Dual Eligible Hospitalizations

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Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

Honor pledge

On my honor, I pledge that I have neither given nor received unauthorized aid on this assignment.

Client description

My client for this project was the Medicare-Medicaid Coordination Office within the Centers for Medicare and Medicaid Services (CMS). Also referred to as the Federal Coordinated Health Care Office, this group is responsible for serving Americans dually enrolled in both Medicare and Medicaid, also known as dual eligibles. The goal of the Medicare-Medicaid Coordination Office is to align and coordinate benefits between the two programs effectively and efficiently to provide dual eligibles with full access to seamless, high quality health care that is as cost-effective as possible. To reach this goal, the Office works with the Medicaid and Medicare programs as well as relevant federal agencies, states, and stakeholders.

Executive Summary

Due to poor healthcare coordination and delivery for individuals who receive both Medicare and Medicaid benefits, hospitalizations for Medicare-Medicaid dual eligibles are too high. Not only do hospitalizations impose considerable costs to society, but they also indicate poor health outcomes. As the population of Medicare-Medicaid dual eligibles continues to grow, this problem becomes more present. While there have been attempts to lower high hospitalization rates for this population in this past, demonstrations that have shown success have only done so on a small scale where their effects on hospitalizations and cost savings have not been enough to combat this growing issue. Early parts of the report outline the costs that dual eligible hospitalizations impose, how Medicare and Medicaid target this population, and the existing landscape of dual eligible care. After background on dual eligibles hospitalizations is explained, the criteria of equity, cost-effectiveness, political feasibility, and quality of life are used to evaluate the following policy proposals: expanding PACE (Programs of All Inclusive Care for the Elderly); aligning cost incentives between Medicare and Medicaid; and coordinating dual eligible care under one program. After evaluating these policy options, a recommendation and implementation strategy is proposed for an expansion of PACE to best address the growing issue of high dual eligible hospitalization rates in the United States.

Dual eligibles

The term "dual eligibles" refers to Americans who are simultaneously enrolled in both Medicaid and Medicare. This population can also be referred to as Medicare-Medicaid eligibles or dually enrolled beneficiaries. Due to Medicaid and Medicare requirements, the dual eligible population consists of lower-income individuals who are either older and nearing the end of life, or younger and possess a sustained need for functional support, likely due to a disability. Because of the need to meet eligibility standards for Medicaid, dual eligibles are younger and more female than Medicare-only beneficiaries. In 2018, about 59.6 percent of the dual eligibles were female, compared to 53.0 percent of Medicare-only (non-dual) beneficiaries.[1] Due to Medicaid and Medicare eligibility, demographic characteristics, health status, and patterns in use of services and spending, this group requires more services than those enrolled in only Medicaid or Medicare with higher per capita costs.[2]

To best evaluate health outcomes for the dual eligible population, this group is often compared to Medicare-only beneficiaries. Medicare-only refers to those over the age of 65 as well as those with disabilities. This proves a more helpful comparison group than Medicaid-only, as Medicaid-only also covers children, pregnant women, and non-disabled adults. While Medicare-only beneficiaries have an average of four chronic health conditions (conditions that last one year or more and require ongoing medical attention), dual eligible have an average of six,[3] and while Medicare-only beneficiaries self-report excellent or very good health 51% of the time, dual

[1] "Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019." *CMS Medicare-Medicaid Coordination Office (MMCO)*, November 2020
[2] "June 2020 Report to Congress on Medicaid and CHIP, Integrating Care for Dually Eligible Beneficiaries: Background and Context." *MACPAC*, June 2020
[3] "Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid." *Bipartisan Policy* Center, September 2016

eligibles only do so at a rate of 22%.[4] Duals are also more likely to struggle with actives of daily living (ADLs). This includes difficulties with walking, eating, bathing, and getting in and out of bed. Due to underlying health conditions as well as their older age, the dual eligible population was particularly affected by the COVID-19 pandemic. In addition to medical issues, dual eligibles are more likely to experience risk factors that can further harm their health. These include lack of access to food, housing, and transportation, as well as low health literacy.[5] These risk factors can also lead to lack of access to primary care which can further exacerbate health issues.

In terms of racial and ethnic demographics, 47.5% of dual eligible in 2018 were of a racial or ethnic minority group, compared to 21.1% for Medicare-only beneficiaries. This presence of minorities within the dual eligible population has grown, as in 2006 the minority presence was closer to 40%. More specifically in 2018, 20.4% of dual eligibles identified as black, 17.8 identified as Hispanic or Latino, 6.4 percent Asian or Pacific Islander, and 0.9 percent American Indian or Alaska Native.[6]

In 2013, the dual eligible population was estimated to consist of roughly 10.8 million individuals. In 2019, this population grew to 12.3 million.[7] As the dual eligible population in the United States continues to grow with an annual percent growth rate of 2.234%, the problem of high hospitalizations will become more present.

High hospitalization rates

An analysis of dually enrolled beneficiary hospitalizations between the years 2004 and 2017 found that hospitalizations, mortality, and hospitalizations related to 30-day mortality were all more common for dual eligibles than for the non-dually enrolled.[8] A 2016 study of social risk factors found that dual eligible status was the most powerful predictor of poor outcomes. In comparison to Medicare-only beneficiaries, dual eligibles in the 2016 study demonstrated 10% to 31% higher risk-adjusted odds for hospital readmission. In terms of measurements of quality of care, scores for dual eligibles were lower for 17 of the 19 quality measures studied.[9] These negative health outcomes and care measures lead to dual eligibles being the most expensive population per capita.

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[4] "Beneficiaries Dually Eligible for Medicare and Medicaid" *Medicare Payment Advisory Commission & MACPAC*, February 2022

[5] "Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans." *U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Health Policy*, 2018

[6] "Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019." *CMS Medicare-Medicaid Coordination Office (MMCO)*, November 2020

[7] ibid

[8] Wadhera, RK., Wang, Y., Figueroa, JF., Dominici, F., Yeh, RW., Joynt, Maddox KE. "Mortality and Hospitalizations for Dually Enrolled and Nondually Enrolled Medicare Beneficiaries Aged 65 Years or Older, 2004 to 2017." *Journal of the American Medical Association*, March 2020

[9] "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." *U.S. Department of Health and Human Services*, *Office of the Assistant Secretary for Planning and Evaluation*, December 2016

Costs to Society

Due to their complex medical needs and the long-term care they receive, America's dual eligible population are responsible for high costs to society. These costs can be categorized as direct costs, opportunity costs, and externalities.

