual Disabilities and Related Conditions	0.1%	$15,993	1.32

Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 9: Full-Benefit Dual-Eligible Beneficiaries Hospitalization Rates for Ambulatory Care Sensitive Conditions, 2011.

Ambulatory Care Sensitive Condition	Full-Benefit Dual-Eligible			
	Zero Hospitalizations (Medicare and Medicaid)	1 Hospitalizations (Medicare and Medicaid)	2 Hospitalizations (Medicare and Medicaid)	3+ Hospitalizations (Medicare and Medicaid)
Hypertension	64%	6%	15%	15%
CHF (Chronic Heart Failure)	50%	7%	19%	24%
COPD	47%	7%	20%	26%

Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 10: All Other Medicare Beneficiaries Hospitalization Rates for Ambulatory Care Sensitive Conditions, 2011.

Ambulatory Care Sensitive Condition	All Other Medicare Beneficiaries			
	Zero Hospitalizations (Medicare and Medicaid)	1 Hospitalizations (Medicare and Medicaid)	2 Hospitalizations (Medicare and Medicaid)	3+ Hospitalizations (Medicare and Medicaid)
Hypertension	73%	17%	6%	4%
CHF (Chronic Heart Failure)	52%	25%	12%	11%
COPD	51%	26%	12%	11%

Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

Figure 11: Impact of Depression and Intellectual/Developmental Disability on Spending for Full-Benefit Dual-Eligible Beneficiaries with Chronic Condition, 2011.

	Patients without Depression			Patients with Depression		
	Full-Benefit Dual Eligible Beneficiaries	Average Medicare Spending	Average Medicaid Spending	Full-Benefit Dual-Eligible Beneficiaries	Average Medicare Spending	Average Medicaid Spending
No Chronic Condition	100%	$2,064	$7,983	N/A	N/A	N/A
1 Chronic Condition	88%	$4,985	$14,369	12%	$9,279	$9,515
2-3 Chronic Conditions	84%	$7,745	$17,689	16%	$13,096	$15,647
4-5 Chronic Conditions	75%	$11,242	$20,921	25%	$17,804	$21,124
6 or more Chronic Conditions	52%	$22,732	$27,230	48%	$31,572	$27,815

Source: Acumen LLC, prepared on behalf of the Bipartisan Policy Center.

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