1. Direct costs

As the frailty of this population results in numerous inevitable hospitalizations, significant research done on the cost of poor health outcomes for Medicare-Medicaid eligibles has focused on hospitalizations within this population that can be categorized as "potentially avoidable." Potentially avoidable hospitalizations are defined by the Centers for Medicare & Medicaid Services (CMS) as hospitalizations that could be avoided either by preventing conditions warranting hospitalization or by managing conditions at home or in nursing facilities.[10] The Center for Strategic Planning conducted a study in 2011 concluding that roughly one in every four hospitalizations for dual eligible beneficiaries in 2005 could be defined as "potentially avoidable."[11] This one in four ratio was also found to be the case in a 2009 study conducted by CMS and General Dynamics Information Technology.[12] The Center for Strategic Planning estimated that these potentially avoidable hospitalizations in 2005 accounted for $5.6 billion in government spending, or about 20% of total spending on inpatient care for the dual eligibles.[13] In 2011, these costs increased to an estimated $7–$8 billion.[14] Hospitalizations are not the only area in which this population accrues high costs, as dual eligibles often require complex medical services such as physician care, as well as care to support functional independence, such as home aids and facility-based care. In 2005, the average combined cost to both Medicare and Medicaid for a potentially avoidable hospital visit was $7,998.[15] That total was split between Medicare and Medicaid, with $7,665 being paid for by Medicare and $333 by Medicaid. With 699,818 total potentially avoidable hospitalizations occurring in 2005, the total cost inherited by both programs for potentially avoidable hospitalizations amounted to $5,597,114,364 (or $5.6 billion).[16]

2. Opportunity costs

When it comes to hospitalizations, one area in which opportunity cost is apparent is with lost wages. When individuals are in the hospital, they are unable to work and thus lose out on the ability to receive income from their jobs. That said, this is a relatively low cost for the dual

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[10] Walsh et al. "Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and CommunityBased Services Waiver Programs" *RTI International,* August 2010

[11] ibid

[12] Segal, M., Rollins, E., Hodges, K., Roozeboom, M. "Medicare-Medicaid eligible beneficiaries and potentially avoidable hospitalizations." *Medicare Medicaid Research Review*, January 2014

[13] Segal, M. "Dual Eligible Beneficiaries and Potentially Avoidable Hospitalizations." *Centers for Medicare and Medicaid Services*, September 2011

[14] Walsh et al. "Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and CommunityBased Services Waiver Programs" *RTI International,* August 2010

[15] ibid

[16] ibid

eligible population. Due to Medicare and Medicaid eligibility requirements, dual eligibles consist of older beneficiaries who are nearing the end of life or younger beneficiaries with sustained need for functional support. In other words, dual eligibles are lower-income and require support either due to their age or because they have a disability, both of which contribute to them being less likely to hold jobs in the first place. Opportunity costs of dual eligible hospitalizations also exist when hospitals are unable to provide to other patients due to their need to take care of dual eligibles. When ambulances and primary care physicians are forced to care for dual eligibles, these healthcare providers have less time to focus on other patients. Avoidable hospitalizations only exacerbate this problem. Furthermore, dual eligible care does not provide the hospital much money; hospitals are reimbursed for their care given to dual eligible beneficiaries from their partnerships with Medicare through the federal government and Medicaid through their state government. In 2020, hospitals received payment of only 84 cents for every dollar spent for Medicare patients. For Medicaid, hospitals received of 88 cents for every dollar spent.[20]

3. Externalities

One externality of hospitalizations are the negative environmental effects that come with hospitalizations. America's healthcare system accounts for 8% of the country's total greenhouse gas emissions.[21] In 2018, the U.S healthcare system emitted 1,692 kilograms of greenhouse gasses per capita.[22] The CMS calculated that in 2005, there were 699,818 total preventable hospitalizations for dual eligibles. This means that preventable hospitalizations for dual eligibles contributed to 1.84 billion kilograms of GHGs (1,692•699,818). Assuming the cost of $51 per ton of CO2, and with 1.84 billion kilograms being equal to 1.84 million metric tons, the total cost of CO2 emitted from preventable hospitalizations amounts to roughly $94 million. This is a conservative estimate of the true cost of CO2 emissions from potentially avoidable hospitalizations as the calculations assume CO2 was the sole greenhouse gas emitted. At $51 per ton, CO2 is one of the least expensive GHGs, far less than nitrous oxide ($18,000) or methane ($1,500).

Breaking Down Costs

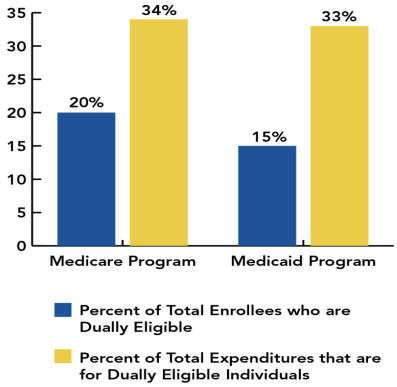
Dual eligible population share vs spending for Medicare and Medicaid

Due to their poorer health status and greater healthcare service needs, dual eligibles are the most expensive population receiving benefits from Medicare and Medicaid.[23] As seen in Figure 1, while dual eligibles account for 20% of Medicare enrollees, they consume 34% of the total Medicare program spending. This amounts to $187 billion in Medicare expenditures for dual

[20] "Underpayment by Medicare and Medicaid Fact Sheet," *American Hospital Association*, February 2022
[21] Shelton, Jim. "U.S. health care emissions continue to rise." *YaleNews*, December 7, 2020
[22] Eckelman et al. "Health Care Pollution and Public Health Damage in The United States: An Update" *Health Affairs*, December 2020
[23] Davenport, Karen., Markus Hodin, Renée., Feder, Judy. "The 'Dual Eligible' Opportunity; Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid." *Center for American Progress*, December 2010

eligibles. Similarly, while this population accounts for 15% of Medicaid enrollees, they consume 33% of the program's total spending.[24] This amounts to $119 billion in Medicaid expenditures for dual eligibles.

Figure 1: Dual Eligible Population and Expenditure Share in Medicare and Medicare[25]
Centers for Medicare & Medicaid Services | Medicare-Medicaid Coordination Office



Who is contributing most to these costs?

To better understand the breakdown of spending done by the federal government and states on dual eligibles, it is important to recognize who the major contributors to program expenditures are. The subset of the dual eligible population that contributes to most government expenditures are dually enrolled beneficiaries receiving long-term care services in nursing facilities or as enrollees in Medicaid home and community-based services (HCBS) waiver programs for the aged or disabled, or those receiving post-acute care in skilled nursing facilities. High spending for this subset population is due to particularly high preventable hospitalization rates found with HCBS waiver programs enrollees as well as those receiving post-acute care. The average Medicare hospitalization cost for potentially avoidable hospitalizations within this subgroup was $7,846, and the average Medicaid cost was $321(total = $8,167). There are roughly 12.2 million dual eligible beneficiaries right now, and this subset amounts to 1,571,920 individuals. Out of the aforementioned subset of dual eligibles, 382,846 of these individuals experienced potentially avoidable hospitalizations in 2005. This means roughly 1 in every 4 individuals in this subset received a potential avoidable hospitalization in 2005 (382,846/1,571,920 = 24%). This amounted to $3.127 billion in total hospitalization costs for potentially avoidable hospitalizations for this group. This group accounts for 13% of dual eligibles (1.57/12.2) but contributes to 56% of total hospitalizations costs of dual eligibles (3.127/5.6).[26]

[24] "Medicare-Medicaid Enrollee Information National." *Centers for Medicare & Medicaid Services | Medicare-Medicaid Coordination Office*, 2012
[25] ibid
[26] Walsh et al. "Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and CommunityBased Services Waiver Programs" *RTI International,* August 2010

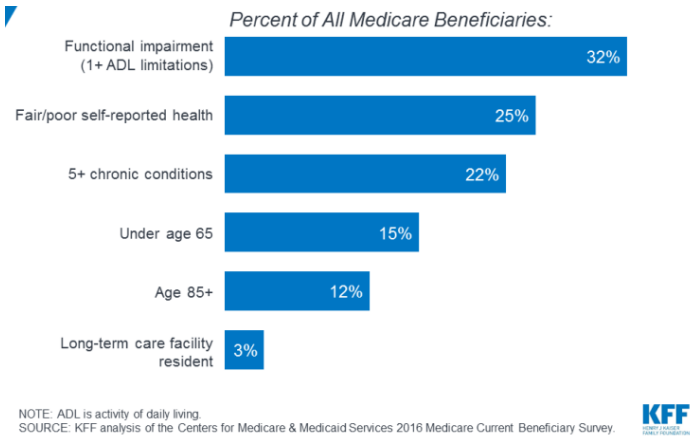
Two Programs, Two Levels of Government

Many of the shortcomings with care-delivery for the dual eligible population can be traced to the difficulties of managing and delivering care for one population between two separate government programs, one federal and on state-led.

Medicare

Medicare, which began in the United States in 1965, provides health insurance for all Americans over the age of 65 regardless of income, medical history, or health status. In 1972, the program was expanded to include coverage for some younger individuals who are disabled. Characteristics of the Medicare population can be seen in the Figure 2 below.[27]

Figure 2: Characteristics of Medicare Beneficiaries
Kaiser Family Foundation



Medicare is currently responsible for providing health insurance to over 60 million Americas. The size of Medicare coverage results in the program accounting for roughly 15% of total federal spending and 20% of total national health spending. Though Medicare is run by the federal government, their primary role in managing the program is to write reimbursement checks to providers for healthcare services. In other words, there is no on-the-ground administration of Medicare conducted by the federal government.

Medicare consists of four parts; Part A, hospital insurance; Part B, medical insurance; Part C, Medicare-approved private insurance; and Part D, prescription drug benefits. Medicare Part C, also referred to as Medicare Advantage, allows beneficiaries to enroll in private plans that provide coverage of for hospital insurance (Part A) and medical insurance (Part B), as well as some prescription drug benefits (Part D). From 2006 to 2018, dual eligible enrollment in Medicare Advantage plans increased from 12% to 37%. Medicare-only enrollment has increased during this time as well.[28]

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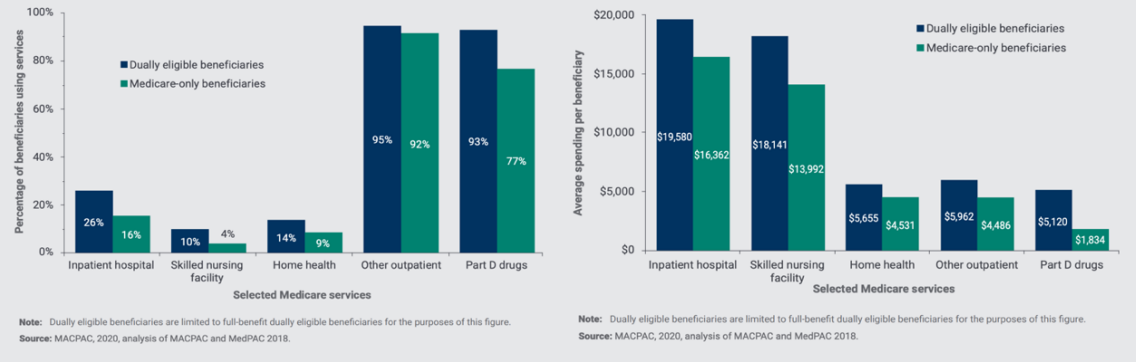
[27] "An Overview of Medicare." *Kaiser Family Foundation*, Feb 13, 2019
[28] "June 2020 Report to Congress on Medicaid and CHIP, Integrating Care for Dually Eligible Beneficiaries: Background and Context." *MACPAC*, June 2020

Dual eligibles use Medicare as the primary payer for primary care, preventative care, inpatient and outpatient acute care, post-acute skilled care, and most prescription drugs. Dual eligible beneficiaries are more likely than their Medicare-only counterparts to use services related to inpatient hospitalizations, skilled nursing facilities, home health, and part D drugs. Though inpatient hospitalization and skilled nursing facility services account for two of the three least used aforementioned services, they account for the greatest costs. Figures 3 & 4 demonstrate how these services are responsible for over triple the cost of the next most expensive service.

Figures 3 & 4: Percentage and average spending for Fee-for-Service Medicare Services for dual eligibles and Medicare-only beneficiaries

MACPAC



Medicaid

Enacted in 1965 alongside Medicare, Medicaid is administered by state governments and covers health insurance costs for Americans with low incomes. While the federal government's role in Medicare primarily revolves around check-writing, state governments possess a much more hands-on role in Medicaid deliver in their states involving on the ground management. In order to qualify for Medicaid, the Affordable Care Act states that an individual must fall within 138% of the federal poverty line. As a result of both the low-income qualification for Medicaid as well as the number of individuals enrolled in the program, Medicaid has become the largest source of funding for health-related services for low-income Americans. Medicaid is the secondary payer for dual eligible care, contributing to cost sharing and covering services not covered by Medicare, as well as helping with Medicare premiums.

In addition to differences in qualification between Medicare and Medicaid (age vs. income), it is important to note that Medicaid grants states the leeway for administering their state's Medicaid program in whatever manner they see fit. While federal guidance and regulations do exist for all Medicaid programs, states differ when it comes to their Medicaid eligibility standards, services covered, and reimbursement rates for physicians and care providers. As policymakers are tasked with determining delivery, funding, and eligibility standards, differences across states in how Medicaid is administered can be heavily influenced by differences in political ideologies. States are also free to not participate in Medicaid at all, though this is not an option currently explored by any states.

Though Medicaid is heavily influenced by state policy, federal funding is still a key component. The share of Medicaid expenditures that the federal government covers is referred to as the federal medical assistance percentage (FMAP). What is left after the FMAP is the state share. The FMAP is influenced by the amount states spend that qualifies as matchable under Medicaid and the FMAP, as well as by the average per capita income for each state relative to the national average. By law, the FMAP cannot be less than 50%.[30]

[30] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." *Kaiser Family Foundation,* 2022

Current Landscape for Dual Eligible Care

Dual Eligible Special Needs Plans (D-SNPs)

In 2003 Congress passed a bill to establish Special Needs Plans (SNPs) to administer healthcare to individuals with specific diseases or characteristics. To best deliver care to the dual eligible population, Dual Eligible Special Needs Plans (D-SNPs) were developed to include only individuals who were eligible for both Medicare and Medicaid.[33] In 2010, the Affordable Care Act authorized Fully Integrated D-SNPs. These plans are required to contract with states to better coordinate Medicaid benefits for dual eligible beneficiaries and to combine Medicare and Medicaid payments from beneficiaries under one budget. This budget is then controlled by a designated managed care organization.[34] Over 20% of dual eligibles are enrolled in a Dual Eligible Special Needs Plan (D-SNP) and these programs have demonstrated success with beneficiary outcomes. One study of a Fully Integrated Dual Eligible SNPs found the integrated programs had decreased the number of hospitalizations and emergency department use by Minnesota beneficiaries. This was also found to be the case in Oregon.[35] Recent changes to federal regulation, stemming the Bipartisan Budget Act of 2018, have further granted flexibility and support to D-SNPs. These reforms continue to make D-SNPs an attractive alternative for states seeking to better integrate care for their dual eligible population.

How the Affordable Care Act granted states flexibility

In response to inefficiencies of integrating care for Medicare-Medicaid eligibles, the Affordable Care Act offered states the opportunity to experiment with different approaches to care delivery, payment strategies, and incentives for both Medicare and Medicaid. One approach that states had the option of choosing was to assume the complete task of managing health care for dual eligibles, both financially as well as from a care delivery standpoint.[36] This contrasts with the current practice of administering dual eligible care through complex coordination or the lack thereof, between Medicare and Medicaid, the Affordable Care Act also allowed for states to amend their current payment structures. By granting states the opportunity to explore new arrangements when it came to health care payments for healthcare providers, institutions, and state governments, the Act attempted to create an environment where best practices could be monitored and expanded.[37]

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[33] Archibald et al. "Integrating Care through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges." *Office of the Assistant Secretary for Planning and* Evaluation, April 7, 2019

[34] Elmaleh-Sachs, Arielle & Schneider, Eric C. "Coordinating Medicare and Medicaid for Patients with the Greatest Health Needs." *The Commonwealth Fund*, June 2, 2020

[35] ibid

[36] Davenport, Karen., Markus Hodin, Renée., Feder, Judy. "The 'Dual Eligible' Opportunity; Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid." *Center for American Progress*, December 2010

[37] ibid

Delivery System

The majority of dual eligibles receive their care through a fee-for-service system. This means that each service a beneficiary receives, they must pay a specified fee. Beneficiaries can receive care so long as their provider has agreed to the type of coverage.[38] Though fee-for-services remains the most popular care delivery system for dual eligibles, with roughly 63% of dual eligible receiving care this way, managed care has grown popular. Managed care refers to health plans where the beneficiary pays a capitated amount for the services they receive. Dual eligible can be a part of a fee-for-service plans, a managed care plans, or enrolled in one for Medicare and another of Medicaid. In addition to the popularity of managed care plans, there has recently been a push within Medicaid towards value-based care.

Recent developments with Medicare-Medicaid policy have allowed for Accountable Care Organizations to provide access for duals. An ACO consists of a group of providers, including hospitals, physicians, and other care suppliers, who come together to provide car for a qualified individual. ACOs have their own measure of quality of care and are just one example of a comprehensive entity that acts as a delivery system of care. ACOs is one example of a growing shift towards value care by incentivizing providers to improve the quality of their care at lowers costs. This shift has increasingly come to incorporate bundle payments. Bundle payments create a target payment amount for a patient's care for any given episode, and providers have a share in either the losses or the savings if there is a difference between actual cost and this predetermined amount. These alternative payment models are a new incentive introduced through recent Medicare amendments which seek to push providers away traditional fee-for-service and towards value care. Unlike fee-for-service, ACOs have quality measures to help ensure providers are delivering the best possible care to their patients.

Regulations and guidance from Health and Human Services

The federal agency responsible for administering Medicare, as well as working with the states to administer Medicaid, is The Centers for Medicare & Medicaid Services (CMS). Originally named the Health Care Finance Administration (HCFA), CMS has become responsible for implementing laws passed by Congress related to Medicare and Medicaid, among other health-related programs. This requires CMS to ensure Medicare and Medicaid beneficiaries are aware of the services for which they are eligible to receive, as well as to enforce legislation related to standards of care for health care services providers authorized by both programs. Though much of the work CMS does is bound by federal and state legislation, CMS must also execute sub-regulatory guidance to address policy issues as well as operational updates and technical clarifications to existing rules and regulations. These subjective interpretations are influenced by administrative control and can impact how interpretive rules and policy statements are operationalized on the ground. As a bureaucratic agency, the Centers for Medicare & Medicaid Services also establishes several regulations to solidify or modify the way in which they administer their programs. The process of implementing these regulations, which eventually

[38] "June 2020 Report to Congress on Medicaid and CHIP, Integrating Care for Dually Eligible Beneficiaries: Background and Context." *MACPAC*, June 2020

impact providers of services for individuals enrolled in CMS programs, involves the proposal of a regulation, a period for public comment, and a review from the Government Accountability Office (GAO) as well as both houses of Congress.

In addition to their work with Medicare and Medicaid, CMS is also tasked with administering standards of care found within the Health Insurance Portability and Accountability Act (HIPA), as well as quality standards for long-term care facilities, both of which effect care-delivery for the dual eligible population. CMS is an operating division within the larger United States Department of Health and Human Services (HHS), and as such, the agency is responsible for adhering to the rules and regulations set in place by HHS. In terms of financial authority, The Centers for Medicare & Medicaid Services are responsible for a larger budget than any other agencies found with HHS.

Inefficiencies in coordinating care

It is important to understand that Medicare and Medicaid were created as two separate programs to serve two separate populations. Medicare was designed to assist the elderly while Medicaid targeted the poor. As a result, the overarching goals of each program, as well as the ways in which each program is administered, are different. When dual eligibles are enrolled in multiple plans that span across the two programs, those plans do not necessarily coordinate with each other. As a result, a lack of synergy between Medicare and Medicaid programs leads to worse health outcomes for the growing number of Americans who depend on both. Specifically, worse health outcomes for dual eligibles can stem from a lack of coordination between Medicare and Medicaid, differences in incentives for both payers and providers across the two programs, as well as general administrative inefficiencies.[39]

When a dual eligible beneficiary is looking to recover after a hospitalization, a breakdown in coordinated care between Medicare and Medicaid benefits can prevent that beneficiary from receiving the resources they need to best recover. This can happen when a Medicaid provider, such as a home and community-based service program, does not communicate with the hospital whose benefits were provided through a Medicare program.

Standards of care

In an attempt to increase state and federal interests in quality care for dual eligibles, the Affordable Care Act sought to identify key standardized measures for care. Though many quality measures do exist for either Medicare or Medicaid, few standardized measures have been implemented to specifically address the overlapping population of dual eligibles. Quality of care measures that do exist can be found within CMS requirements for Medicare Advantage Special Needs Plans. That said, many of these measurements are not designed to address healthcare delivery to the dual eligible population as a whole, but instead to either Medicare or Medicaid delivery or a specific subset of dual eligibles. Furthermore, standardized measures for dual eligibles fail to address the coordination of integrated care that Medicare-Medicaid beneficiaries require. Current considerations for evaluating integrated care approaches for dual eligibles

[39] Verma, Seema "Better Care for People Dually Eligible for Medicare and Medicaid." *Health Affairs*, April 24, 2019

include measuring quality of life, long-term services and supports, behavioral health, and coordination of care.

Quality of care

The current system of quality of care involves three measurable facets. The first set of measurements are structural measures which address a health care providers ability to provide high-quality care through the resources they possess. This often includes a health care provider's capacity, systems, and processes, and can be as specific as their ratio of providers to patients, the number or proportion of board-certified physicians, or whether they use electronic medical records or medication order entry systems. The second set of measurements are process measures. Process measures evaluate what a provider does to maintain or improve a patient's health. Process measures can include the percentage of people receiving preventive services, such as mammograms or immunizations, as well as the percentage of people with diabetes who had their blood sugar tested and controlled. The final measurable facet includes outcomes measures that are used to evaluate how care-delivery effects the health status of patients. As such, typical outcomes measures include surgical mortality rates or hospital-acquired infections. With outcomes measures, it is important to keep in mind that outcomes are heavily influenced by baseline health characteristics of patients that healthcare providers cannot control. As a result, risk-adjustment measures, though not a perfect science, attempt to control for baseline characteristics.

Policy Alternatives

Policy Option #1: Expanding PACE

PACE (Programs of All-Inclusive Care for the Elderly) are comprehensive medical and social service programs that allow for participants to age in their communities while still receiving the care they need. Rather than receive care in a nursing home or equivalent live-in facility, PACE participants are transported from their homes to program facilities where services include physician care, occupational and recreational therapies, meals, social work, prescription drug access, dental care, and more.[40] Due to the comprehensive services provided by PACE, participants are forced to change their existing provider relationships when they enroll. In order to qualify for PACE, a potential participant must be 55 or older, live in the service area of a PACE organization, be eligible for nursing home care, and be able to live safely in their community.[41] Due to these requirements, 90% of PACE participants are dually eligible for both Medicare and Medicaid.[42] In addition to Medicare and Medicaid being a source of funding, PACE programs are funded through capitation rates which their participants must pay. These rates vary among PACE programs and participants.

The history of PACE dates to the 1970s, and it is known as the first model of Medicare and Medicaid integrated services at that involves a center-based approach. As of January 2020, there are 132 PACE organizations across 31 states. PACE centers in the United States have a total enrollment of roughly 50,000 participants.[43] Though this amounts to relatively small sample size in comparison to the greater dual eligible population of 12.3 million Americans, PACE programs have demonstrated success with regards to dual eligible hospitalization rates in comparison to rates for non-PACE dual eligibles. Lower hospitalization rates for PACE enrollees are a product of numerous factors, a major one being that PACE programs do a better job at managing preventative care. PACE programs have the capacity to carry out preventative health campaigns they deem necessary to ensure their participants are safer and healthier, such as flu vaccination campaigns or fall prevention campaigns. These efforts work together to help keep enrollees out of hospitals. In addition, preventative measures can be used to address social determinants of health and ensure that participants are in a safe housing population. Lastly, PACE staff have the resources to constantly monitor their participants, from when a staff member helps a participant into the center transportation van in the morning to when that participant is dropped off safely that night. This constant monitoring ensures that any issues with participants are identified before they manifest in hospital-level care.

Policy Option #2: Aligning cost incentives

Another approach to decrease hospitalizations for America's dual eligible population would be to increase the cost responsibility assumed by states when it comes to acute health care and long-term care services for this population. The current misalignment of incentives which exists grants

[40] "Is PACE for you?" *The National Pace Association*, 2021
[41] "Program of All-Inclusive Care for the Elderly." *Medicaid.gov*
[42] "Medicaid Rate Setting for PACE." *National Pace Association*, February 2021
[43] Kruse, Alexandra & Herman Soper, Michelle. "State Efforts to Integrate Care for Dually Eligible Beneficiaries: 2020 Update." *Center for Health Care Strategies*, February 2020

each program the ability to shift liability from one program to the other."[44] This can be done through coverage interpretations and other strategies that avoid costs and lead to expensive and inefficient care. An example of misaligned cost incentives is that Medicare is currently responsible for paying inpatient hospital costs; in 2005, the total Medicare costs of potentially avoidable hospitalizations were $3 billion compared to $463 million for Medicaid.[45] This cost responsibility dynamic grants Medicaid programs few financial incentives to limit hospitalizations.[46] In exchange for increased Medicaid funding from the federal government this alternative ensures Medicaid will become responsible for an increased share of hospital costs. An increase in Medicaid funding will likely come from the Medicare budget, as Medicare's cost share for dual eligibles will likely decrease as a result of this policy. This would incentivize Medicaid programs to do what they can to eliminate potentially avoidable hospitalizations.

Policy Option #3: Coordinating dual eligible care under one program

As dual eligibles possess more complex clinical care needs than the only-Medicare or only-Medicaid beneficiary populations, they require heightened levels of care coordination for healthcare services and supports. This can be accomplished by integrating Medicare and Medicaid services for dual eligible beneficiaries into a single, policy coordination and program integration strategy. Though still within the scope of CMS's policy jurisdiction, this program would operate independently of Medicare and Medicaid, and will facilitate the delivery of care to dual eligibles and no one else. In order to ensure the standardization of best practices across the United States, as well as to solve issues of disparate dual eligible funding and health outcomes across states, this program will operate at the federal level. A federal program will also ensure take-up in all states. The program will require an expanded role of the federal government when it comes to dual eligible care delivery, bringing with it increased federal spending. To lessen the burden of federal expenditures, current funds that are used at the state level to cover costs for dual eligibles can be granted to this new program, as states will no longer be responsible for their dual eligible populations.

Policy Option #4: Status quo

Status quo policy addressing this issue involves the current complex coordination and administration of Medicare and Medicaid programs, specifically the overlap of care delivery between these two programs. Current dual eligible care primarily relies on fee-for-service models, where providers are reimbursed based on the number of services or procedures they provide. As a result, status quo care often incentivizes quantity of care, rather than quality. Though there has been little done to directly target the dual eligible population when it comes to health care delivery, there have been a few attempts at a state level. Many of these state

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[44] Davenport, Karen., Markus Hodin, Renée., Feder, Judy. "The 'Dual Eligible' Opportunity; Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid." *Center for American Progress*, December 2010

[45] Walsh et al. "Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and CommunityBased Services Waiver Programs" *RTI International,* August 2010

[46] Segal M. Dual Eligible Beneficiaries and Potentially Avoidable Hospitalizations. Washington, DC: Centers for Medicare and Medicaid Services, 2011.

demonstrations are made possible through flexibility of care delivery granted by the Affordable Care Act. While best practices have been publicized, there has been no trend of replication.

Criteria

Equity

Dual eligibles make up a particularly vulnerable population as they possess fewer financial resources and experience worse health outcomes. While there is a population of Medicare beneficiaries who would still be able to receive health services without Medicare assistance, this is not the case for Medicaid beneficiaries. The problems that Medicaid beneficiaries experience are exacerbated for dual eligibles as Medicare requirements for dual eligibles limits an already in-need Medicaid population to only those who are older than 65 or disabled. In terms of racial equity, dual eligibles are far more likely to be of a racial or ethnic minority group than Medicare only beneficiaries. In 2018, 47.5% of dual eligibles identified as a racial ethnic minority as compared to 21.1% for Medicare-only, and the share of minorities making up the dual eligible population continues to grow.[47]

Quality of life

This criterion will take into account the current quality-of-care metrics used by CMS and healthcare providers which assess how well dual eligibles are being care for. It is critical to evaluate all policy proposals with a quality-of-life metric as reducing hospitalizations does not necessarily translate to better quality of life. The easiest way to reduce hospitalizations would be to implement a policy limiting dual eligible hospital admissions either through a cap, tax, or other incentive. While this may cut costs, it does not translate to healthier outcomes. Limiting hospitalizations without accounting for quality of life will likely lead to a sicker dual eligible population.

Political feasibility

While evaluating how a policy addresses the issues of high dual eligible hospitalization rates, it is important to keep in mind that some policies have a higher likelihood of being signed into law than others. This criterion takes into account both state and federal political infrastructures, public opinions influencing legislators and the bureaucracy, and internal and external pressures that policymakers may face. This is important to consider as Medicaid is a state-run program while Medicare is federal. Key legislators can also be found within the House Ways & Means Committee's Subcommittee on Health, as they are tasked with handling legislation and oversight related to Medicare. Political feasibility will also incorporate the stance of the Biden administration on potential policy proposals.

Cost-effectiveness

Cost-effectiveness uses a baseline year of 2019 and a future projection toward 2029 to compare how policy rank against each other when it comes to their cost-effectiveness. Assuming a

[47] "Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019." *CMS Medicare-Medicaid Coordination Office (MMCO)*, November 2020

hospitalization cost of $7,998, this criterion looks at how much money will be saved or spent based on how a policy option impacts hospitlaization rates.

Methodology for cost-effectiveness

In order to weigh the aforementioned policy proposals against each other using cost-effectiveness, cost-estimates have been projected out over years 2019-2029. Using a base year of 2019, this ten-year period includes both the rollout of each policy as well as the operating costs and cost savings once the policy is fully phased in. These cost-effectiveness projections assume the current hospitalizations rate for dual eligibles remains the same if no changes are made, and total hospitalizations grow at the same rate as the dual eligible populations (annual percent growth rate: 5.0984%).

For policy proposals that require constant investment, such as expanding PACE or coordination dual eligible care under one program, it is assumed that all cost savings from reduced hospitalizations go directly back into implementing the proposed policy. This means that if $5 million are saved in the first year of expanding PACE, that money will go back into expanding PACE to further decrease hospitalizations. In other words, the net savings of these policy proposals will be zero.

Findings

Status quo

Status quo policy addressing this issue involves the current complex coordination and administration of Medicare and Medicaid programs, specifically the overlap of care delivery between these two programs. Current dual eligible care primarily relies on fee-for-service models, where providers are reimbursed based on the number of services or procedures they provide. As a result, status quo care often incentivizes quantity of care, rather than quality. Though there has been little done to directly target the dual eligible population when it comes to health care delivery, there have been a few attempts at a state level. Many of these state demonstrations are made possible through flexibility of care delivery granted by the Affordable Care Act. While best practices have been publicized, there has been no trend of replication. This has contributed to unfavorable results from both a quality and equity standpoint.

Poor landscape of care for dual eligibles

The current landscape of dual eligible care has failed to provide sufficient healthcare to dual eligible, with hospitalizations for this population reaching as high as 96.2% in some cases. This care consists of the overlap between Medicare and Medicaid, where Medicare is the primarily payer and Medicaid is the secondary payer for dual eligible care, contributing to cost sharing and covering services not covered by Medicare, as well as helping with Medicare premiums. Though the Affordable care act has granted states the opportunity to explore new arrangements when it came to health care payments for healthcare providers, institutions, and state governments, best practices have failed to be replicated to the extent that they can make a substantial difference in lower hospitalization rate for all dual eligibles. This has also been the case for Dual Eligible

Special Needs Plan (D-SNP), who cover roughly 20% of the dual eligible population.[48] While this policy option has failed dual eligibles when it comes to quality of life, it is important to note that it is the easiest policy to implement.

A lack of change is costly

Status quo policy would maintain that dual eligibles use Medicare as the primary payer for primary care, preventative care, inpatient and outpatient acute care, post-acute skilled care, and most prescription drugs, with the federal government continuing to act as checkwriters for Medicare beneficiaries receiving care. In 2019, combined Medicare and Medicaid spending for dually eligible beneficiaries totaled $440.2 billion.[49] With a total cost $312.4 billion in 2013, dual eligible expenditures have been growing a relatively steady rate of around 5.8% annually. If that dual eligible cost growth continues over the next 10 years, in 2029 costs will amount to $779.6 billion.[50]

Policy Option #1: Expanding PACE

PACE scores high with quality of life by bringing down hospitalization rates

PACE programs have demonstrated success with regards to lowering dual eligible hospitalization rates. The Massachusetts Division of Health Care Finance and Policy found that inpatient days, average length of stay, and outpatient emergency department visit rates were lower for PACE participants than for nursing home participants. PACE participants in Massachusetts also demonstrated lower rates of inpatient discharges, days, and emergency department visits than those who opted out of PACE.[51] The same findings were discovered in a study conducted on the dual eligible populations in Wisconsin[52] and New York City.[53] An analysis of PACE enrollees in comparison to dually eligible aged or disabled waiver (ADW) enrollees published in the Journal of the American Geriatrics Society found the following: 30-day readmission rates were 19.3% for PACE enrollees in comparison to 22.9% for the control group; potentially avoidable hospitalization rates were 100/1000 for PACE enrollees in comparison to 250/1000 for the control group; and hospitalization rates were 593/1000 for PACE enrollees in comparison to 962/1000 for the control group. The study also found variations in hospitalization rates among different PACE centers, demonstrating that changes to quality care practices across PACE programs can be made to further improve the positive effects PACE programs have on readmissions, hospitalization rates, and potentially avoidable hospitalizations.[54]

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[48] "CMS and Michigan Partner to Coordinate Care for Medicare-Medicaid Enrollees." *CMS.*gov, April 3, 2014

[49] "Beneficiaries Dually Eligible for Medicare and Medicaid" *Medicare Payment Advisory Commission & MACPAC*, February 2022

[50] $779.60 = 440.2(1 + 5.882/100)^{(10)}$

[51] "PACE Evaluation Summary." Executive Office of Elder Affairs, *Division of Health Care Finance and Policy*, August 2005

[52] Kane et al. "Variations on a Theme Called PACE." *The Journals of Gerontology: Series A*, July 2006, Pages 689–693

[53] Nadash, P. "Two models of managed long-term care: comparing PACE with a Medicaid-only plan. Gerontologist." October 2004

[54] Segelman et al. "Hospitalizations in the Program of All-Inclusive Care for the Elderly" J*ournal of the American Geriatrics Society,* January 13, 2014

PACE is cost-effective

With a hospitalization rate of 593/1000 for PACE participants compared to 962/1000 for non-PACE enrollees, PACE has demonstrated a 38% reduction in hospitalization rates for participants. With PACE programs imposing no extra costs to Medicare,[55] and with hospitalization being the most significant source of expenditures for dual eligibles it is reasonable to assume expanding PACE could cut slow dual eligible cost growth by 25%. With an annual growth rate of dual eligible expenditures closer to 4.4%, and a baseline 2019 dual eligible cost of $440.2 billion, total costs in 2029 for this policy option are projected to amount to approximately $677.10 billion.[56] That is a cost saving of 102.5 billion in by 2029 ($677.10 billion vs $779.6 billion).

Expanding PACE may lack political feasibility

Current lack of PACE implementation is indicative of the greater lack of support by legislators for these types of healthcare services targeting the dual eligible population. Opposition will also arise from the existing healthcare provider infrastructure and will depend heavily on policymakers' stances on PACE on a per-state basis. This policy proposal will also rely heavily on the existing relationship between CMS and PACE, a relationship which has historically been inefficient. PACE center investment requires a long regularly approval process, including a 3-year audit process by CMS. CMS also has the ability to halt PACE enrollment whenever they decide financial requirements or operational procedures of a program do not meet their standards. This has become a frequent occurrence. In a system where participants are lost at a high rate due to death, halted enrollment can be detrimental. Lastly, PACE has designated service areas which do not allow for multiple providers to operate in the same area, further limiting growth.

PACE struggles to ensure equity

There are several factors that contribute to lack of PACE enrollment. To begin, many do not know what PACE is. It is important to keep in mind that elderly individuals are resistant to change, a contributing factor to why once a potential participant is made aware of PACE, they remain hesitant to leave their primary care physician despite the fact that a PACE medical staff is able to provide its participants with more personalized attention than what they would receive outside of PACE. It is also possible that potential participants do not live in a designate service area, or if they do, they believe the commute to the PACE site is too far. Lastly, alternative care, such as home waiver programs that many states are pushing on their elderly, are an attractive alternative to PACE as these programs are often cheaper.

The reality that PACE programs require enrollees to change their existing provider relationships can be unattractive to potential participants. Changes to existing provider relationships can be detrimental to potential enrollees, as existing providers often have a better understanding of their

[55] Leavitt, M. "Interim report to Congress; The quality and cost of the Program of All-Inclusive Care for the Elderly." Secretary of Health and Human Services, 2009

[56] $677.10 = 440.2(1 + 4.4/100)^{(10)}$

patients' health history and needs.[59] Requiring enrollees to change existing provider relations may also lead to a selection bias which must be considered when analyzing PACE program success. Because individuals who are less healthy may be less inclined to switch away from their current provider who is treating whatever illness they may have, it is possible the PACE population is healthier than the non-PACE population they are being compared to.

Policy Option #2: Aligning cost incentives

Aligning costs saves money

Aligning cost incentives would not be very costly as it targets existing inefficiencies with reimbursement structures and has the potential to save future costs if health outcomes for dual eligibles do improve. A study of the results of Medicare-Medicaid cost incentive alignment found an average hospitalization rate in Massachusetts to be 17.05% lower than for the control group. A study of the same demonstration in Washington demonstrated a 15.82% reduction.[61] With roughly a 16.5% hospitalization rate reduction, and with hospitalizations acting as the major source of expenditures for dual eligible, we can assume a 10% reduction to current dual eligible cost trends. If the annual cost growth rate for dual eligible expenditures is closer to 5.3% as opposed to 5.8%, and a baseline 2019 dual eligible cost of $440.2 billion, total costs in 2029 are projected to amount to roughly $737.79 billion.[62] That is a cost saving of $41.81 billion in by 2029 ($737.79 billion vs $779.6 billion).

Struggles with political feasibility

Though no state has implemented this alternative, it is currently an option being considered by Vermont.[63] CMS's State Demonstrations to Integrate Care for Dual Eligible Individuals initiative has granted funding for 15 states to design similar integrated programs for dual eligible beneficiaries, and some of those states are exploring programs in which the state would manage the Medicare funds.[64] Furthermore, increasing the Medicaid cost-share will likely receive pushback from states as it increases financial risk for states as they become more responsible for the costs of their dual eligible populations.

Limited impact on quality of life

Although integrating Medicare and Medicaid financing can facilitate a high level of coordination between the programs, financing changes alone do not guarantee parallel changes in health care delivery and other key characteristics of effective integration, such as health outcomes.

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[59] Davenport, Karen., Markus Hodin, Renée., Feder, Judy. "The 'Dual Eligible' Opportunity; Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid." *Center for American Progress*, December 2010

[61] "Financial Alignment Extension Opportunity Memorandum." *Centers for Medicare & Medicaid Services*, January 19, 2017

[62] $737.79 = 440.2(1 + 5.3/100)^{(10)}$

[63] "Report to the Congress: Medicare and the health care delivery system." *Medicare Payment Advisory Commission*, June 2011

[64] ibid

Policy Option #3: Coordinating dual eligible care under one program

A proposal to create either a state-run or federal program to address issues specific to dual eligibles, such as potentially avoidable hospitalizations, has been explored by health reform legislation in the past. As a result of the Affordable Care Act, states were given the option to take this approach. The ACA allowed states to "assume full financial and programmatic responsibility for managing the health care of dual eligibles."[65] This contrasts with current dual eligible care coordination which requires financial costs and management challenges to be shared by two programs, with one program managed by the states, one by the federal government, and each with different coverage and payment parameters.[66] In many states, "aligned plans" are used to better coordinate benefits and care delivery for individuals seeking benefits from both Medicare and Medicaid.[67] These private plans, provided by either the same or similar companies, are a healthy starting point for a managed care organization tasked with delivering care to the dual eligible population.

Improvements to quality of life

An analysis of Wisconsin's state demonstration to integrate care for dual eligibles found that an integrated care strategy was able to reduce enrollee use of hospital services as well as redirect long term services and supports use from nursing facilities to home and community-based care.[68] Efforts to better coordinate Medicare care coordination have also been promising. In a study of 11 demonstration programs, researchers found that among a high-risk subgroup of Medicare FFS enrollees, four of the programs each had significant reductions in hospitalizations of about 15 per 100 patients. This amounted to a reduction rate of roughly 11%.

Coordinating care under one program is costly

In 2018, total expenditures on a demonstration which coordinated care for dual eligible population in Michigan amounted to $7.89 billion. This demonstrates significant increases to costs that result from coordinating dual eligible care under one program.[69] This policy option will likely increase expenditures from a current annual cost growth rate of 5.8% to closer to 10%. Beginning with a 2019 expenditure amount of $440.2 billion, a 10% annual cost increase would result in $1.142trillion spent on dual eligible by 2029.[70] This is a $362.17 billion cost increase from current projections ($1.142 trillion vs $779.6 billion)

Coordinating dual eligible care lacks political feasibility

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[65] Davenport, Karen., Markus Hodin, Renée., Feder, Judy. "The 'Dual Eligible' Opportunity; Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid." *Center for American Progress*, December 2010

[66] ibid

[67] "Medicare and Medicaid: Alignment of Managed Care Plans for Dual-Eligible Beneficiaries." *U.S. Government Accountability Office*, March 13, 2020

[68] "State Demonstrations to Integrate Care for Dual Eligible Individuals Design Contracts Summary of State's Initial Design Concepts" *Centers for Medicare & Medicaid Services*, May 2011

[69] "CMS and Michigan Partner to Coordinate Care for Medicare-Medicaid Enrollees." *CMS.*gov, April 3, 2014

[70] $1{,}142 = 440.2(1 + 10/100)^{(10)}$

One potential consequence of this alternative is that states could potentially respond by making it easier for their residents to qualify as dual eligible so that the federal government will then become tasked with care provision for those residents. Furthermore, establishing a new, federal program to handle all things dual eligible lacks political feasibility. Difficulties will also arise due to differences in providers across state levels.

Outcomes

Figure 5: Outcomes Matrix

*Scale: 1-3 (3 being best)	Equity	Quality of life	Political feasibility	*Cost effectiveness	Total (out of 12)
Expanding PACE	**2**	**3**	**2**	**$677.10 billion 2**	**9**
Aligning cost incentives	**2**	**2**	**1**	**$737.79 billion 3**	**8**
Coordinating dual eligible care under one program	**3**	**3**	**1**	**$1.142 trillion 1**	**8**
Status quo	**2**	**1**	**3**	**$779.6 billion 1**	**8**

Recommendation and Implementation

Policy Option #1: Expanding PACE

Due to its ability to provide better health outcomes for the dual eligible population while controlling government expenditures, expanding PACE is the best policy alternative to address the growing problem of dual eligible hospitalizations in the United States. PACE programs continue to demonstrate proven success when it comes to hospitalization rates and cost savings, and though these effects have only been seen on a small scale, PACE has the capacity to produce far larger effects should the government choose to invest in this model.

Why hasn't PACE already been expanded?
Limited PACE expansion is a result of several factors currently experienced existing PACE providers as well as programs seeking entry into this market. To begin, PACE operates within a complex regulatory environment. PACE providers are required to sign agreements between themselves and CMS, as well as between themselves and the state in which they operate. Investors in PACE programs also experience the high upfront costs PACE centers bear. Upfront costs include the construction of the program centers, establishing care teams for the centers, and acquiring the information systems necessary to run the centers. Further operating costs are

imposed as PACE programs must deal with the reality that initial enrollees are typically the least expensive participants. This means that that the more enrollees a center adds, the higher their costs will be. These costs have the ability to limit financial investment, especially from the non-profit organizations who lack capital. This issue is particularly pertinent as non-profits make up the majority of PACE sponsors.[75]

Subsidies

In order to address high barriers to entry for PACE programs so to increase their presence United States, the Centers for Medicare and Medicaid Services (CMS) must extend financial aid in the form of subsides that amount to 30% of all upfront costs for a given PACE program. In exchange, PACE programs must pay CMS back that amount with an agreed upon interest rate over the first 7 operating years of the PACE site.

CMS-PACE collaboration

Implementation of this policy alternative will rely heavily upon the existing PACE-CMS infrastructure. PACE programs are already required to sign an agreement between themselves and CMS, as well as be subject to extensive audits from the CMS. This subsidy agreement will now become a part of that larger PACE-CMS agreement and relationship. In addition to PACE expansion from a provider perspective due to subsidized upfront costs, CMS will also be incentivized through this agreement to work with PACE programs to ensure they remain in operation. This is not currently the case, as CMS is quick to halt PACE enrollment from centers who do not pass their frequent, in-depth audits, a regulatory act that has proven detrimental to PACE growth. Instead of halting enrollment, CMS will now seek to work through these processes alongside new and existing PACE programs. In order to do so, CMS will have to increase its administrative capacity. The operation funds CMS will receive from PACE programs can help contribute to future administrative costs.

Improved guidance from CMS

The existing relationship between CMS and PACE consists of little guidance from CMS. This limits the capacity for shared learning and progress for both groups. Due to the current regulatory environment of Medicaid, states and individual programs bare nearly all the burden when it comes to planning for new PACE centers, finding enrollees, receiving reimbursement for Medicaid, and many of the other difficulties of planning and operating a PACE center. By increasing CMS' role in PACE, it will reshape the regulatory infrastructure which has led to PACE being a relatively uncommon service across the United States.

Informational campaign

In order to increase PACE enrollment, CMS must work with PACE programs to address the information barriers that currently limit enrollment from a potential participant perspective. Publicized efforts to expand PACE programs will educate potential participants on what the PACE model is, as many are unfamiliar. In addition, an information campaign must target potential participants concerned with switching away from their existing provider relationships. These potential PACE participants must be provided with information outlining the proven health benefits of PACE as well as the health services their center would provide and any

[75] "CMS and Michigan Partner to Coordinate Care for Medicare-Medicaid Enrollees." *CMS.*gov, April 3, 2014

additional information concerning their potential PACE care team. This will also help address the issue of low health literacy that is common among dual eligibles.[76]

Evaluating success

To continue to evaluate the success of PACE programs, it will be important to use the current system of quality of care. PACE expansion is a deserving policy proposal due to PACE's high scores with process measures, or criteria used to evaluate what a provider does to maintain or improve a patient's health. Process measures can include the percentage of people receiving preventive services, such as mammograms or immunizations, as well as the percentage of people with diabetes who had their blood sugar tested and controlled. PACE programs are successful in providing preventative care to their participants. While process measures evaluate providers and their services, outcomes measurements can be used to evaluate how care-delivery effects the health status of participants in PACE programs.

Though PACE does a good job targeting the dual eligible population, it is important to keep in mind that 10% of the participants enrolled in PACE are not dual eligibles.[77] That said, it is unfair to say these individuals are not deserving of PACE services, and while government expenditures on dual eligibles will likely be higher due to the cost incurred from these individuals, expenditures will still be contributing to overall better health outcomes for all Americans.

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